ARE EMERGENCY DEPARTMENTS THE BEST PLACE TO CARE FOR PSYCHIATRIC PATIENTS IN CRISIS?

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Objectives

- Objective 1: Identify at least 2 strategies in which the psychiatric mental health nurse can implement psychiatric standardized treatment protocol to collaborate with the emergency care nurse in order to bridge crisis stabilization with crisis management.
- Objective 2: Articulate the program evaluation metrics related to a psychiatric emergency stabilization and crisis management program based in the Emergency Department.
- Objective 3: Distinguish the unique and complimentary roles that psychiatric and emergency nurses have in providing emergency stabilization and crisis management.

Conflict of Interest

- Speakers have no conflict of interest to disclose.

St. Joseph Hospital Orange, CA

- 463 Licensed beds
  - Paramedic receiving
  - Chest pain
  - Stroke
- Employees - 3,100
  Physicians on staff - 971
  Volunteers – 80
- Magnet Nursing Facility
- ED visits
  - 8,600 per month

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Background

- Decrease in psychiatric inpatient/outpatient services results in greater use & longer stays in emergency departments (ED) (Owens, Mutter, Stocks, 2010).
- Psychiatric complaints are a component of 1 of every 8 ED visits (National Center of Health Statistics, 2012; Owens et al., 2010).
- Elopement associated with increased risk of suicide &/or self-harm (Barr, 2005).

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Safety Concerns

- ENAs - Emergency Department Violence Surveillance Study found more than half (54.8 percent) surveyed experience physical or verbal abuse at work in the last seven days (Emergency Nurses Association (ENA) , 2012; ENA, 2010)
- Every week, between 8 and 13% of ER department nurses are victims of physical violence (2010)

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Impact on Behavioral Health Patients

- Isolation by ED staff may worsen psychiatric symptoms (Barr Gilbert, 2009)
- Staff attitudes – demeaning, judgmental, increasing stigma (Loucks et al., 2010)
- Patients experience restrictions, coercing, and unnecessary force (Nadler-Moodie, 2010)
- Some indicate inequitable care related to perception that BH patients are less ill & than medical patients (Winokur & Senteno, 2009; Wolf et al., 2015).

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Delayed Throughput

- Average LOS for psychiatric patients in the emergency setting is upwards of 15+ hours
- Overcrowding
- Decrease in bed turnover and lost revenue (Weiss, 2012)
- Restraints can add on an extra 4-6 hours longer
- Prolonged ED LOS associated with increased risk of symptom exacerbation and/or elopement (Weiss, 2012)

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Administrative Costs

- Average cost to board a psychiatric patient in ED is estimated at $2264 (Nicks & Manthey, 2012)
- Increase in security, sitter or nursing time (Weiss, 2012)
- Recruitment and retention problems
- Decrease in productivity and efficiency
- CMS and TJC quality standards and reporting requirements
- Risk management
- Patient legal challenges associated with restraint

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Hospital Focus

- Limited County Resources shifting responsibility to Emergency Departments
- Recruited a Manager with Psychiatric Nursing experience
  - UniHealth Grant
  - SB 82 Grant (California)
- Hospital-wide Evidence Based Practice Conference on Mental Health Oct. 2015
- Health System – Strategic Goal 2016 - 2017

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Specialized Training for ER Nurses

- Four hour training (2015)
  - Major diagnosis
  - Psychopharmacology
- Standardized Treatment Protocol rollout (2016)
  - 2-hour training along with self learning module
  - Major diagnosis – case studies
- Two hour training (2016)
  - Suicide risk assessment
- Ongoing pharmacology training by pharmacist
- All new hires receive concentrated training

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COMPLIMENTARY ROLES OF PSYCHIATRIC NURSES AND EMERGENCY NURSES

ED Nurses *Traditional*	BHS Nurses *Traditional*	SJO ECC ***Complimentary***
• **Medical Model** • Diagnosis • Emergent medication & acute symptom management • Maintain safety	• **Recovery model** • Provide therapeutic care • Acute psychiatric symptom management • Maintain safety	• **Medical & Recovery Models** • Rapid psychiatric stabilization • Patient & staff engagement • Maintain safety

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STANDARIZED TREATMENT PROTOCOL

Rapid Stabilization and Standardized Mental Health Care

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ANXIETY AGITATION SEVERITY SCALE

Assessment findings indicate patient is a candidate for early medication administration as part of stabilization treatment. Nurse completes the 17-item Agitation Severity Scale Decision Scoring Grid and selects the appropriate medication based on the scores

Agitation Severity Scale	Scoring	Criterion: Anxiety / Agitation		Results/Criterion		Action
Spitting	4		x	0-1	Anxiety	reassess per routine
Red in the Face	4		x	2-3	Anxiety	medicate mild anxiety
Darting Eyes	1	x		4+	Anxiety	medicate mod. anxiety
Yelling, louder than baseline	2		x			
Demanding	2		x	0-1	Agitation	reassess per routine
Speaking more quickly than baseline	1	x		2-3	Agitation	medicate mild agitation
Angry tone of voice	2		x	4+	Agitation	medicate mod. agitation
Persistent disruptive verbalizations	4		x			
Physical violence towards self or others	4		x			
Violating Self or Others	3		x			
"In your face"	3		x			
Decreased self-control, impulsiveness	4		x			
Puffed up, chest out, threatening posture	3		x			
Tapping, clenching, involuntary movement of hands	1	x				
Restless	1	x				
Confrontational	2		x			
Unable to be calmed	2	x				

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MILD ANXIETY Based on Anxiety/Agitation scale Anxiety Criterion Score of 2-3	MODERATE/SEVERE ANXIETY Based on Anxiety/Agitation scale Anxiety Criterion Score of 4 or greater
Give HydrOXYzine HCL (Atarax) UNLESS patient has allergy or adverse drug reactions to hydroxyzine or antihistamine (contact physician for alternative drug) Patient will not be given Atarax if any of the following Exclusion criteria conditions are present: 1) glaucoma,, 2) inability to void, 3) current constipation, 4) hypotension systolic less than 90mm Hg ***For patients > or = 65 years old, give order below*** HydrOXYzine HCL (Atarax) 25 mg Po x 1 dose. Repeat x 1 dose if patient still anxious 60 mins after initial dose. ***For patients < 65 years old, give order below*** HydrOXYzine HCL (Atarax) 50 mg Po x 1 dose. Repeat x 1 dose if patient still anxious 60 mins after initial dose.	Give HydrOXYzine HCL (Vistaril) UNLESS patient has allergy or adverse drug reactions to hydroxyzine or antihistamine (contact physician for alternative drug): Patient will not be given Vistaril if any of the following Exclusion criteria conditions are present: 1) glaucoma, 2) inability to void, 3) current constipation, 4) hypotension systolic less than 90mm Hg HydrOXYzine HCL (Vistaril) 25 mg IM x 1 dose. Repeat x 1 dose if patient still anxious 30 mins after initial dose.
MILD AGITATION Based on Anxiety/Agitation scale Agitation Criterion Score of 2-3	MODERATE/SEVERE AGITATION Based on Anxiety/Agitation scale Agitation Criterion Score of 4 or greater
Give Olanzapine (ZyPREXA) UNLESS patient has any of the following Exclusion criteria (contact physician for alternative drug) •Allergy or adverse drug reactions to olanzapine •Dementia diagnosis (black box warnings) •On IV/IM benzodiazepines (e.g., Ativan) and IM olanzapine (risks of additive adverse events) • hypotension systolic less than 90mm Hg ***For patients > or = 65 years old, give order below*** Olanzapine ODT (ZyPREXA Zydis) 5 mg Po Q 2 Hrs Prn agitation or psychosis. Not to exceed 20 mg/24 Hrs. If unable to take Po, give Olanzapine (ZyPREXA) 5 mg IM Q 2 Hrs Prn agitation or psychosis. Not to exceed 30 mg/24 Hrs. **For patients < 65 years old, give order below Olanzapine ODT (ZyPREXA Zydis) 10 mg Po Q 2 Hrs Prn agitation or psychosis. Not to exceed 40 mg/24 Hrs. If unable to take Po, give Olanzapine (ZyPREXA) 10 mg IM Q 2 Hrs Prn agitation or psychosis. Not to exceed 30 mg/24 Hrs.	Give Olanzapine (ZyPREXA) UNLESS patient has any of the following Exclusion criteria (contact physician for alternative drug) •Allergy or adverse drug reactions to olanzapine •Dementia diagnosis (black box warnings) •On IV/IM benzodiazepines (e.g., Ativan) and IM olanzapine (risks of additive adverse events) • hypotension systolic less than 90mm Hg ***For patients > or = 65 years old, give order below*** Olanzapine (ZyPREXA) 5 mg IM Q 2 Hrs Prn agitation or psychosis. Not to exceed 30 mg/24 Hrs. **For patients < 65 years old, give order below Olanzapine (ZyPREXA) 10 mg IM Q 2 Hrs Prn agitation or psychosis. Not to exceed 30 mg/24 Hrs.

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Staffing

- Department Managers (one RN-BC PMH)
- UniHealth & SB 82 Grant Funding
- Mental Health Triage Personnel
  - Psychiatrist
  - Psychologist
  - Psychiatric Nurse Practitioner
  - LSCW

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Metrics

- Reduce the number of restraint episodes
- Reduce the amount of time in restraints
- PRN medication within 15 minutes
- Community linkage
- Discharge Safety Plan and follow up call

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Restraint Metrix

2015

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
#s	36	41	28	32	20	14	14	5	13	16	18	12
Time in Restr.	4:21	4:46	5:11	4:01	3:51	3:05	2:07	6:06	2:30	2:09	3:14	2:28
Time 1st Med	48	36	48	38	29	24	18	24	19	14	16	16

2016

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
#s	21	22	24	18	21	17	11					
Time in Restr.	3:01	5:55	2:50	2:30	3:02	2:26	2:01					
Time 1st Med	16	23	27	10	10	12	14					

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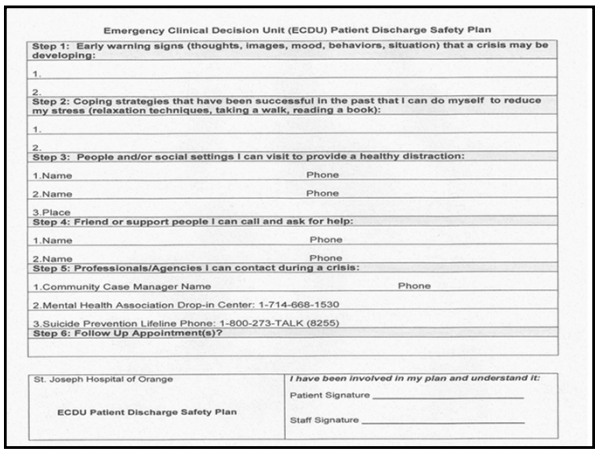

Emergency Clinical Decision Unit (ECDU) Patient Discharge Safety Plan

Step 1: Early warning signs (thoughts, images, mood, behaviors, situation) that a crisis may be developing:

1.

2.

Step 2: Coping strategies that have been successful in the past that I can do myself to reduce my stress (relaxation techniques, taking a walk, reading a book):

1.

2.

Step 3: People and/or social settings I can visit to provide a healthy distraction:

1.Name Phone

2.Name Phone

3.Place

Step 4: Friend or support people I can call and ask for help:

1.Name Phone

2.Name Phone

Step 5: Professionals/Agencies I can contact during a crisis:

1.Community Case Manager Name Phone

2.Mental Health Association Drop-in Center: 1-714-668-1530

3.Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Follow Up Appointment(s)?

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ECDU Patient Discharge Safety Plan

I have been involved in my plan and understand it:

Patient Signature _____

Staff Signature _____

Future

- Planning for dedicated Psychiatric Emergency Room
- Crisis Stabilization Unit

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