

Strategies for the Handling the Psychiatric Patient Population
Collaborative discussion facilitated by Stephen Schenkel, MD, MPP
July 2006

Many collaborative teams have noted that the increased numbers and disposition times for psychiatric patients are negatively affecting access to emergency medical care for all patients, causing longer wait times, limiting the availability of hospital staff and decreasing the number of available emergency department beds. While there is marked variability from hospital to hospital, many departments see and treat over a dozen psychiatric patients daily and may board up to a dozen for days at a time.

Despite the pressures, many departments in the collaborative have developed innovative ways to improve the care and safety of psychiatric patients. The collaborative team call held in July 2006 provided an opportunity to share these ideas. The conversation started with this question:

*What are some of the solutions you are using
for the psychiatric patient population?*

Representatives from ten hospitals took part in the conversation (*Atlantic General Hospital, Carroll Hospital Center, Harbor Hospital, Mercy Medical Center, Peninsula Regional Medical Center, Prince George Hospital Center, St. Joseph Medical Center, Shady Grove Adventist Hospital, Upper Chesapeake Health System.*) Below are notes on the conversation.

Strategies	Description
Inpatient Psychiatric Units	<ul style="list-style-type: none"> • A potential long-term solution, several departments have developed close relationships with their in-patient psychiatric units. While this may not decrease length of stay when the unit is full, it can improve access to psychiatric consultation and enhance teamwork across disciplines. • A team from the psychiatric inpatient unit may be available to perform a psychiatric evaluation and initiate definitive care.
Separate Emergency Department based areas or units for Psychiatric Patients	<ul style="list-style-type: none"> • Separately staffed 6 – 10 bed holding unit staffed with a nurse and technician, with an emergency physician overseeing the care of the patient. The major benefit is that psychiatric patients are removed from the distractions of the main ED. Factors such as ambulance traffic, continuous overhead paging, and constant communication over the police radios tend to escalate the patient’s behavior. • Emergency Physician provides ongoing care for the patients until a bed in an inpatient facility is available. • A partial solution with the same goals is to set up a “psychiatric area” or two or three rooms in a designated portion of the ED which are specifically intended for psychiatric emergencies. In one approach, a “pod” developed around four rooms supplied with cameras to assist in patient monitoring.

<p>Development of Formal Mental Health Care Teams</p>	<ul style="list-style-type: none"> • A Mental Health team is responsible for the care of the patient from initial evaluation to discharge, freeing the ED staff to care for other patients. An on-call psychiatrist is available. • Emergency Physicians perform the initial evaluation followed by a psychiatric counselor from the inpatient unit with a more in-depth evaluation.
<p>Availability of Psychiatric Consultation</p>	<ul style="list-style-type: none"> • There are many modules for psychiatric consultation. Many departments have organized 24 hour / 7 day availability, most typically of a psychiatric social worker. • In one model, the Emergency Physician performs the initial medical evaluation followed by the psychiatric social worker who is responsible for a mental health evaluation and discharge procedures if patient is being released. • On-call psychiatrist availability varies from none to 24 hours.
<p>The Certified or Suicidal Patient</p>	<p>A number of additional safety techniques were discussed with specific regard to the potentially suicidal patient.</p> <ul style="list-style-type: none"> • Several departments have availability of sitters in the emergency department. Others have recruited security for the monitoring of psychiatric patients. At least one department uses cameras to assist in monitoring. • Stripping the room of dangerous objects is harder or easier depending on whether it is a psychiatric room or a general emergency department bed. Note was made of the importance of clearing the room of objects that a patient might use to harm him or herself but that it is not as straightforward as it sounds. It is the job of the nurse and tech to ensure that the room is bare. • It is standard to remove patients belongings and place them in a gown.

<p>Holding Patients</p>	<p>After formal psychiatric evaluation, patients may be held for days. Mechanisms to improve care for these patients include:</p> <ul style="list-style-type: none"> • During high volume periods, nurses may be recruited from an inpatient psychiatric unit to add staff to the ED. While they cannot take over care of other ED patients, they can relieve ED nurses by taking over care of the psychiatric patients. • Holding orders may help maintain consistent care for the boarding patient. It also helps develop the idea that the boarding patient is now essentially an “inpatient” and requires regular evaluation and medication. This becomes most important when there are concurrent chronic medical concerns. • Encourage the initiation of psychiatric medications. This may mean re-starting the patient’s usual psychiatric medication regimen. At least one site has developed a protocol to validate medications with family or others. • Subtle designation of the patient as a boarding psychiatric patient may help staff keep the patient’s special needs in mind. Techniques include separately colored charts or armbands. • Frequent attending physician re-evaluation. Some sites require formal re-evaluation with documentation every shift. • Psychiatrist or psychiatric social worker re-evaluation every 24 hours.
-------------------------	--

A full transcript of this call is available on the collaborative portal. If you interested in learning more about any of the strategies described, we encourage using the discussion forum on the portal to pose questions to collaborative teams.

If you any questions regarding the Maryland Patient Safety Center Emergency Department Collaborative contact:

ZeAmma Walker
 Delmarva Foundation
 Project Manger
 410-712-7426
walkerz@dfmc.org

Stephen Schenkel, MD, MPP
 Mercy Medical Center
 Collaborative Chair
sschenkel@verizon.net