Beyond 5150: Pitfalls in the Care of the Psychiatric Patient

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Objectives

- Identify high risk psychiatric patients
  - Suicide
  - AMA
  - Elderly
  - Medical clearance
- Understand circumstances that increase risk
  - Injury potential
  - Elopement
- Employ techniques to reduce the risk

Case: Suicide

- A 24 year old male presents with not sleeping, cutting at his wrists and seeing shadows. The emergency physician stated the patient was feeling depressed.
- EP performs a medical clearance and leaves the rest of the evaluation to a mental health worker.
- The mental health worker patient was given the diagnosis of bipolar disorder and depressive disorder. The patient was sent home with a contract for safety and scheduled an appointment for intake in two months.
Who Does the Psychiatric Evaluation

- ED MD
- In-house psychiatry
- ED mental health worker
- Telepsychiatry
- Community mental health
- Contracted outside service

Formal Mental Status Examination

- Elements routinely assessed while interviewing pt
  - Appearance, behavior and attitude
  - Mood and affect
- Not routinely assessed while interviewing pt
  - Disorders of thought: Suicidal & homicidal ideation, ?admit
  - Insight and judgment: Knowledge about illness
  - Disorder of perception: Hallucinations & delusions
  - Sensorium and intelligence: Cognitive impairment, ?delirium

Suicide Assessment

- No perfect tool with scores
- Suicide Assessment
  - High – admit
  - Medium – consult psych
  - Low – home with follow up
- Use static and dynamic risk factors
- Good documentation
Dynamic Risk Factors for Suicide

- High risk suicide attempt
  - Use of highly lethal means (guns-hanging)
  - Planned and or rehearsed ahead of time
  - Efforts to not be discovered-going to remote site
  - Suicide note-putting affairs in order

- Moderate risk
  - Use of limited # of medications or substances of abuse
  - High likelihood of being discovered or calling for help
  - Suicide note overtly manipulative or designed to gain attention
  - Ambivalence about lack of success

- Low risk attempt (gesture)
  - Taking a small number of pills
  - Attempt in front of another person
  - Happy that the attempt was not successful or feels “stupid”

Staff Attitudes about Suicide

“Suicidal behavior appears to elicit mostly negative feelings among staff members…”

- If not acknowledged and properly handled...may lead to premature discharge.”
- “It is important task for staff members is to contain and work through negative feelings towards patients.”
- Key element influencing whether a patient commits suicide

Contracts for Safety

- Setting of pre-existing, deep, committed doctor patient relationship
  - Pros – deepen commitment, strengthen therapeutic alliance, facilitate communication, lower anxiety, document precautions
  - Cons – anger or inhibit client, introduce coercion, false sense of security
- Conclusion – “…Never enough to protect against legal liability and lead to adverse consequences for the clinician and the patient.”
Case: Suicide

- The patient was sent home with a contract for safety and scheduled an appointment for intake at community mental health clinic two months later.
- The patient returned to the ED 2 days later as DOA
- The corner reported the cause of death as asphyxia due to hanging with a clinical history of previous suicide ideation and drug and alcohol abuse.

What Went Wrong?

- Reliance on mental health worker
- Failure to diagnosis
- Failure to assess suicide risk
- Failure to take appropriate action
- Failure to refer to psychiatry
- Failure to obtain collateral information
- Failure to involve family
- Failure to provide a safety plan

Case: Protecting Patient and Staff

- The EP psychiatric patient screaming at the nurses in the ED states that she wants to leave. The patient is restrained supine by all four limbs. All of the psychiatric ED beds are full so the patient is placed in the procedure room.
- The patient is searched for weapons and allowed to keep her clothes on in order not to agitate her any further.
Suicide Completions in ED

- Since 1995, suicide has ranked in the top five by The Joint Commission.
- 8.02 percent of all inpatient suicides occur in the ED
- Hospitals must be diligent to identify building and environmental factors that can contribute to a patient's ability to commit suicide.
- The ED is responsible for the safety of the patients within the hospital confines.

Precautions

- Most suicides are hangings, jumping off the building, cutting with a sharp object or OD
- Look for materials that can be weaponized
- Remove nurse call system bell cords, bandages, sheets, restraint belts, plastic bags, elastic tubing and oxygen tubing.
- Remove medications, cleaning supplies and other chemical used in EDs
- Use metal detectors to screen all patients

Case: Protecting Patient and Staff

- The patient keeps screaming in the procedure room so that door is closed. The patient has her overalls on and able to get her lighter out of her upper pocket. She uses her lighter to start the curtains on fire. The curtain falls on her and lights her clothes on fire.
- She is found to have second and third degree burns over 43% of her body and smoke inhalation.
What Went Wrong

- Failure to search patient
- Failure to use proper space for patient care
- Failure to comply with one-to-one observation
- Failure to properly assess suicidal patient

Case: Elopement

23 year old newly diagnosed bipolar disorder patient is being transported to a psychiatric facility. While being transported to the ambulance, the patient run out of an exit door to the street. The ambulance attendants run after him.

Elopement of Psychiatric Patients

- Identify patients at high risk for elopement
  - Agitated
  - Schizophrenic
  - Bipolar
  - Involuntary admissions
- Ensure proper monitoring of patients
  - One to one observation
  - Video monitoring
  - Electronic or visual means
  - Cannot use seclusion or restrain for this purpose alone
  - Family members may assist but not responsible
Assessing Risk of Elopement
- Verbalizes desire to leave the hospital
- Past history of elopement
- History of substance use
- Leaving the unit without notifying the staff
- Patients with complex social situations

Steps to Prevent Elopement
- Room patient close to nursing station
- Perform routine risk assessment
- Request family member to stay with patient
- Use nursing to watch the patient
- Use automatic door locks, alarms, diversion activities

Elopement of Children
- Commonly seen in Autistic, Autistic spectrum, Asperger syndrome, mental retardation
- Does not understand risk of behaviors
- Older the child, the higher the risk
- Sitter or family usually necessary
Responding to Elopement: “Code Green”

- Notification of the operator of a Code Green/Elopement
- Notification of security with description of missing patient
- Immediate search of the unit and surrounding area by unit staff
- Notification of the patient’s physician

Case: Elopement

23 year old newly diagnosed bipolar disorder patient is being transported to a psychiatric facility. While being transported to the ambulance, the patient run out of an exit door to the street. The ambulance attendants run after him but he is much faster than they are. Patient is found hypothermic three days later sleeping in an alleyway between two building

What Went Wrong?

- Failure to initiate a system-wide search shortly after patient was noted to be missing
- Failure to follow hospital policy
- Failure to communicate event
- Lack of risk assessment and prevention measures
Case

- 86 year old female is brought by the family because their mom is not acting right. The patient states she feel fine and she is ready to go home. How to assess her competency?

Patient Wants to Leave AMA?

- Competent patients have the right to refuse treatment
  - Ensure current capacity
- Drug and/or alcohol use in itself is not criteria for treatment
- Presence of psychiatric illness is not defacto criteria for treatment
- Endangered third parties must be notified
- Get family involved in AMA process

Roberts, J: discharging psychiatric patients against medical advice. EMN August 2010

Short Tests


<table>
<thead>
<tr>
<th>Test</th>
<th># Items</th>
<th>Application Administered by</th>
<th>Time</th>
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<tr>
<td>Mini-Mental State Exam</td>
<td>30</td>
<td>clinical, screening</td>
<td>5-10</td>
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<tr>
<td>Clock Drawing Test</td>
<td>1</td>
<td>clinical, screening</td>
<td>self</td>
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<tr>
<td>Short Portable Mental Status Survey</td>
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<td>screening, Interviwer</td>
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<tr>
<td>Cognitive Capacity Screening Exam</td>
<td>10</td>
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**Clock Drawing Test**

- Preferred as a screening test
- Self-administered and takes a short time to complete.
- The Clock test is scored on a six point scale from no errors to no reasonable representation of a clock.
- Patients with a score of one or two are considered without impairment and those with three or greater have cognitive impairment.

**Case**

- 86 year old female is brought by the family because their mom is not acting right. The patient states she feel fine and she is ready to go home.
- Patient was sent home
- Patient returned to the ED the following day delirious.

**Medical Clearance Purpose**

- **Primary Purpose** - To determine whether a medical illness is causing or exacerbating the psychiatric condition.
- **Secondary Purpose** - To identify medical or surgical conditions incidental to the psychiatric problem that may need treatment.
Primary Purpose
Etiology
- Drug and alcohol intoxication or withdrawal
- Medical
  - Hypoglycemia
  - Hyperthyroidism
  - Delirium
  - Dementia
  - Head Trauma
  - Temporal Lobe Epilepsy
- Psychiatric

Primary Purpose - Differentiate Medical from Psychiatric Etiology
- History, physical exam, mental status examination, testing?
  - Obvious medical etiology
    - Exposure to toxins or drugs
    - Substance intoxication or withdrawal
    - No prior psychiatric history
    - Abnormal vital signs
    - Delirium
    - Cognitive deficits
    - Focal neurologic findings
  - Not so obvious
    - May need admission

Testing Approach to Geropsych Patients
- Clinically focused testing
  - Abnormality identified
- Most likely etiology:
  - Infectious - CBC, UA, CXR
  - Trauma - CT scan
  - Vascular - CT scan, coags
  - Substance use - CBC, lytes, liver enzymes
  - Metabolic/endocrine - lytes, thyroid, liver enzymes
  - Medication related - drug levels
Incidence of Mental Illness in Elderly

- 1004 patients screened
- 36% had no mental illness
- 50% >70 yrs old cognitive impairment
- 27% delirium
- 8-32% depressed
- 9% agitation
- 6% hallucinations

Mortality Rate of Delirium

- ED incidence 7-20%
- Frequently missed
- 24% maximum detection rate
- Due to lack of screening
- High rate of mortality
- 36% vs. 10%
- High rate of morbidity
- High rate of incontinence, decubitus, malnutrition

Tool to Detect Delirium

- 24 delirium scales found in literature
- CAM, CAM-ICU, DRS, MDAS, NEECHAM
- Confusion Assessment Method (CAM)
  - 4 questions – Need 1 & 2 and 3 or 4
    - (1) Acute onset and fluctuating course
    - (2) Inattentive
    - (3) Disorganized thinking
    - (4) Altered level of consciousness
  - Tested in ED
  - Commonly used with other tests - MMSE or RASS
  - 10 minutes to perform
Delirium Etiologies

Predisposing
- Comorbid illness-dementia
- Age and male gender
- Medications-polypharmacy, psychoactive & substance use
- Functional & sensory status
- Psychiatric

Precipitating
- Infections-pneumonia, UTI
- Endocrine/Metabolic-electrolytes, glucose, thyroid
- Medication-new meds, pain, substance use
- CNS events-CVA, SZ
- Cardiovascular-CHF, AMI, shock, resp failure
- Iatrogenic-surgeries, catheters, restraints

Common Disorders to Identify in the Elderly

- Dementia and Delirium – abnormal vital signs can be key
- Depression – may present with other symptoms
- Suicidalty – less likely to admit to their thoughts
- Psychosis – consider medication related
- Substance use disorders – high denial rate

Case

- 86 year old female is brought by the family because their mom is not acting right. The patient states she feels fine and she is ready to go home.
- Patient was sent home
- Patient returned to the ED comatose the following day. She was found to be delirious from urosepsis. She did poorly.
What Went Wrong?

- Failure to identify that the patient has cognitive impairment
- Lack of communication with the family
- Failure to diagnosis delirium
- Failure to admit the patient

Case - 36 year old male who presents to the emergency department with ingesting lorazepam and drinking last night.

- The patient decides he does not want to be seen in the ED.
- Won’t wait for his tests to come back
- Can he sign out AMA?

Is the Patient Competent to Sign

Consider the MacArthur test

- Takes 20 minutes
- Evaluates four areas: understanding, appreciation, reasoning, expression of a choice


- No definitive test for capacity
- “There are no formal practice guidelines from professional societies for the assessment of a patient’s capacity to consent” - Applebaum, PS: Assessment of patients’ competence to consent to treatment. New Engl J Med 357:1834-1840.

- Document meticulously – capacity, risks, discussion and patient understanding
Are drug and alcohol testing indicated?

- Most drugs or their metabolites are positive for 1-3 days or longer after use
  - "Routine urine toxicologic screens for drugs in alert, awake, cooperative patients do not affect ED management and need not be performed as part of the ED assessment" (ACEP Guideline)
- Blood alcohol concentrations do not correlate with the degree of intoxication
  - "The patient’s cognitive abilities, rather than a specific blood alcohol level, should be the basis on which the clinicians begin the psychiatric assessment." (ACEP Guideline)
- Urine drug screen are limited
  - Does not test for all drugs
  - Interference with meds
  - False negative and false positives

Evaluation of Intoxication?

- Intoxication is a clinical diagnosis; not a lab diagnosis
- Clinical Assessment of intoxication
  - Level of consciousness
  - Cognitive function
  - Neurologic function
    - Coordination
    - Gait
    - Nystagmus

Case - 36 year old male who presents to the emergency department with ingesting lorazepam and drinking last night.

- The patient decides he does not want to be seen in the ED.
- Patient waiting on lab tests
- Nurse had patient sign the AMA form
- Patient drove the wrong way on the highway and was brought back to the ED from trauma scene
What Went Wrong

- Physician needs to assess patient’s desire to leave AMA
- Proper assessment of the patient’s capacity
- Reliance on waiting for urine drug screen and alcohol level
- Involvement in security to stop patient from leaving

Take Home Point

- Suicidal patients need a risk assessment
- Staff attitudes towards psych patients can have a detrimental effect on patient outcome
- All psychiatric patients must be provided a safe environment
- Identify and secure patients at risk for elopement
- EPs have responsibility in determining need for psych admissions delegated to a crisis worker
- Patients who want to leave AMA must have MD evaluation with capacity assessment