The Safe Management of Behavioral Health Patients in Non-Behavioral Health Settings

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In order to be taken seriously you need to present as...

- Immature
- Dependent
- Manipulative
- Hysterical
- Demanding
- Difficult
- Untruthful
- Attention seeking
- Sad
- Lonely
- Bored
- Pathetic
- Manipulative

Seriously ill

Morinda Epstein
1995
OBJECTIVES

• Identify the degree to which behavioral health patients present in health care organizations.
• List the potential liabilities associated with behavioral health patients.
• Describe the major risks associated with behavioral health patients in non-psychiatric settings (ED and medical surgical units).
• Discuss Enterprise Risk management strategies to mitigate the risk of harm to staff and patients.
Behavioral Health Patients Throughout the Continuum

- Emergency Departments
- Medical-Surgical and Intensive Care Units
- Long Term Care
- Outpatient Clinics
- Primary Care
Prevalence of Behavioral Health Patients

Best Guess:
How many BH patients are in the general medical/surgical population?
Medical/Surgical Units

• Significant mental health issues

• Increased average length of stays

• Increasing suicide rates
Emergency Department

SIGNIFICANT ISSUES
Emergency Department

- Over 1,900 ED visits per day for self-inflicted injury.
- 8% of visits related to Mental Health
- 8% are related to alcohol use
- 1.2 million visits are drug-related
Long Term Care Settings

- Rates of depression are increasing
- Rate of suicide in the elderly population is on the rise
- Chronic pain and Depression
- Dementia
Chemically Dependent

• Found across the continuum at alarming rates

• Can be the most difficult BH population to manage
Liabilities and Exposures With Behavioral Health Patients
The Risk Exposures

Possible loss of marketshare
Adverse Media Potential
Healthcare Professional Licensure Action Potential

Liability Risk Potential
Regulatory Risk Potential
Health Facility Licensure Action Potential

Behavioral Health Risks
Most Frequent Legal Claims

- Inadequate risk assessments
- Lack of a safe treatment environment
- Lack of appropriate monitoring procedures
- Untrained staff
- Untimely transfers to appropriate setting
“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*
Suicide Statistics

- 11th leading cause of death (30,000 lives)
- 17% involve the elderly (65+)
- Estimated 25 suicide attempts for each completion
- 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
INPATIENT CASE STUDY
Self Destructive Behavior

• Cutting
• Pulling out tubes
• Saving up Medications
• Drugs brought in by visitors
Aggression/Violence

- Drug use
- Psychosis/mental illness
- Sociopathic personalities
- Organic pathology
- Cessation of medications
Elopement

“Premature Patient Prompted Discharges”
Case Study: Elopement

Julia, an 18 year old with history of panic attacks
RISK STRATEGIES
Suicide Risk Screening

• Determine suicidal ideation/ immediate risk
• Consider: patient’s injuries, psychiatric/ substance abuse history, family situation
• Tools focused on risk factors
• Completed to determine if further assessment/evaluation is needed
Suicide Risk Assessment/Reassessment

- After the screening
- Change in level of functioning
- Critical Junctures in care
- At Discharge
**SAMPLE Suicide Risk Screening Tool**

(This risk screening tool should be completed on patients that present with current or history of a behavioral health disorder).
Comments on risk factors should be written in the space provided.

<table>
<thead>
<tr>
<th><strong>RISK FACTORS</strong></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Past history of self-harm attempts:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Current thoughts of self-harm:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current suicide plan:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to lethal methods (firearms, stock medications):</td>
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<td></td>
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<tr>
<td>History of family member suicide:</td>
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<tr>
<td>Feeling of hopelessness, anxiety, panic, or experiencing command hallucinations (including recent losses):</td>
<td></td>
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<tr>
<td>History or current diagnosis of depression:</td>
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<td>Recent significant life changing events (including divorce, financial worries):</td>
<td></td>
<td></td>
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<td>Social isolation or lack of support:</td>
<td></td>
<td></td>
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<tr>
<td>Recent events leading to shame, humiliation, or despair:</td>
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<td>Serious chronic, debilitating illness:</td>
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<td></td>
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<tr>
<td>Current alcohol or other substance abuse:</td>
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**PROTECTIVE FACTORS**

<table>
<thead>
<tr>
<th></th>
<th>Moderate</th>
<th>Strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate-Strong religious/cultural beliefs</td>
<td></td>
<td></td>
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<tr>
<td>Communicative and engaging</td>
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<td></td>
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<tr>
<td>Coping Skills are adequate</td>
<td></td>
<td></td>
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<tr>
<td>Responsible for children or pets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are available of social supports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting of treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Low Risk</strong></th>
<th><strong>Moderate Risk</strong></th>
<th><strong>High Risk</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Several Factors that are Protective</td>
<td>2 or more Factors that are Protective</td>
<td>Less than 2 Factors that are Protective</td>
</tr>
<tr>
<td>Risk Factors are minimal/manageable</td>
<td>4 or more Risk Factors</td>
<td>Strong history of suicidal ideation, suicide plans, or co-morbidity</td>
</tr>
<tr>
<td>No Immediate Risk</td>
<td>May have suicide plan, but means not readily available</td>
<td>Intent is immediate or in the near future. Means are lethal and accessible.</td>
</tr>
<tr>
<td><strong>Routine Monitoring</strong></td>
<td><strong>Close Observation</strong></td>
<td><strong>Constant Observation</strong></td>
</tr>
</tbody>
</table>
Barriers to Screening

• Lack of staff competency

• Individual attitudes/stigma about patients with mental health or substance abuse disorders

• Patient or family denying high risk activity
ED Strategies

- Don’t make patient wait
- Move out of the waiting room
- Reassess frequently
- Constant supervision
- Elopement procedures
ED Environment of Care

- Establish a “safe” room/area in the ED
- Psychiatric SW and BH techs
- Provide distractions
ED Strategies

- Ensure Medical Clearance
- Establish detoxification protocols
- Rapid stabilization of psychosis/agitation
- Security in the ED
- Use of electronic metal detectors
- Safe transfer between treatment areas
- Enlist help of family member/friend
Aggression

- Zero tolerance
- Set limits
- Determine patient need
- Prevent the “point of no return”
INPATIENT PATIENT RISK STRATEGIES
Inpatient Strategies

- Assess and reassess regularly
- Appropriate monitoring/observation levels
- Do NOT ignore – MEET THE NEED
- Set limits on inappropriate and drug seeking behaviors
MANAGE MANIPULATION

- Communicate expectations firmly
- Set clear limits on behaviors that affect the wellbeing of the patient or others
- Do not be punitive
- Give a rationale for the limit
- Do not engage in a power struggle or debate
- Make the consequences clear and ones you can carry out
- Do not set limits in public. Manipulative patients love an audience
- Communicate the limits and consequences to all staff caring for the patient
- Stand firm when limits are tested by the patient
- Give positive feedback regularly if the patient is following the limit
Safe Environment

• Close to nursing station
• ”Safe” rooms
• Remove all sharp objects, medications, belts, shoelaces and other potentially harmful objects from the patient room
• Assess need for disposable meal trays, no metal, or glass
• Routine surveillance of the environment
Case Study
Inpatient Strategies

- Sitters
- Utilize safety restrictions
- Psychiatrically trained staff/consults
- Behavioral Health Response Team
- Communication between care givers
- “Hand off” Communication
- Documentation of the plan of care- safety
Inpatient Strategies

- Utilize various safety restrictions
- Use of trained advocates/personnel
- Family involvement/education
- Adequate Discharge Instructions
Long Term Care Strategies

- Assess for a history of psychiatric disorders
- Request psychiatric consultation
- Grief counseling
- Reassess routinely and document
Long Term Care Strategies

• Institute appropriate precautions/monitoring
• Safe environment/routine safety searches
• Assure that patients have taken their medication
• Involve family members
Discharge Practices

- Provide resources for crisis hotlines/treatment
- Inform family/friends of the signs for increased suicide risk
- Provide discharge instructions on follow-up appointments and telephone numbers
- Obtain signed release of information for next level of care
- Document suicide risk assessment at discharge
How Can We Keep Patients Safe When They Have Visitors?

1. Put visitors on notice

2. Search Items

2. Educate

4. Limit/restrict
Discharge

- Know your local resources
- Connect with NAMI
- Use your shelters for stable patients
- Tap into PCP’s for follow up with mental health issues
- Document the denial of suicidal/homicidal ideation
Staff Competency

- Assessment/management/ crisis prevention
- Major psychiatric diagnosis/pathology
- Restraint/seclusion training
- Safe procedures for housekeeping, maintenance, and auxiliary staff
- Sitter/patient monitoring training
- Annual update trainings
Organizational Patient Safety

BH patients are THROUGHOUT the organization
Leadership

- Establish a culture of safety
- Evaluate the risk to the organization
- Provide resources for consultation
- Establish effective training/competencies
CASE STUDY

ENTERPRISE RISK ISSUE
Organizational Risk Assessment

✓ Specific risks related to the environment of care
✓ Training
✓ Communication of roles/ responsibilities
✓ Procedures and controls (both human and environmental)
✓ Security protocols
Organizational Strategies

• Conduct a tracer on a behavioral health patient

• Monitoring, analyzing, and trending of data

• Promote efforts to reduce possibility of harm

• Adequate Screening/Assessment/Reassessment

• Access to behavioral health resources/consults

• Promote efforts to shift the culture of safety for the BH population
Organizational Strategies

- Hand off communication
- Improve and expand environment surveillance
- Behavioral health specialist for ED and consultation
- Conduct Mock behavioral health emergencies
Policies

✓ Inter-hospital transfers
✓ Suicide Risk Screening
✓ Suicide/Observation Precautions
✓ Management of high risk patients
✓ Search Policy
✓ Visitor Policy
✓ Detoxification protocols
SUMMARY: Key Concepts

- Assessment and Re-assessment
- Communication-Communication-Communication
- Observation/monitoring
- Environment of Care/Surveillance
- Patient and belongings search
- Hand-offs to next care provider
- Education/Training
- Discharge planning/Community Resources
CONCLUSION

✓ Decrease in BH patients not likely

✓ Risk assessment and risk mitigation strategies

✓ Organizational wide approach to safety
You're not paranoid. Due to terrorism, feeling anxious all the time is the "new normal."
Resources

- Guidelines for Design and Construction of Hospital and Health Care Facilities at www.aia.org
- American Society of Suicidality - www.suicidology.com
- Alcohol Screening and Brief Intervention (SBI) for Trauma Patients, Committee on Trauma, www.SAMHSA.gov
- NASMHPD Six Core Strategies© to Reduce the Use of Seclusion and Restraint in Inpatient Facilities: www.nasmhpd.org
- National Institute of Mental Health http://www.nimh.nih.gov
Resources

- Crisis De-Escalation Training for Staff and Consumers in Inpatient and Other Service Delivery Settings, National Research and Training Center (NRTC)  
  [http://www.psych.uic.edu/UICNRTC/dep-training.htm](http://www.psych.uic.edu/UICNRTC/dep-training.htm)


- *Roadmap to a Restraint-Free Environment*, published by SAMHSA:  

- Restraint and Seclusion: A Risk Management Guide: Stephan Haimowitz, J.D.  
  Jenifer Urff, J.D., Kevin Ann Huckshorn, R.N., M.S.N, CAP, ICADC, 2006  
Resources

- American Foundation for Suicide Prevention – [www.afsp.org](http://www.afsp.org)
- Ending Suicide.Com – [http://www2.endingsuicide.com](http://www2.endingsuicide.com)  
  *(Information on suicidal risk in Adults and Older Adults and gives a list of the Suicide Assessment Scales that are available and their validity).*
- American Society of Suicidality - [www.suicidology.com](http://www.suicidology.com)
- Suicide Prevention Resource Center – [http://www.sprc.org](http://www.sprc.org)
- NAMI – [www.nami.org](http://www.nami.org)
- Training Institute for Suicide Assessment & Clinical Interviewing – [www.suicideassessment.com](http://www.suicideassessment.com) *(Helpful links and the CASE Approach interview strategy for suicidal patients)*
References


- American Academy of Experts in Behavioral Health and Safety at www.aaubhs.org

Thank you for inviting me to present on
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Questions/Comments can be forwarded to:
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