Section: HRMC Division of Nursing

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APPROVAL: _____

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PROTOCOL

TITLE: Care of Psychiatric Patients in the ED

PURPOSE: To establish guidelines for the assessment of the psychiatric patient/suicide risk/homicidal risk patient and documentation of such on all patients presenting to hospital with a primary behavioral or emotional disorder including those related to substance abuse.

LEVEL: ___ Dependent _x_ Independent ___ Interdependent

DEFINITIONS: Behavioral or Emotional Disorder: Any DSM (psychiatric) diagnosis or condition, including those related to substance abuse.

SAD PERSONS Scale: A 10-point scale used to screen patients for risk of suicide based on presence of specific factors.

CONTENT STATEMENTS:

1. All patients presenting to the Emergency Department with behavioral health complaints will be assessed for suicide risk during the triage process.

2. The patient with a behavioral health compliant or emotional disorder will be asked if they have had any thoughts of hurting themselves in triage. This will be documented on the triage form.

3. If the patient answers yes to above question, the triage nurse will use the SAD PERSONS scale, and select all criteria that apply.
    a. RN will score the scale using one point for each of the 10 criteria
    b. RN will complete the scoring section and sign and date it.
    c. RN will select the appropriate intervention, based on the SAD PERSON score. RN will initial after intervention that is initiated.
        i. Low risk (1-2 points) patient may wait to be seen per triage policy
        ii. Moderate risk (3-6 points) Patient will remain in constant eye site with assigned staff.
        iii. High Risk (7-10 points) patient place immediately in a room in the treatment area. 1:1 observation initiated by trained staff.
        iv. If RN feels the patient is a higher risk than the score indicates, he/she may initiate high risk interventions immediately

4. Patient will be place in a Room close to the nursing station. Room 4 if possible. Belongings, cords and equipment will be removed from the room. Personal items and clothing will be placed in a bag, labeled and placed in the Nursing Station. **Two nurses must inspect and take possession of belongings, valuables and clothing.**

5. Patient will be placed in a hospital gown.

6. Patients screened as high risk will have 1:1 continuous observation and the Sitter Responsibility form will be completed to document 1:1 observation until the physician orders that 1:1 be discontinued, and be triaged as a Level 2

7. The charge nurse will assign a primary nurse to care for the patient.
    a. The primary RN will be responsible and accountable for all care provided to the patient, including care provided by ancillary staff.
    b. RN will maintain on-going assessment and monitoring of the patient for imminent harm to self or others.
    c. VS will be obtained at least every 4 hours, more frequently if patient condition warrants.
    d. Food and liquids will be offered, unless contraindicated by patient condition.

8. The ED physician will conduct a medical screening exam. This will include CXR, Cardiac work-up, serum pregnancy test, TSH level, ETOH level, Urine Drug screen, Acetaminophen, Saliysilate levels, and any pertinent drug levels based on the patients current medications.

9. Once the patient is determined to medically clear by the ED physician, the primary RN will coordinate with Social Services and the Crisis team. No patient will be cleared medically until considered legally sober. If there is no suicidal ideation once sober patient will be referred to CAC.

10. Primary RN will ensure assessment and monitoring as above until a safe disposition has been accomplished.

11. Any patient who has been discharged from the Emergency Department to home will be provided with contact information for a counseling services as determined appropriate by the both the physician and Social Service.

REFERENCE:

Robie, D., Edgemon-Hill, E., Phelps, B., et. Al. Suicide Prevention Protocol. American Journal of Nursing. Vol. 99 (12), December 1999. p. 53, 55, 57.

Mitchell, A.J. and Dennis, M. Self harm and attempted Suicide in Adults; 10 Practical Questions and Answers for Emergency Department Staff. Emergency Medicine Journal. Online:emj.bmj.com. 2006; 23; p.251-255.

Patterson, W., Dohn, H. Bird, j, et.al. Evaluation of suicidal patients: The SAD PERSONS score. Psychomatics. 1983; 24; 343-5.

EMERGENCY DEPARTMENT
SAD PERSONS SCALE

SAD PERSONS Scale	**Intervention Key:**	
Patient at suicide risk because: □ S = Sex (male) □ A = Age (<19 years or > 45 years) □ D = Depression: decreased concentration, appetite, sleep or libido □ P = Previous suicide attempt or psych. care □ E = Excessive alcohol or drug use □ R = Rational thinking loss; organic brain syndrome or psychosis □ S = Separated, divorced or widowed □ O = Organized plan or serious attempt or stated future attempt □ N = No social supports, close family, friend, job or active religious affiliation □ S = Sickness (chronic debilitating disease)	Interventions: One point for each of the 10 criteria □ 0-2 points = low risk □ 3-4 points = mild risk □ 5-6 points = moderate risk □ 7-10 points = high risk	
	Low risk:	Patient may remain in waiting room until placement in triage policy. Patient will be monitored closely by nursing.
	Mild risk: Moderate risk:	Place patient in treatment room. Patient must be in constant eyesight with assigned staff. Initial elopement precautions.
	High risk	Place patient immediately. MD evaluation within 15 minutes. 1:1 observation by trained staff. Initiate elopement precautions.

Guidelines for Action with the Scale	
Total Points	**Proposed Clinical Action**
0 to 2	Send home with follow up
3 to 4	Close follow up; consider psychiatric/substance abuse hospitalization or intensive outpatient treatment
5 to 6	Strongly consider psychiatric/substance abuse hospitalization, depending on confidence in the follow-up arrangement
7 to 10	Voluntary or involuntary psychiatric hospitalization