Section: Division of Nursing
Approval: _____

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* **PROTOCOL** *
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HACKETTSTOWN REGIONAL MEDICAL CENTER

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ED
(Scope)

TITLE: PSYCHIATRIC AND/OR SUICIDAL PATIENT IN THE EMERGENCY DEPARTMENT

PURPOSE: To outline the management of the psychiatric and/or suicidal patient in the Emergency Department.

SUPPORTIVE DATA

1) If, at anytime, the RN determines that the patient is a danger to self, staff or others, the patient will be classified as Emergent.

2) A patient with a non-threatening psychiatric complaint is classified as Urgent.

PATIENT SAFETY

1) Maintain patient safety:
   a. Remove all clothing, hospital gown to be worn
   b. Two Nurses to inspect and take possession of belongings and follow Valuables and Clothing Policy.
   c. If emergent, utilize Rm. 6, if possible and ensure a safe environment.
   d. 1-on-1 continuous observation is maintained if suicidal ideation or behavioral restraints used.
   e. Institute Restraint Policy if indicated.
   f. Institute Dr. Strong if indicated.

MEDICAL ASSESSMENT

- Once ED physician has evaluated the patient and determined the need for psychiatric evaluation, the following criteria shall be assessed and documented:
  a. All medical complaints shall be stabilized.
     - Patients must be medically cleared prior to transfer to appropriate facility.
     - The Patient Care Review Department or a Certified Crisis Clinician from the Crisis Intervention Center may be consulted. The patient may be interviewed in the ED for a possible involuntary commitment, assistance with a voluntary admission or have arrangements made for an outpatient consultation. A psychiatrist on the medical staff may be consulted (See Addendum 4, The Psychiatric Patient in the ER and Psychiatric Screening Answer Tool)

ADMISSION

b. If the patient is not medically stable for transfer: patient to be admitted to ICU, room 3 or 4 or private room on 4 South with 1-on-1 continuous observation if indicated or whichever of these may be appropriate.

NURSING ASSESSMENT AND DOCUMENTATION

- Assessment and documentation shall include:
  a. Patient history to include psychiatric history.
  b. Patient's complaint
  c. Observation of signs and symptoms of mental, consistent with the patient's condition, emotional, behavioral or suspected substance abuse
  d. Vital signs
  e. Lab values
  f. Documentation of potential danger to self, staff or others
  g. Level of consciousness
  h. Documentation of restraints, if utilized

TRANSFER

- Prior to transfer
  EMTALA form completed (original to be sent with patient to facility)

The psychiatric patient in the ER

Above all else, maintain the safety of staff, other patients/visitors and the patient! In the event that the patient poses bodily threat to self or others, call Dr. Strong and use chemical and/or physical restraints as per policy.

Patient must be medically cleared before patient can be either screened or transferred (this includes a blood alcohol below 100) to ensure that the presenting problems are not medically related.
At minimum, the patient must have a drug screen and a blood alcohol level. Additionally, a patient must have any other appropriate lab work and testing to rule out a medical cause for aberrant behavior (ex: CT scan if indicated, blood levels for medications if appropriate, etc).

If patient is unstable medically, they must be admitted to the hospital for treatment. Of special consideration is the patient who may have overdosed on cocaine who must be monitored for cardiac complications.

Assessment is the key to all plans and referrals!
It is inappropriate to call the Crisis Clinician (Warren County Screener) or the Patient Care Review Department for screening and provide only minimal information. For best and quickest response, be prepared to give a pertinent history and description of behavior **- use the attached questionnaire as a guideline**. Additionally, the Crisis Clinicians are under strict mandates from the State on how and when to respond to the initial telephone request for screening.

Be prepared to accurately describe the presenting behavior.
Give examples – i.e. seeming to be talking/listening to others without anyone being present, lack of apparent comprehension on what you are saying, elaborate story telling, manipulative behavior, self inflicting injuries, rocking back and forth, screaming, uncontrollable crying, overly paranoid behavior, or assaultive behavior.

When calling the Crisis center, it is imperative to tell the screener if the patient had any type of restraint, and/or that the patient was making threats about themselves of others.

Of special note is the intoxicated patient. While inebriated, many patients may state that they want to kill themselves or that they want to die. Reassess suicidal ideation after blood alcohol returns to below 100. If in doubt, call the Crisis Clinician. Ask for their expertise. You may be told there is no issue and to release them when medically cleared, to call CAC for an assessment, or that they will be out to screen patient in the ER.

If the Crisis Clinician feels this is not an appropriate crisis referral, the patient is suicidal but wanting to seek help or treatment and is medically cleared, or the ER staff has questions or requires assistance concerning disposition of case, page the Patient Care Review staff member on call for the ER.

Psychiatric Screening Assessment Tool

1. Assess whether the patient is a danger to self or others. Ask the patient if they want to hurt or kill themselves, or anyone else. Do they have a plan and the ability to carry out that plan?

2. What was the precipitating event/s? Can they say what seemed to set off this current crisis?

3. Obtain prior history, both medical and psychiatric. Ask about history of depression, suicide attempts, treatment for psychiatric problems, hospital admissions for psychiatric reasons.

4. Are they on any medications? If on psych meds, who prescribes them?

5. Are they receiving any psychiatric treatment, where and from whom.

6. Have there been any changes in sleeping or eating patterns?

7. History of drug abuse, both recreational and prescription. Have they ever been in a detox program?

8. History of alcohol abuse. Have they ever been in in-pt rehab, are they in AA?

9. Any legal or school problems.

10. Ask about relationship with spouse/significant other and family. Do they have any emotional supports?

11. Ask about history of abuse (sexual, physical, verbal, emotional).

12. Any history of mental illness in the family?