Pitfalls in the Care of the Psychiatric Patient

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Disclosure

- Bioxel
Objectives

- Identify high risk psychiatric patients
  - Suicide
  - AMA
  - Elderly
  - Medical clearance
- 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.
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

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 and protective factors

Good documentation
ED Risk Assessment

- Static risk factors
- Dynamic risk factors
- Protective factors
- Document thought process

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."
Who Assess the Patient?

- Emergency physician/PA
- Psychiatrist
- Mental health worker
- Outside/contracted service
- Cannot be delegated to someone not in the ED or some with lesser credentials

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.
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.
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
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 great 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.
- What is the proper evaluation process?
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
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

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 Gero-Psych 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

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 comatose the following day. She was found to be delirious from urosepsis. She did poorly.
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”

- Document meticulously – capacity, risks, discussion and patient understanding
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
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

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