Crisis response in Emergency Departments

-New standards for Mental Health triage
-Implications of the 1 hour response time

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Plan

Background
Safety concerns raised by Health Services Investigation Branch (HSIB)
Mental Health triage
Observations
Definitions of the 1 hour standard
Getting rid of “medically cleared”
Implications for good practice
The Big Picture – UK HES ED MH Attendances 2009/10 – 2017/18

MH attendances have increased by 133% since 2009
HSIB Index case - Diane

57 year old lady, known mental health problems, known to community and crisis teams – anxiety, self harm

4 ED attendances with self harm, on 2 occasions DNW. 2 days after the 4th attendance she saw the GP, but went on to commit suicide that day.

• The process of triage for mental health was lacking in the ED
• Missed opportunities to intervene by MH teams as she did not wait
• Integrated Liaison Psychiatry ED teams had a very positive effect on care for MH patients in the ED (i.e. when she had been seen by Liaison Psychiatry in the past).
Recommendations by HSIB

• NHSE to ensure sustainable funding for 24/7 Liaison Psychiatry
• Review of NICE guidelines for self-harm
• RCEM and RCPsych develop national guidance for Mental Health Triage
• CQC to update its inspection criteria for acute hospitals for quality of care for Mental Health patients
Pathway - MH triage on arrival

Nurses confident to ask some simple questions and listen to the patient.

Brief Risk Assessment – Prompts but no tools!

Decide on level of observation

Consider safeguarding

Physical Description of patient recorded

Search the patient – need a policy

Do they have a ED management plan?

Does the patient have the capacity to decide to leave?
# Mental Health Triage

### Why is this person presenting now?

### Are there any events that precipitated this presentation?

### Does the person have any close family/friends/social support?

### Are there any child protection issues? □ Yes □ No

### Is this person in any way vulnerable? □ Yes □ No

### 1. Does the person have any immediate plans to harm self or others or to damage property?

### 2. Is the patient obviously disturbed, threatening, agitated or unpredictable in their behaviour?

### 3. Does the person have history of violence?

### 4. Does the person have a history of significant mental health problems or self harm?

### 5. Is there any suggestion that the person may abscond?

### What level of risk do you think this patient has?

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>High</th>
<th>Med</th>
<th>Low</th>
</tr>
</thead>
</table>

### Observation level required

<table>
<thead>
<tr>
<th>Observation Level</th>
<th>Red</th>
<th>Amber</th>
<th>None</th>
</tr>
</thead>
</table>

### Has this patient been searched for means to self harm, weapons or medicines?

□ Yes □ No

### Do you think this patient has capacity to decide to leave?

□ Yes □ No

### Physical description — include height, build, distinguishing features, clothing, skin colour, hair colour and style

### Green

- No special observations required

### Amber

- Consider 15 minute amber special observations
- If patient absconds inform nurse and doctor in charge, and security.

### Red

- Start red continuous special observations, inform nurse in charge of patient’s presence in ED
- If the patient absconds, inform nurse and doctor in charge, security and the police.

### Has this patient been searched for means to self harm, weapons or medicines?

□ Yes □ No
VISA Assessment Tool
for patients at risk of self harm

Name
DOB
Hospital No

- V - Violent Method/Preplanned attempt
- I - Irrational thinking or psychotic features
- S - Suicidal intent remains
- A - Alone (in the department or at home)

If VISA + request early clinician assessment

Description of patient________________________
__________________________________________

Initial assessment – is there anything we can do to make you safer? (consider search)________________

If you are discharged, where will you go?_____
__________________________________________

Presentation out of keeping with previous attendances? _________________________________
Intoxicated?_________________________________
Police present?_______________________________
Section 136 Y/N ____________________________

Continuing Observations
Complete every 15 min or ______

If the patient is either agitated, aggressive or has expressed desire to leave, discuss with the nurse-in-charge +/- bleep-holder and consider prioritising for assessment. Consider level of engagement/observation required and document this. If patient absconds then discuss with the nurse-in-charge +/- the bleep-holder – as they may require police safe-and-well check.

Plan

Liaison Psych referral Y/N    signature_________
Mental Health in Emergency Departments

A toolkit for improving care

Revised:
March 2018
1. Patients should have mental health triage by ED nurses on arrival to briefly gauge their risk of self-harm or suicide and risk of leaving the dept before assessment or treatment is complete. This is used to determine what level of observation the patient requires whilst in the ED.

2. Patients at medium or high risk of suicide or of leaving before assessment and treatment are complete should be observed closely whilst in the ED. There should be documented evidence of either continuous observation or intermittent checks (for example every 15 minutes), whichever is most appropriate.
1 hour time standard referral to response

- 1hr from A&E referral to face to face assessment, 4hr total time in A&E to discharge/transfer/admission
- 24hr from referral to assessment for referrals from general hospital wards

Potentially very good and many places already meet this....... 

Needs more definition and needs to prevent gaming
NHSE are clear that the response is face to face.
Cases – when should referral / assessment happen?

1. 1400 - 25 year old - self harm - 16 paracetamol and 10 ibuprofen – calm and wanting help.
2. 2300 - 45 year old man very intoxicated and suicidal – 1st presentation.
3. 1100 - 30 year old lady EUPD, who has taken 30 Quetiapine, fit for assessment but needs observation, will be admitted to CDU for 6 hours.
4. 0100 – 18 yr old lady emerging EUPD, deep lacerations which need sutures.
5. 2100 – 55 year old man who has had 3 pints of beer and taken 16 15/500 cocodamol, he’s a bit morose and slurred.
Should the standard be 100% seen in 1 hr?

- No – to allow for those who are not fit for assessment
- No – places with 1 practitioner on can only have 1 referral every 90 min, if they get 2 referrals in an hour, then none for the next hour, they will not meet the standard

Need an audit to determine how many patients are fit for assessment on arrival and unlikely to have to stay in.

Need to prevent gaming

80%???
Time to MH referral (hours) – NHSE data
Referral pathways to Liaison Psychiatry
Bleep 157 733

Mon-Fri 0800-midnight April 1st onwards 2014
Weekends 0800-1800...

Outside these hrs bleep duty Dr before 2100 and Fulbourn Duty Nursing officer after 2100
All healthcare professionals must work together to eradicate terms such as ‘medically fit’ or ‘medical clearance’. The terms ‘fit for assessment’, ‘fit for review’ or ‘fit for discharge’ should be used instead to ensure parallel working.
Getting rid of “medically cleared”

Origins of the term?
Mental health team frightened to admit a patient to a MH bed and miss a medical cause.
ED team being too quick to absolve themselves of responsibility to a MH patients.

1st presentation of psychosis / elderly mental health patients require medical work up to look for medical causes for their psychosis / mental deterioration, but we can rarely ever “clear” someone!

→ Poor working relationship, distrust
→ MH team demanding tests / tox screens

Where people with an existing psychiatric condition attend the ED with characteristic symptoms, routine screening tests rarely change management (Janiak 2012; Shah 2012).

What do patients think?
Why are patients referred to Liaison Psychiatry?

- Assessment of ongoing mental health needs and arrangement of suitable aftercare
- Support to patients, families and treating medical teams
- Advice about clinical care or diagnosis in hospital
- Advice and support on mental health and mental capacity law

All these requests should be on a 1 hour clock too.
Good joint working

- Co-location
- Communication – sharing of information, opportunities to learn.
- Competence – ED needs to engage in mental health. MH needs to be able to work in parallel
- Joint ownership of patients
- Reciprocal teaching
- Shared language “fit for assessment”, “Fit for discharge.”
- Joint governance
Conclusions – drivers of safety and quality

- MH triage is key to patient safety in ED.
- ED may need help with putting effective MH triage and observations in place, and with training.
- 1 hour time standards will be a good thing to drive quality, but funding needs to follow.
- Sorting out referrals from triage and identifying “fit for assessment” – use a common language.
- Input to NHSE on fit for assessment, responses if help required that is not an assessment. Clarify that patients going to the ward are not necessarily going to get a 1 hour response.
- Driver for CAMH service development.
References


https://www.rcem.ac.uk/docs/RCEM%20Guidance/Mental%20Health%20Toolkit%20(revised%2019%20Mar%202018).pdf

https://www.england.nhs.uk/publication/clinical-review-nhs-access-standards/

https://www.ncepod.org.uk/2017mhgh.html
