STANDARDIZING AN EMERGENCY ROOM MEDICAL ASSESSMENT STABILITY/CLEARANCE PROTOCOL FOR QUALITY IMPROVEMENT: A PILOT COLLABORATION BETWEEN EMERGENCY MEDICINE AND MENTAL HEALTH PROFESSIONALS

Katie Bingham\textsuperscript{a}, Nalin Aaluwalia\textsuperscript{b}, Kuldeep Sidhu\textsuperscript{a,c}, Thomas Ungar\textsuperscript{a,c}

A University of Toronto, Department of Psychiatry & North York General Hospital, \textsuperscript{b} Toronto Western Hospital, \textsuperscript{c} The Hospital for Sick Children

ABSTRACT

- Population: all patients (adult and children) presenting to hospital with a mental health issue and requiring later follow-up, leaving NYGH and HRRH
- Use HRRH as a model of successful implementation for the rest of the LHIN
- May 22, 2014: Protocol revised based on feedback and final version distributed to hospitals
- May 1, 2014: Pilot results shared with pilot sites and working group

SUMMARY OF PILOT IMPLEMENTATION

- Convened small-group workshop of psych-ED leadership (NYGH and HRRH)
- Performed literature review
- Elicited feedback from stakeholders (ED and psychiatry leadership and frontline staff)
- Conducted Central LHIN Integration Network (CLIN) to promote engagement and circumvent institutional stigma
- Developed potential protocol from one available in the literature for use in psych patients being transferred from ED (first draft Jan, 2014)
- Action March 3-April 3, 2014:
  - Pilot of draft protocol at 3 hospitals in the CLHIN using quality improvement framework. One hospital later dropped out, leaving NYGH and HRRH
  - Population: all patients (adult and children) presenting to hospital with a mental health issue and requiring external transfer/admission
- Assessment: May, 2014
  - Elicited feedback from ED physicians re: protocol during pilot phase
  - Literature review update
  - Protocol revised based on feedback and final version distributed to hospitals
- Next steps: Ongoing improvement of protocol based on feedback

CONCLUSIONS

- Medical stability protocols provide a means of standardizing quality of care for patients with psych presentations in the ED
- The protocol developed for NYGH and HRRH is appropriate for use in external transfers but may need to be refined for use in psych admissions
- It is clear from this process that different EDs may have vastly different needs based on the practices and cultures of the institutions. This area requires a high degree of interprofessional collaboration
- More research is needed on the utility of medical stability protocols in improving patient quality of care, wait times and costs

CHALLENGES

- Individual and institutional stigma involving patients presenting with mental health/behavioral concerns
- Differences in ED and psychiatry cultures
- Differences in resources (e.g., ease of performing blood work on psych units vs. ED)
- Tests that guide initial psychiatric management (e.g., urine tox) may not be included in ED management
- Conflict over whether testing should be done in ED

WHAT IS THE EVIDENCE?

- No evidence that routine laboratory investigations change disposition of psychiatric patients in the ED in the context of appropriate histories and physical exams
- The American College of Emergency Physicians’ (ACEP) clinical policy suggests that testing should be guided by history and physical/mental status exam: “Routine laboratory testing of all patients is of very low yield and need not be performed as part of the ED assessment”
- Limited evidence that routine urine drug screening affects management in the ED beyond self-report, but adds to wait-times
- Evidence that diagnostic overshadowing/stigma may contribute to reduced quality of care for patients with a psych history presenting to the ED
- Limited literature re: the use of med stability protocols. Evidence that they are cost-saving

PROTOCOL: MENTAL HEALTH MEDICAL STABILITY CHECKLIST

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is this the first presentation of a psychiatric/mental health problem?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2</td>
<td>Mental status exam (physical exam must be done)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>3</td>
<td>Have physical concerns?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>4</td>
<td>Medical history or chronic medical illness screening evaluation?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>5</td>
<td>Is there need for the patient to be monitored for acute medical illness?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>6</td>
<td>Evidence of commission or denial of history of substance abuse?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>7</td>
<td>Signs of suicidal ideation?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>8</td>
<td>History of invalidate?</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

If all of the above questions consider no further investigations and proceed to question #11:

11. Investigation ordered (if indicated):

- Laboratory Test
- Diagnosis Imaging
- EEG/EP, EEG, Aud, Brain, MRI (if patient requires)
- EKG

12. Medications reviewed (and ordered if appropriate)? | Yes/No |

Patient’s medical condition is deemed stable for transfer/admission to a Mental Health hospital? | Yes/No |

Treatments Zone in the ED: Additional Comments

<table>
<thead>
<tr>
<th>Treatment Zone</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Critical</td>
</tr>
<tr>
<td>B</td>
<td>High</td>
</tr>
<tr>
<td>C</td>
<td>Low</td>
</tr>
<tr>
<td>D</td>
<td>Discharge</td>
</tr>
</tbody>
</table>

Thanks to Ashley Quigley from the Central LHIN for assistance in developing the flow chart and compiling data.