SHIP Pathway

Self Harm Intoxicated Patients

Liverpool Hospital Experience

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Common ED Scenario

* Intoxicated patient
* Expresses self harm / wants to die…
* Psychiatry assesses patient
* Still too drunk/ drowsy = no capacity
  thus unreliable assessment for risk of suicide
* Needs longer observation time until sober / alert
* Meanwhile… ED still getting busier, more crowded, other patients arriving…

Background

Liverpool Hospital is Major Referral Centre:

* Declared Mental Health facility
* Large volume of mental health patients
* Psychiatry Emergency Care Centre (PECC) referrals from ED range between 200-300 per month
* 17% of PECC referrals from ED stay an average 10 hours
* No Toxicology Department

Background

* Strategy to address issues of ED overcrowding, in particular for those with mental health issues
* Working with Psychiatry Department, C/L Psychiatry, MAU Department and Drug Health Service
* Created pathway for inpatient management until patient assessable
* Liverpool Hospital Policy (Dec 2013)

Aim

* Facilitate safe assessment of patients intoxicated with alcohol and drugs, requiring a period of observation and improved level of sobriety

* Expedite transfer out of ED

* Improve ETP KPI for this group of patients

Advantages

* Decrease ED overcrowding & free up beds for other patients

* Optimize adequate safer mental health assessment when patient fully alert

* Ongoing medical assessment by MAU / Acute Medicine during period of observation.

Risks

* Medical conditions may be masked by alcohol /drugs
* Difficulty of assessment when intoxicated
* Risk of absconding, and need for scheduling under the MHA

Risks

* Serious intoxication may require critical care
  * Initial pathway - Acute Medicine Service does not take admissions requiring ICU /HDU care
  * Subsequent pathway – now incorporate ICU / HDU patients

SHIP Pathway to MAU

Management of Self Harm /Suicidal Intoxicated Patients

Intoxicated patient in ED with expression of self harm / suicide

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Medical assessment by ED medical staff

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INCLUSION criteria:

- medically stable intoxicated patient with expression of self harm / suicidal ideation
- intoxication requires period of observation until sober for psychiatric assessment to be completed

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EXCLUSION criteria:

- requiring cardiac monitoring
- suspected serious drug overdose
- evidence of serious intoxication requiring higher level care (ICU/HDU) or antidote treatment such as NAC infusion for Paracetamol overdose, Naloxone for opioid overdose
- evidence of mod-severe end organ damage (liver failure/encephalopathy)
- evidence of head injury
- aggressive or disruptive patients

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Initial Psychiatry team assessment (PECC CNC or Registrar) and Drug and Alcohol CNC review
if patient already scheduled under 20/22 (ambulance or police) will need to be re-scheduled under Schedule 1(section 19) for MAU ward admission

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limited mental health assessment due to intoxication

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ADMIT to MAU under MAU Consultant on call

- Once admitted to ward, ongoing MAU management
- Further inpatient assessment by Mental Health Team
  - Consultation Liaison Psychiatry (M-F, 8:30- 17:00)
  - Psychiatry Admitting Registrar/Psychiatrist on-call (weekend/after hours)

Inclusion criteria

* **Intoxicated** or overdosed patient (alcohol or drugs) with expression of **self harm** / suicidal ideation

* Intoxication / sedation requires observation on a medical ward until sober before full psychiatric assessment can be completed

Exclusion Criteria

* Requiring cardiac monitoring (eg TCA overdose)
* Requiring NAC for Paracetamol overdose
* Evidence of mod- severe end organ damage (Liver failure / encephalopathy)
* Evidence of head injury
* Potentially aggressive/ disruptive patients after initial treatment in ED

Psychiatry Assessment

* Initial psychiatry team assessment by PECC CNC or Registrar, (Drug and Alcohol CNC if required)
* PECC must be advised by ED Staff
* PECC must do **preliminary** assessment in ED including **collateral history** and then handover to C/L team
* If scheduled under MHA (Section 20/22 – ambulance or police) may need to be re-scheduled under Section 19
* May need security or nurse special

Admit to MAU / ICU HDU /Ward

* Admitted under the care of MAU consultants (Acute Medicine Service)
* Ongoing medical management
* Automatic Psychiatric team follow up once admitted to ward, as handed over by PECC CNC from ED to C/L Team
  * Consultation Liaison Psychiatry team (Mon- Fri 0830-1700) follows up the patient for re-assessment in the ward
  * Psychiatry admitting Registrar on weekend / after hours

Disposition

* Once assessed by Psych team and medically cleared, either discharged home from MAU

* Or admitted under Psych if deemed still suicidal or ongoing psychiatric issues

Progress

* Commenced SHIP early 2013
* Initial slow to pick up momentum (unfamiliarity, new pathway, staff turnover)
* Smoother implementation late 2013 to early 2014
* Approved as formal Liverpool Hospital Policy July 2013

SHIP (SELF HARM INTOXICATED PATIENTS) **Pathway to MAU/Medical Ward**

Intoxicated patient (16 years and over) in ED with expression of self harm / suicide

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Medical assessment by ED medical staff

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INCLUSION criteria:

- medically stable intoxicated or overdosed patient, with expression of self harm/suicidal ideation or actual overdose
- intoxication/sedation requires observation on a medical ward until sober/unsedated before psychiatric assessment can be completed

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EXCLUSION criteria for this pathway:

- serious intoxication/overdose requiring ICU/HDU – see Attachment 2
- requiring Naloxone for Opioid overdose – refer for ICU assessment, and see Attachment 2 if requires ICU/HDU
- requiring cardiac monitoring (eg for Tricyclic overdose) – refer to Cardiology
- requiring NAC infusion for Paracetamol overdose – refer to Gastroenterology
- evidence moderate-severe end organ damage (liver failure/encephalopathy) – refer to Gastroenterology or other relevant specialty
- evidence of head injury – refer to Neurosurgery or other relevant specialty
- persistently aggressive or disruptive patients after initial treatment in ED (such patients should generally be admitted under Mental Health)

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Initial Psychiatry team assessment by PECC CNC or Registrar and Drug and Alcohol CNC review (if available – may be limited due to intoxication/sedation)

If patient is already scheduled on arrival under Section 20/22 (ambulance or police), ED medical staff will need to assess whether there is a need to reschedule under Section 19

If rescheduled under Section 19 (medical practitioner) the patient must have 1:1 special (security or nurse) on the MAU or other medical ward.

PECC must be advised by ED medical staff of each admission before transfer to ward

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ADMIT to MAU/Medical Ward under Acute Medicine

- If no bed is available on MAU, admit to another ward under Acute Medicine
- Once admitted to ward, ongoing Acute Medicine management
- If more than one scheduled patient is admitted to MAU, there needs to be a separate 1:1 special for each patient.
- Mental Health Team is alerted by PECC about the need for further Mental Health assessment next morning, together with medical clearance by Acute Medicine
  - Consultation Liaison Psychiatry (Mon-Fri, 0830 -1700 hours)
  - Psychiatry Admitting Registrar/Psychiatrist on-call (weekend/after hours)
- Acute Medicine ensures continued Drug and Alcohol review, as required.

SHIP (SELF HARM INTOXICATED PATIENTS) **Pathway to ICU/HDU**

Intoxicated patient (16 years and over) in ED with expression of self harm / suicide

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Medical assessment by ED medical staff

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INCLUSION criteria:

- intoxicated or overdosed patient, with expression of self harm/suicidal ideation or actual overdose, who has respiratory, cardiac and/or neurological instability requiring admission to ICU/HDU
- patient requiring Naloxone for opioid overdose, considered at risk of further respiratory depression after review by ICU

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EXCLUSION criteria:

- requiring cardiac monitoring (eg for Tricyclic overdose) – refer to Cardiology
- requiring NAC infusion for Paracetamol overdose – refer to Gastroenterology
- evidence moderate-severe end organ damage (liver failure/encephalopathy) – refer to Gastroenterology or other relevant specialty
- evidence of head injury – refer to Neurosurgery or other relevant specialty
- requiring admission to ICU/HDU for reasons other than intoxication – refer to relevant specialty

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Advise PECC CNC or Registrar and Drug and Alcohol CNC (if available) of the admission. Assessment will not be possible at this stage.

If patient is already scheduled on arrival under Section 20/22 (ambulance or police), ED medical staff will need to reschedule under Section 19 before transfer to ICU/HDU

If rescheduled under section 19 (medical practitioner) the patient may not need a 1:1 special (security or nurse) in the ICU/HDU, but it will be required if still under the schedule on transfer to a general ward

ED medical staff must advise PECC of each admission before transfer to ward

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ADMIT to ICU/HDU under Acute Medicine

- Acute Medicine liaises with ICU medical staff re management in ICU/HDU
- Acute Medicine takes over full medical care on transfer to a general ward
- Patients are not to be transferred from ICU/HDU to the MAU
- Mental Health Team is alerted by PECC about the need for further Mental Health assessment next morning
  - Consultation Liaison Psychiatry (Mon-Fri, 0830 -1700 hours)
  - Psychiatry Admitting Registrar/Psychiatrist on-call (weekend/after hours)
- Acute Medicine is responsible for medical clearance
- Acute Medicine ensures continued Drug and Alcohol review, as required

Outcomes

* Audit show SHIP pathway working well in terms of early referral system and early decision to admit under SHIP pathway

* Number of patients admitted under pathway and transferred to MAU ward within 4 hours – over 50%

* Overall Length of stay in MAU ward – (set within 48 hours as per MAU's model of care) within target standard 80-90%

Barriers

* Despite pathway and admitted status, ED access block problematic, patients still end up staying in ED, and then discharged (under the care of MAU team)

* Junior medical staff turnover, require ongoing education and information dissemination about the pathway

* Gaps in the referral process between PECC CNC and C/L Psychiatry handover, requiring MAU staff to chase C/L team

Key Issues

* Addresses ED overcrowding
* Safe assessment of intoxicated mental health patients expressing self harm/suicide
* Improved flow and management of this particular group of patients

Future Directions

* Formal audit for Quality Improvement Project submission
* Share experience across the health districts
  * Presented at the Emergency Care Institute symposium Nov 2014

THANK YOU

Questions?

Reference

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