PORTAGE PATH BEHAVIORAL HEALTH

TITLE: PATIENT EMERGENCIES

DEPT.: CLINICAL POLICIES AND PROCEDURES

POLICY NO.: X. **EFFECTIVE DATE:** 5/22/95

DATE REVISION APPROVED: February 21, 2019

AUTHORIZED SIGNATURE: _____

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Vice President of Outpatient Clinical Services

PURPOSE:

To establish guidelines, standards and procedures to effectively manage patients whose behavior is assessed to be disruptive and/or dangerous to themselves or others.

POLICY:

Portage Path outpatient offices will provide emergency evaluation and ongoing treatment during operating hours, Monday through Friday, to Portage Path patients and, to adult residents of Summit County who are not actively obtaining psychiatric services from another source. Any other individual who presents to the agency will have the emergency assessed and addressed, and then will be referred to their home county or ongoing treatment personnel for continued services.

During closed agency hours, emergency services are provided, by Portage Path's Psychiatric Emergency Services (PES) and general hospital emergency rooms.

The first priority, in situations where the patient displays out of control or dangerous behavior, is the protection of the patient, other patients, agency visitors and staff.

PROCEDURE:

I. CLINICAL EMERGENCIES

A. GENERAL GUIDELINES

1. Urgent behavior is defined as, but is not limited to:

   a) Suicidal ideation
   b) Homicidal intent
   c) Combative, threatening
   d) Overtly psychotic, paranoid
   e) Bizarre or inappropriate

2. An assessment will be made of the urgency and potential dangerousness of patient behavior.

   a) The potential dangerousness of the patient's behavior to self and others, and the history of this type of behavior, will be specifically addressed during the initial Clinical Evaluation (Intake Assessment). The patient's response, including denial of this behavior, and Evaluator's assessment will be documented in the Clinical Evaluation (intake report).
   b) Patients who have a history of suicidal ideation, homicidal intent, bizarre behavior, and acting out will be regularly assessed for dangerousness during ongoing treatment. The patient's response and staff member's assessment will be documented regularly in the progress notes, with accelerated frequency of documentation after an occurrence.
   c) Statements indicating dangerousness made to support or administrative staff, will prompt immediate notification of the patient's therapist, psychiatrist or Team Coordinator who will complete an immediate assessment.
   d) When the Evaluator's assessment indicates an immediate or significant potential for dangerous behavior, a psychiatrist or Health Officer will be consulted (if not already involved) for further treatment recommendations.
   e) When there is the potential need for involuntary hospital admission, a Health Officer will be consulted. The Vice President of Outpatient Clinical Services is available through "beeper" and can be paged if additional assistance in needed in an emergency situation.
   f) If the assessment of dangerousness is confirmed, one of the following arrangements will be made with psychiatric or clinical administrative approval.

      i) General hospital inpatient treatment,
      ii) Referral to Psychiatric Emergency Services (PES) for treatment in the Crisis Stabilization Unit (CSU).
      iii) Enlistment of a support person who is in agreement to take the

arrangements will be made with psychiatric or clinical administrative approval.

i) General hospital inpatient treatment,
ii) Referral to Psychiatric Emergency Services (PES) for treatment in the Crisis Stabilization Unit (CSU).
iii) Enlistment of a support person who is in agreement to take the responsibility to remain with the patient constantly until a follow up session is attended. The support person will be provided with a list of 24 hour emergency resources.
iv) Development of an alternate plan for safety of the patient and others.

3. A professional staff member will be responsible for responding to the patient's urgent behavior.

a) If imminently dangerous, the nearest professional staff member will intervene.
b) If danger does not appear imminent, the patient's therapist will be notified to immediately intervene and assess the situation. The therapist will be interrupted in session, if necessary.
c) When the ongoing therapist is not available in the building, the therapist's clinical supervisor, Team Coordinator, or a Clinical Evaluations (intake) Therapist will be notified to immediately intervene.

When the receptionist or support staff member is the first to identify the patient's potentially dangerous behavior, he/she will immediately notify one of the previously identified staff members (items a, b and c).
d) The first staff member to respond or the staff member who is most familiar with the patient, will be designated to coordinate the response to the patient's emergency. This staff member will request assistance when needed.
f) When appropriate, urgent psychiatric intervention will be requested.

4. If involvement of a number of available staff, ("show of force") is needed, a "STAT" page with the patient's location will be announced over the public address system.

a) All available Safety/Customer Service staff members will initially respond.
b) Announcements are accomplished by activating the page system.
c) If the location announced is a staff member's office, the first person to

arrive will go into the office while the other staff remain outside. The treating staff member will identify the assistance needed. At least one staff member will remain outside of the office with a view of the patient until the situation is resolved.

5. Protective measures will be taken when the patient is acting out or disruptive.

   a) The disruptive patient will be isolated and other patients will be cleared from the area. If the waiting room, the other patients will be moved to a safe location.
   b) The urgent patient will not be taken into an internal office or other location from which removal could prove difficult.
   c) An emergency patient in the agency will not be left alone. At the minimum, the patient will remain in sight of a professional staff member who is specifically observing the situation.
   d) Initial efforts will be focused on calming the patient and defusing the disconcerting behavior.
   e) If physically acting out, any items which the patient could easily use to harm him/herself or others will be removed from the area.
   f) A patient will not be restrained unless physically attacking someone or doing bodily harm to him/herself.
   g) The Police will be called when necessary to protect patients and staff and/or to provide transportation.
   h) Verbal and/or physical threats assessed as potentially lethal, by the patient towards self or others, will be reported to the Police and the individual in potential danger. If appropriate, the patient will be notified of the necessity of this action.

6. All staff, including Customer Service will be available during the urgent situation in order to obtain information, make phone calls, assess treatment alternatives, arrange transportation, etc.

B. **SPECIFIC CIRCUMSTANCES**

1. Involuntary admission: Inpatient refusals by patients who have been assessed as potentially dangerous to themselves or others.

   a) The patient will be evaluated by a psychiatrist or licensed psychologist. The "Application for Emergency Admission" (pink slip) will be completed.
   b) Emergency transportation to the Psychiatric Emergency Services by police, ambulance, EMS (911) or patient relatives will be arranged.

Which type of transportation is utilized will be determined based on the specific patient circumstances. PES will be called to inform them of the patient referral and to provide relevant clinical information.

c) The patient who attempts to leave the agency will not be physically restrained.

d) If the potentially dangerous patient leaves, the Police and a significant other will be immediately notified, providing any information as to the patient's location.

2. When unfamiliar noises emanate from an office such as loud voices, screaming, crashing, pounding, and/or threatening:

a) The office will be immediately called by anyone hearing the commotion.

b) A staff member will physically go to the office to see if assistance is needed.

3. Walk-ins: Patients who present themselves at Portage Path without a designated appointment.

a) All Walk-ins will be assessed by a professional staff member who will evaluate the individual and document contact information on the "Patient Contact Sheet" (0005). Urgency, dangerousness, and appropriateness of admission will be identified and documented.

b) If the Walk-in patient appears psychotic, bizarre, combative, threatening, or inappropriate, he/she will not be taken to an isolated area such as an office.

i) The waiting room will be cleared or office door left open.

ii) Another staff member will be notified to remain in visual contact and to provide assistance as required.

c) Minimal paperwork needed to implement Portage Path admission, will be completed by the therapist, patient's relative, or the patient while the emergency is addressed.

4. The "Contact" information taken during the initial phone call or walk-in to schedule an appointment, identifies a history of acting out, combative, threatening, bizarre, or unpredictable behavior.

a) When the patient comes in for the Initial Clinical Evaluation (Intake Assessment), the office door of the staff member conducting the interview will be left open.

b) A second staff member will be notified to be alerted to possible

problems.

5. The urgent behavior is identified through a phone call and the patient or caller is unwilling or unable to come to the agency for assessment and intervention:

   a) A staff member will keep the patient talking on the phone as long as possible.
   b) If possible, an adult at home with the patient will be spoken with in order to access further information regarding the urgency of behavior, and to ascertain ability to transport the patient.
   c) If potential of dangerousness is assessed and the address is known, the police will be called to intervene.
   d) If address is unknown, the phone company can be asked to trace the call.
   e) When possible, a significant other will be informed of the concern and the actions taken.

6. The police bring an individual to Portage Path for evaluation and treatment:

   a) The police officer will be asked to remain until the interview is complete.
   b) The police officer will be asked to sit in during the interview, if there is a specific concern regarding acting out behavior.

7. The patient demonstrating urgent behavior is suspected of abusing drugs and alcohol:

   a) The psychiatrist will be informed of this prior to conducting his/her portion of the assessment.
   b) Specialized assessment and follow up will be provided to patients who have a history of suicide attempts and substance abuse. The elements and implementation of this individualized consideration will be documented in the "Progress Notes".

8. The patient who has evidenced high risk, urgent or dangerous behavior does not return for treatment:

   a) Every effort to contact the patient through phone or letter will be made and documented in the "Progress Notes".
   b) If concerns remain as to dangerousness to self or others, a significant other will be informed of the reasons for this concern and the patient's failure to participate in treatment.
   c) The incidences of urgent behavior and treatment recommendations will

be documented in the "Discharge Summary" to assist staff if the patient returns to treatment.

9. The police or PES contact treatment staff with a request to intervene with an urgent patient situation outside of the agency.

   a) Clinical administration will be consulted.
   b) Staff members will generally not intervene outside the agency in emergency situations unless specific clinical circumstances dictate. This will require the approval by the Vice President of Outpatient Clinical Services or his designee.

10. When a patient death is suspected of being a suicide, the following steps will be taken.

   a) The incident will be immediately reported to all involved treatment staff, Quality Improvement, the clinical supervisor, Team Coordinator, and the Vice President of Outpatient Clinical Services.
   b) The incident will be processed as designated under "C. Unusual/Safety Incident Reports".
   e) When appropriate, a clinical staff member will contact the patient's family to offer condolences and support.

C. UNUSUAL/SAFETY INCIDENT REPORTS

1. All patient incidents will be documented on the "Unusual/Safety Incident Report" form by the intervening staff member.

2. All incidents are documented for active patients. Major incidents, such as suicide, homicide, rape charges, etc. are documented for former/inactive patients.

3. Reportable incidents include, but are not limited to:

   a) Suicide
   b) Suicide attempt
   c) Patient Death
   d) Felony Arrest
   e) Disposition Difficulty
   f) Disruptive/Dangerous Behavior
   g) Medication Concern
   h) Alleged Patient Abuse or Neglect

i) Patient Medical Emergency
j) Child Abuse or Neglect
k) Any patient behavior which could be considered dangerous to the patient or others.

4. The form is considered part of the agency's internal Quality Assurance and Improvement process, and will not be filed in or referenced in the patient's chart.

5. The original Unusual/Safety Incident form will be submitted to the Quality Improvement/Assurance Program Manager.

6. Copies of the report will be provided to Clinical Administration.

7. The Incident form will be reviewed and recommendations formulated at the next regularly scheduled Unusual Incident Committee Meeting.

8. As a result of the Unusual Incident Committee meeting(s), feedback will be provided to the clinical staff. Appropriate recommendations for changes in policies and procedures will be forwarded to the Clinical Administration. High Risk patients will be reviewed by the committee on an ongoing basis.

9. The agency's President, Vice President of Outpatient Clinical Services and the Alcohol, Drug Addiction and Mental Health Board's Chief Clinical Officer will be notified of any "major unusual incidents" as defined in the Ohio Department of Mental Health Standards (5122-24-01) within 24 hours of agency notification.

   a) Major unusual incidents can involve patients, agency staff (during working hours) and visitors.
   b) Major incidents are death, serious bodily injury, alleged criminal act, and alleged abuse or neglect. These incidents also include any life threatening situations, or serious consequences, related to the use of medication.
   c) At Portage Path, the reporting responsibilities will be coordinated through the Quality Improvement Director.

II. MEDICAL EMERGENCIES

A. The Paramedics ("911") will be called if the patient (staff member, visitor, etc.) indicates acute, urgent medical or physical problems.

B. The Paramedics will assess the need for further medical treatment.

C. Only qualified agency personnel will administer CPR or the AED, if the individual's symptoms warrant this intervention.

D. The "Unusual/Safety Incident Report" form will be completed by intervening staff. It will be processed as noted on page 10.6

11/86
Rev.Approved: 8/88
Revised: 3/91 8/91 1/92 2/92
5/95; 2/21/19

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LIST OF REFERENCED FORMS:

1. REFERRAL FOR INPATIENT HOSPITALIZATION
2. APPLICATION FOR EMERGENCY ADMISSION (PINK)
3. UNUSUAL/SAFETY INCIDENT REPORT
4. PROGRESS NOTES
5. DISCHARGE SUMMARY