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Quality Improvement of Psychiatric Care: Challenges of Emergency Psychiatry

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The presence of one or more risk factors—such as a major mental disorder, alcoholic dependence, and previous suicide attempts as well as acute psychosocial stressors—that bring a severely mentally ill person to the hospital emergency setting needs careful consideration and assessment before patient disposition. However, many factors and procedures, both patient and systems related, potentially diminish the quality of care provided and are burdensome to implement. Our article highlights the numerous lapses and obstacles to appropriate care that can occur and some proposed solutions to enhance the quality of care quality. The case example serves to illustrate one such scenario.

Case Presentation

"Mr. X," a 58-year-old married white man treated in the emergency department for complaints of low mood and suicidal thoughts, filed a patient complaint about his treatment in the psychiatric emergency department. We reviewed his case to identify quality of care concerns and ways to promote safety and appropriate care in the emergency department for patients with psychiatric complaints.

Mr. X contacted a clinical coordinator of our Affective Disorders Clinic seeking treatment. He reported a history of affective illness and ongoing suicidal thoughts. He wanted an inpatient admission arranged in order to "straighten out" his medications. The coordinator, concerned by his description of suicidal thoughts, told him to go to the nearest emergency room, as his problems sounded emergent. Furthermore, she could not confirm that a bed would be available on our inpatient unit, and she was uncertain that his insurance company would cover an admission at our facility.

Despite these warnings, Mr. X drove 70 miles, past numerous other hospitals, and came to our emergency department with a chief complaint of suicidal thoughts, planning either to hang himself or end his life by carbon monoxide poisoning. He was triaged directly to the psychiatric emergency services in the emergency department.

Mr. X's history and assessment were performed by a psychiatry resident. He was later seen by an emergency department resident and the attending physician. The patient's family history was significant for depression in both of his parents, as well as a sibling and three of his five children. One parent had a history of alcohol dependence. There were no known suicides in his family or any other known psychiatric disorders, including substance or alcohol abuse or dependence.

He did well in school, achieving advanced degrees, and had served as a high-ranking corporate official in several companies. He had, however, recently lost his job for unclear reasons. Mr. X had been married for 35 years and had several adult children. He had had an extramarital affair within the recent past and told the resident in the emergency room that he was "obsessed" with this woman, who had since moved away. He said his wife had decided not to leave him in his current state of psychiatric health, although the patient said he planned to separate from her.

His medical history was remarkable only for a series of back surgeries he had undergone for chronic back pain. He described escalating alcohol use, now at two "doubles" of gin per day. He reported no illicit drug use, including misuse of prescription pain medication.

His medication regimen included the following: lamotrigine, 75 mg b.i.d.; trileptal, 400 mg b.i.d.; extended-release venlafaxine, 450 mg/day; clonazepam, 0.5 mg at night; and ziprasidone, 20 mg at night. He said he was taking up to six clonazepam tablets in addition to alcohol to help with his sleep.

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He had been followed for major depressive disorder for 7 years, although his psychiatrist had recently rediagnosed his case as one of bipolar disorder type II. He had had only one prior psychiatric admission, 2 weeks before this presentation, for low mood and suicidal thoughts. He was discharged against medical advice after 1 day. He was seeing his psychiatrist weekly and numerous medications had been tried without success to alleviate his depressive symptoms. The duration of medication trials was unknown as were the doses used. The degree to which he was actually compliant with medications could not be ascertained, although his misuse of clonazepam raised the possibility of poor compliance with his other medications.

Mr. X told the psychiatry resident that he had felt depressed for the last several months, despite many changes in his medications. He had lost his job a month ago, which he called a "knife in the back" delivered at a board meeting. He described 2 weeks of increasing suicidal thoughts. He said he'd been driving around with duct tape and a hose in his trunk for days. He noted the

strain in his relationship with his wife for the last year since his infidelity had been discovered. He attributed his current mood to his affective illness and blamed his medications for "not doing a damned thing." He complained of decreased self-attitude and confidence and poor appetite. He told his wife that "no one cares about (him)."

When examined he remained alert throughout the initial interview, but was tearful and showed poor eye contact. He was ambiguous about his safety if he were to leave the emergency department. He was fully oriented. His insight into his condition and his judgment were both assessed as poor. A toxicology screen revealed no presence of alcohol and no drug metabolites, prescription or illicit, in his urine. He was formulated as having an exacerbation of bipolar affective disorder type II, depressed, severe, and alcohol and benzodiazepine abuse. The initial plan was for voluntary admission. Attempts to reach his psychiatrist were unsuccessful. Mr. X had informed the treating team that he had "fired" his psychiatrist.

Course of Events in the Emergency Department

Among the serious tasks to be undertaken in the emergency department is a suicide risk assessment. The Joint Commission had included assessment for suicide risk in its 2007 National Patient Safety Goals. There are multiple articles describing the clinical process by which one makes the assessment. Residents must be systematically educated to do so, regardless of what the patient reports (1).

As part of the patient's workup, outside informants were contacted and history and impressions collected. The patient was given his standing psychotropic medications. While in the emergency department, he showed no signs or symptoms of alcohol withdrawal, and his vital signs remained stable. After waiting for several hours, the patient complained of back pain and was allowed to lie down in a more comfortable chair. It became clear that the patient would not be admitted to our hospital for insurance reasons, as it was out-of-network for his insurance, and the cost of a stay would have been prohibitively expensive even for someone of substantial means.

Given the protracted wait while hospitalization at an alternative in-network hospital was sought, the patient insisted on leaving the emergency department to his wife's care. However, she told the resident she worried for the safety of the patient and herself if he were to leave the emergency department. Despite her concerns she insisted that this information not be made available to the patient. Unfortunately, because of insurance and other problems described below, he had a prolonged stay in our emergency department, and his demanding behavior persisted and even escalated through subsequent shifts.

As the patient continued to wait for some resolution of his insurance issue, he attempted to exert some control over the situation. He was aware that the young doctor he had seen was a physician in training. He tried intimidation, mentioning his prominence in the community and important people he knew. He then tried to expedite his admission to our facility and later listed the hospitals to which he would or would not be admitted.

Ultimately, he tried to bully the resident into releasing him as things were taking too long. He threatened to sue the resident and the hospital for holding him against his will. He told a resident on a later shift that the previous resident was being unreasonable and that the new resident (who was fully aware of the patient's precarious situation) seemed like a more reasonable person who could likely see things as they really were and that he should be allowed to leave. The patient was not allowed to leave. As his demand increased in frequency and tone, the resident told him that he would be admitted involuntarily, although commitment proceedings were not pursued.

After much delay, the patient's insurance authorized admission to the hospital in which he'd previously stayed and to which he said he would not return. Despite this, he signed a voluntary admission form for the hospital. His total length of stay in the emergency department was 31 hours.

As the patient's ambulance neared the accepting hospital, the patient jumped out in an attempt to escape. He was eventually admitted and apparently stayed several days, although treatment details are unknown. Following his discharge from the outside hospital, he drafted a letter to our hospital president, mentioning their friend in common, complaining of poor treatment and imprisonment, and vaguely threatening legal action. His complaint was forwarded to our physician advisor (G.J.) who spoke to the patient, assuring him that an examination of the emergency department procedure was being conducted to enable positive changes in the patient evaluation process.

Discussion

While there was a temptation to attribute this patient's complaints solely to his clinical condition, we suspected that some of his complaints had merit. The time he spent in the emergency department, for example, seemed remarkably long, given the straightforward nature of his presentation, evaluation, and disposition decision. This case prompted an evaluation of the internal and external factors related to quality of care and safety in our psychiatric emergency department. Sateia et al. (2) recommended focused quality studies when assessing management of psychiatric emergencies, examining both structural and process factors and their correlation to outcomes to identify deficiencies in care and remedy them. Selecting outcomes in the emergency department that will have a positive effect on overall patient care can be challenging. Suicide, for example, is a tragic, but generally infrequent, event (11 of 100,000 people) that is difficult to predict, making generalization difficult beyond basic suicide screening. Changes implemented in response to rare events may have little effect on the overall quality of care provided in the emergency department.

Methods of reviewing quality care in a psychiatric emergency department are reviewed in the literature (3, 4). Some examples include comparisons of outcomes based on insurance status (5), the need for increased training in key decision making (6), and the study of quality dimensions such as factors influencing length of stay in the

emergency department (7), as well as reduction in care quality by workload demands (8). The case described here effected a more comprehensive evaluation of care processes that potentially can impact quality.

During our literature search, we found no articles listed on MEDLINE or PsychInfo that addressed the *systems perspective* in the analysis of a case seen in the emergency department for a psychiatric complaint.

Quality Factor: Timeliness

The first resident saw the patient and made her evaluation and treatment plan fairly quickly. Despite this, the patient remained in the emergency department for over 30 hours. We looked more closely at the amount of time patients spend in our emergency department and found that over the last decade, both patient volume and length of stay have steadily increased. The reason for this is multifactorial and involves both internal and external factors. Within a teaching hospital, there are inherent inefficiencies that come with the mission of providing an educational experience for medical students and residents who are learning the processes by which patients are evaluated and treatment decisions are reached in the emergency setting. In most cases, in our emergency department, a patient is seen by three physicians (a psychiatry resident, an emergency department resident, and an emergency department attending). As it was a busy day when this patient was seen, it was over 3 hours before the psychiatry resident was able to get to the patient. The case did not require an extensive medical workup, although the patient had to be seen and "cleared" by the emergency department resident and attending before a disposition could be effected. The clinical decision in this case was clear, and a decision to admit the patient to the hospital was quickly formulated; the next stage in the admission process accounted for the majority of this patient's stay in the emergency department.

Quality Factor: Insurance-Related Delays

Insurance issues and finding a bed in an overstretched system of psychiatric care played a significant part of the patient's long stay in the emergency department. The offices of this patient's insurance company were open only during regular business hours during weekdays. In this case, admission to our hospital would not be covered by his insurance as we are out-of-network for his plan. The patient had the option of covering the cost of admission to our hospital himself, which would likely have run into the tens of thousands of dollars. As this was prohibitively expensive for the patient because of his precarious financial situation, admission to some other hospital had to be arranged. The insurance company offered no assistance in this process beyond a list of eligible hospitals. Our staff had to then contact each hospital to inquire about open beds.

If a bed is available at an outside hospital, clinical information is then faxed to and reviewed by staff there. This process may take hours, and without preauthorization (which in this case could not be obtained as the insurance company was inaccessible overnight) hospitals are reluctant to accept transfers. The patient remained in the emergency department until preauthorization was obtained and the rounds of calls and faxes could commence. Hospital admissions for acute medical or surgical problems require no such preauthorization; this suggests an inherent form of discrimination against persons with acute psychiatric problems. In addition, it causes obvious inconvenience for patients, families, and staff and creates unnecessary delays in care. In Maryland, a law was recently passed that requires insurance companies to be available 24 hours a day every day for preauthorization of care (9). The law does not apply to the numerous plans subject to the federal Employee Retirement Income Security Act (ERISA).

Quality Factor: Absence of Therapeutic Relationship

An insurance company may contend that they do not require preauthorization for admission and that the patient can be admitted "anywhere." The next day, however, once the patient has been admitted to the out-of-network facility, the insurance company will inform the treating team that the patient's care will not be covered for the facility and he or she will need to be sent elsewhere to a hospital in-network. A transfer within hours of admission is remarkably disruptive to the therapeutic relationship. The patient is transferred to another hospital to be reengaged in another treatment setting. This reinforces the complaint of some patients that they are now regarded as "customers" or "clients" by their physicians not patients with individual complaints as well as unique concerns seeking care. In these circumstances, establishing a meaningful and effective therapeutic relationship with the patient is challenging, if not impossible.

Quality Factor: Delayed Care

As this patient stayed longer than a day in our emergency department, should we have treated him as an inpatient? With prolonged emergency department stays, patients are often being restarted on medications, even started on new ones and periodically reassessed. This is in addition to the nursing and other specialized care they receive in an emergency department. The emergency department has in many cases become a short-stay psychiatric service by default, often without compensation for the services provided.

On an inpatient service, much is done for a patient during the first 48 hours. Intense observation and workup, including obtaining information from various sources that would have otherwise been available to this patient on an inpatient service, have to be postponed while the patient, family, and staff wait for a bed. Although our patient's decision to travel so far from home may have added to the delays he experienced, he would likely have experienced similar delays had he gone to the nearest out-of-network emergency department for help.

Quality Factor: Patient Safety

Increasing amounts of time spent in the emergency department and increasing patient volume for patients with psychiatric complaints also raise clinical concerns. In this case, the patient became increasingly restless and demanding in a busy, crowded emergency department. While our residents performed admirably given the circumstances, with a prolonged stay and a nagging patient, the temptation to take him at his word and discharge him could have been an issue, simply to settle one of the many problems to be faced that day and in spite of significant risk to the patient and others for doing so. The data on crowding and agitation are clear. Lack of space, overcrowding, risk of violence, and the lack of privacy often encountered in emergency departments could escalate a patient already in distress (10).

Quality Factor: Confidentiality and Privacy

Persons presenting to an emergency department with a psychiatric complaint often find themselves answering personal, sensitive questions in a crowded, noisy setting not conducive to sharing such information comfortably (11). This can certainly affect the quality of the information elicited, as the patient may be naturally reluctant to speak freely. In this era of protected confidentiality rights of the Health Insurance Portability and Accountability Act of 1996, the emergency department is often a place of unintentional infringement of these rights because of space issues. While some have proposed practical approaches to guaranteeing greater privacy in the emergency department (12), this is not the universal experience of patients and may in some settings reflect the exception, not the rule.

Quality Factor: Patient Satisfaction

The lack of daily comforts such as meals, availability of a shower, comfortable seating are all factors that contribute to the perception of poor care despite an extraordinary effort to secure the safety of the patient. Sateia et al. (2) and Roper and Manela (13) have pointed out that patient satisfaction may often be related to nonmedical factors, such as an attitude of caring, educational videos, etc., and not to the stabilization of the immediate crisis. Time to evaluation can have an impact on patient satisfaction (14) although efforts to inform patients about the reasons for delays in care can have a positive effect on their perception of their emergency department experience (15).

Quality Factor: Determination of Dangerousness

The staff in the emergency department correctly handled the patient's threats, narcissism, and efforts to dictate his care despite impaired insight and judgment. Had the patient succeeded in bullying the resident, his safety might have been compromised. Although staff did well in assessing his risk for suicide and other unpredictable behavior, no one took responsibility to warn the emergency medical transport team about the possibility of an escape attempt. Every member of a care team, including nursing assistants, technicians, lab workers, security staff, and others, must be involved in communications about dangerousness to self and others. Too often, paramedical personnel are "invisible" in the care of seriously ill patients. They, too, must be included in patient care decisions to ensure handoffs are appropriately performed at every point of care transition.

Quality Factor: Relationships Within the Emergency Department and Continuity of Care

The residents in this case communicated quite well while handing off care at the time of sign out. Had a resident on a later shift not been aware of the seriousness of the patient's situation, a bad outcome could have ensued. Direct communication and effective handoffs are of paramount importance in the emergency department, where busy schedules at times prohibitively interfere with communication.

The conversation this case produced eventually led to a decision by the department to invest more resources in the emergency department to ensure better oversight of cases. We also instituted 24-hour specialized psychiatric nursing coverage. Residents were provided extra training and supervision in handling those with splitting of staff or concern on the part of medical personnel and those with delays in hospitalization. Two committees were formed that meet regularly to review problems in the emergency department.

Quality Factor: Efficiency

The influx of patients in the emergency department and external factors, such as insurance delays, are beyond the control of emergency department personnel. Space issues are also a concern in many emergency departments. Despite this, a focus on efficiency of the process may reap benefits. We have been able to implement changes in communication that we believe will improve the flow of patients from triage to our psychiatric area. Efforts are currently under way at our institution to assess and practice readiness to handle large caseloads, including during disaster scenarios.

Appropriate triaging by medical staff, bed availability, and compatibility of service with patient needs have also been areas of focus.

Conclusions

Griffey and Bohan (16) have advocated using health care workers' complaints as an aspect of customer care to promote care quality. Also, Taylor et al. (17) and Summers and Happell (18) advocate scrutiny of issues of communication, staff attitude, and courtesy that significantly affect patient satisfaction. Improvement in the environment of the emergency department and effective pain relief greatly enhance a positive perception of quality of care (19). Handoffs are critical in the care of acutely ill psychiatric patients, as in the example given earlier, because their mental states can change quickly (20).

Although we have mentioned some broad areas of care quality cited in the literature, there has been no report of

an examination of a system of care that affects the care process in emergency psychiatry.

In our report, we sought to highlight a complex system of factors that affects patient outcomes in a busy emergency department. Our case example illustrates that through examination of the care process, an exploration of the multiple difficulties that may be encountered in arriving at a safe disposition of a seriously ill patient may lead to useful interventions. Such an examination has led to a better understanding of management practices in our emergency department. In addition, we note that developing a quality assurance system for psychiatric emergencies requires:

- A comprehensive understanding of personal and systemic factors that impact the quality of care delivered
- A valid and reliable method of measuring care quality that may differ from place to place; dangerousness is only one target symptom
- A system for assessing and promoting positive changes
- A coordinated team of medical and psychiatric personnel who drive such changes continuously
- A method of evaluating change through the use of data and interventions
- Ongoing monitoring of the system through objective feedback from patients and other outcomes such as length of waiting time.

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Dr. Jayaram is on the speakers bureau for Janssen and GlaxoSmithKline. Dr. Triplett reports no competing interests.

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