Releasing A Patient Following A Behavioral Health Crisis

GENERAL OPERATING POLICY

Release of Patients Presenting in Behavioral Health Crisis

Effective: 10/2019

PMH, PPMC, PSVMC, PWFMC, PNMC, PHR, PSH, PMMC

OBJECTIVES:

To enhance patient safety and provide the best care of the patient presenting in behavioral health crisis in Providence Oregon Region Emergency Departments and Inpatient Behavioral Health units.

To establish a policy that assures the compliance with the discharging of patients in behavioral health crisis from the Emergency Department and all inpatient units, medical and behavioral, that is in accordance with Oregon House Bills 2023, 3090 and, as applicable, 3378 (Chapters 263, effective January 2016).

POLICY STATEMENT:

Passage of HB 2023 and HB 3090 (ORS 441.196; Oregon Laws 2017, chapter 272), mandates that Oregon hospitals must adopt and implement a policy for the discharge of a patient who presented with a behavioral health crisis. The hospitals policy must be publicly available to patients and their lay caregiver(s). H.B. 3378 also requires hospitals to adopt and maintain written discharge policies for all inpatients, including psychiatric inpatients covered under the provisions of H.B. 2023. The law applicable to general discharge policies requires hospitals to provide the patient and designated lay caregiver with instruction or training prior to discharge, as necessary for the caregiver to perform aftercare functions. This is equivalent to existing federal standards which require hospitals to counsel the patient, family members, or other interested persons as necessary for post-hospital care, also applicable to all inpatients

This policy applies to all patients being discharged from an Emergency Department or Inpatient unit in any Providence Acute Care Ministry. This policy, as required, will be publicly available on the Providence Oregon website (providence.org, choose Oregon, choose “Releasing a patient following a behavioral health crisis” under Programs toward the bottom of page) and given to the patient, and lay caregiver if available, during
admission and at discharge.

**DEFINITIONS:**

**Lay Caregiver:** either an individual designated by the patient or a parent or legal guardian and whom a health care provider may disclose protected health information without a signed authorization (ORS 192.567) or an individual who, at the request of a patient, agrees to provide aftercare to the patient in the patient's residence (ORS 441.198). It is Providence practice to obtain a release of information prior to disclosing health information except in emergency situations and/or when patient condition is such their confusion or level of consciousness prevents their ability to give consent and care would be negatively impacted.

**Lethal means counseling:** counseling strategies designed to reduce the access by a patient who is at risk of suicide for suicide by lethal means, including but not limited to firearms (OAR836-053-1403)

**Behavioral Health Crisis:** a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate treatment to prevent a serious deterioration in the individual's mental or physical health (ORS 441.053).

**Behavioral Health Clinician:** a) licensed psychiatrist; b) a licensed psychologist; c) a certified nurse practitioner with a specialty in psychiatric mental health; d) a licensed clinical social worker; e) a licensed professional counselor or a licensed marriage and family therapist; f) a certified clinical social work associate; g) an intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or h) any other clinician whose authorized scope of practice includes mental health diagnosis and treatment (ORS 743A.012b).

**Caring Contacts (ED Only)** Brief communications between the patient and a community provider to successfully transition the patient to outpatient services. The provider can be a behavioral health clinician, peer support specialist, peer wellness specialist, family support specialist or youth support specialist. Peer support, peer wellness, family support and youth support specialists are persons certified by the Oregon Health Authority, Health Systems Division who provide supportive services to persons receiving mental health or addiction treatment.

- Caring contacts can be facilitated through a contract with a qualified community based behavioral health provider or through a suicide prevention hot-line;
- A caring contact may be conducted in person, teledicine or by phone.
- A caring contact must be attempted within 48 hours of release from the Emergency Department if a patient has attempted suicide or experienced suicidal ideation.

**Warm Hand off:** All Acute Care Inpatient Psychiatric Units must provide a warm hand-off at discharge under The United States Department of Justice/Oregon Performance Plan for all patients meeting the definition of severely and persistently mentally ill. A warm hand-off is the process of transferring a patient from one provider to another, prior to discharge, which includes face-to-face meeting(s) with the patient as well as hospital staff if possible. A face to face meeting may be accomplished through technological solutions that provide two-way video-like communication on a secure line (*telehealth*), when either distance is a barrier or individualized clinical criteria support the use of telehealth.

**Evidence based practices:** The integration of clinical expertise, patient values, and the best research evidence into the decision-making process for patient care.

**Publicly available:** Posted on the hospital's website and provided to each patient and to the patient's lay
Procedure:

The Oregon Health Authority administrative rules address general discharge planning requirements including specific requirements for discharging a patient hospitalized for mental health treatment or releasing a patient from an Inpatient Unit or Emergency Department who presented with a behavioral health crisis.

These went into effect June 24, 2015 and December 1, 2018 respectively and apply to all Oregon ministries regardless of availability of behavioral health clinicians (Psychiatrist, CSWA, LCSW, LPC) to perform an assessment and discharge planning.

For the purpose of this policy, the following defines a patient in behavioral health crisis:

A. Admission to an inpatient unit, medical or behavioral, and does not exclude patient in observation status, for whom admission occurred as a result of a behavioral health crisis.

B. Patients receiving care while in the emergency department and assigned to the behavioral health safety tab in EPIC.

The following elements are required for patients who are at least 14 years of age or older when discharging from an Inpatient Unit or Emergency Department who presented in Behavioral Health Crisis and elements may incorporate evidence-based practices:

A. Behavioral health assessment conducted by a behavioral health clinician that includes: a best practice suicide risk assessment with lethal means counseling and a safety plan, input from the lay caregiver as available, as well as any other relevant collateral contacts.

B. Request patient sign authorization form (ORC 240A) and encourage patient to identify lay caregiver to participate in safety and discharge planning. The patient handout/summarization informs the patient that he/she can revoke the release of information at any time, the hospital does not require disclosure without patient permission and that only the minimal information necessary will be shared.

C. Provide information on benefits of involving lay caregiver and disclosing information to him/her, as well as limits to disclosure as outlined within the patient summarization given during admission and at discharge and noted on the release of information disclosure form.

D. Patient long-term needs assessment that includes:
   1. Capacity for self-care including but not limited to risk of self-harm, available support network at the location of anticipated discharge and resources available to access prescribed medications or travel to follow-up appointments,
   2. Need for community-based services, and
   3. Potential appropriate discharge placement, including whether the patient may return to the place from which they resided prior to hospital admission or emergency department visit or if step-down resources are needed.

E. Provider will accept unsolicited information from family and friends not authorized for disclosure.

F. Care coordination including transitioning to outpatient treatment that includes one or more of the
following: community-based providers, peer support, lay caregivers or others who can implement the patient's plan of care.

G. Schedule follow-up appointment that occurs within 7 days of discharge with a provider that is appropriate to address crisis follow up and ensure the next provider of care receives adequate documentation of the crisis visit. If a follow-up appointment cannot be scheduled within 7 days, document the applicable barriers in the patient's medical record as well as provide documentation if follow up is not applicable due to patient transfer to another inpatient/residential facility.

H. Case management that includes clinical review of the patient record and interview of patient and/or lay caregiver, if present, to determine and address any medical, functional and/or psychosocial barriers to safe discharge, recommend resources and supports, and agreed upon by the patient.

I. Educate lay caregiver on diagnosis, treatment recommendations, outstanding safety issues, discharge criteria as well as inform lay caregiver of patient discharge prior to discharge.

J. Provide discharge instructions (verbally and in writing) to the patient and lay caregiver addressing how to provide care and assistance to the patient that may include safety plans, administration of medications, community appointments, or any other anticipated assistance relating to the patient's condition. Document discharge plan.

K. Notification to the designated lay caregiver of the patient's discharge from the hospital is required. This notice should be provided enough in advance to allow the lay caregiver to be present if that is necessary.

All elements are required to be completed in a timely manner so as not to delay discharge or transfer to another facility. If at any time a patient refuses resources or supports, safety plan and/or discharge plan/instructions, the physician will be consulted to reassess readiness for discharge, to include suicide risk. By completing a BH clinical assessment that includes care management and long-term needs assessment the hospital is ensuring the discharge plan is appropriate to the needs and acuity of the patient and the abilities of the lay caregiver. For additional information on the who/what/where the required elements for emergency department discharge are, please use the workflow attachment linked below. For patients discharged from the emergency department following a behavioral health crisis, a caring contact by a peer support specialist or behavioral clinician will occur within 48 hours of discharge.

WRITTEN BY:
Kristin Powers-Regional Director Acute & Integrated Behavioral Health

IN COLLABORATION WITH:
Oregon Regional Emergency Department Clinical Collaborative

REFERENCES/RESOURCES:

The United States Department of Justice/Oregon Performance Plan: www.oregon.gov/oha/HSD/BHP/Pages/Oregon-Performance-Plan.aspx

HB 3378 https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB3378/Introduced
PolicyStat ID: 4235921

ORC 240A Authorization to use, disclose & release protected health information

**Attachments: HB3090 patient handout**

**Approval Signatures**

Kristin Powers - Regional Director Acute & Integrated Behavioral Health

Angela Graves - Regional Manager Professional Practice & Development/Quality

**Applicability**

OR - Clinical Support Staff (CSS), OR - Connections, OR - Credena Health (CH), OR - Home Health (HH), OR - Home Medical Equipment (HME), OR - Home Services, OR - Home Services Pharmacy (HSRx), OR - Hospice (HO), OR - Providence Ctr for Medically Fragile Children, OR - Providence Hood River Memorial Hospital, OR Providence Medford MC, OR - Providence Medical Group, OR - Providence Milwaukie Hospital, OR - Providence Newberg MC, OR - Providence Portland MC, OR - Providence Seaside Hospital, OR - Providence St. Vincent MC, OR - Providence Willamette Falls MC

**Attachments**

- 9.30.20 FINAL-BH Crisis workflow.pdf
- Brown_StanleySafetyPlanTemplate.pdf
- ED Practice Guideline- Suicide Screening and Care of Behavioral Health Patients.pdf
- HB 3090 Lay Caregiver Brochure_Patient Handout.pdf

**Approval Signatures**

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BH Crisis Identified

Behavioral Health Clinician completes BH assessment

BH Assessment:
- Clinical assessment form
- Physician documentation

Suicide Risk Assessment/CSSRS
Lethal Means Counseling
Safety Planning (Stanley Brown)

Long Term Needs Assessment
- Capacity for self care
- Need for community-based services
- Potential appropriate discharge placement

Coordinating Care
Notification to next provider of care (ex: PCP, therapist, peer support)
Document discharge plan

Case Management
Medical, functional, psychosocial

7 day follow up appt

Primary RN completes suicide screening and organizes patient care activities.

Add patient to the BH safety tab. Patient will then be queued up for Caring Contact post discharge.

Within 2 hours of admission, give patient HB 3090 Lay Caregiver Brochure/Handout and request ROI for Lay Caregiver.

At discharge give patient and lay caregiver (if present) HB 3090 Lay Caregiver Brochure/Handout, with the AVS. Document that the handout was given.

Positive=required

If a patient declines safety planning or follow up care, alert ED physician for re-assessment and collaboration.

BH Clinician, defined:
- a) licensed psychiatrist;
- b) a licensed psychologist;
- c) a certified nurse practitioner with a specialty in psychiatric mental health;
- d) a licensed clinical social worker;
- e) a licensed professional counselor or a licensed marriage and family therapist;
- f) a certified clinical social work associate;
- g) an intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or
- h) any other clinician whose authorized scope of practice includes mental health diagnosis and treatment

Caring Contact provided by Providence Peer Support Program*

*Seaside Behavioral Health Clinician completes their own Caring Contacts.

Policy owner reviewed/approved 9/1/2020
Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. 
2. 
3. 

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. 
2. 
3. 

Step 3: People and social settings that provide distraction:

1. Name____________________________________________________ Phone______________________________
2. Name____________________________________________________ Phone______________________________
3. Place__________________________________________ 4. Place______________________________

Step 4: People whom I can ask for help:

1. Name____________________________________________________ Phone______________________________
2. Name____________________________________________________ Phone______________________________
3. Name____________________________________________________ Phone______________________________

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name____________________________________________ Phone______________________________
   Clinician Pager or Emergency Contact #___________________________
2. Clinician Name____________________________________________ Phone______________________________
   Clinician Pager or Emergency Contact #___________________________
3. Local Urgent Care Services
   Urgent Care Services Address____________________________________
   Urgent Care Services Phone_____________________________________
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. 
2. 

The one thing that is most important to me and worth living for is: ____________________________________________
# ED Practice Guideline: Suicide Screening and Care of Behavioral Health Patients

Note: This practice guideline describes essential components of assessments and intervention. The hospital may incorporate established evidence based practices. The implementation of the guideline is based on the patient's chief complaint and clinical presentation. Implementation of the guideline and removal of the guideline is acceptable ONLY upon the provider's judgment, and should be reflected in documentation by the provider and/or the patient's primary nurse. (Provider: document in Nurse Communication Order; primary nurse document in the electronic health record (EHR). All discharge policies must be made publicly available.

## Guideline Goals:

1. To maintain safe conditions for patients, visitors, and caregivers.

## Triage RN Safety Assessment and Interventions

1. Assess and document patient's chief complaint.
2. Assess for possible medical conditions associated with, or independent of a mental health complaint presentation.
3. Refer emergent medical issues for immediate ED Provider evaluation.
4. Assess mental status.
5. Place the patient in an appropriate location, considering safety needs to include:
   a. Observation needs
   b. Removal and securing of patient belongings
   c. Environmental safety and mitigation
   d. Possible need for restraints or seclusion (Refer to Restraint and Seclusion Policy).

## Risk for Violence/Suicide Risk Assessment

1. All patients who present with potential behavioral health concerns (including, but not limited to,
complaints of suicidal or homicidal attempt or ideation, depression, and anxiety) must have their suicidal/homicidal risk level assessed. The Columbia Suicide Severity Rating Scale (CSSRS) Screening Tool in EPIC must be completed as part of the triage screening for patients.

2. If the patient answers "yes" to any of the screening questions, the RN must chart the patient's level of risk for violence/suicide. (see below, Safety Classifications)

3. The patient's immediate safety needs should be addressed and documented, including appropriate setting for treatment and consideration of observation needs. This also includes possible seclusion and/or restraint defined in the Restraint & Seclusion policy.

4. The triage RN should document whom they notified of the patient's safety risk within the Electronic Health Record (EHR)

5. If a patient is identified as being at risk and is able to cooperate with treatment, the patient may be able to wait to be evaluated for presenting complaint. In the event that the patient's condition changes and is unable to cooperate with treatment, a nursing reassessment including the Behavioral Activity Rating Scale (BARS), should be documented and further steps as indicated in collaboration with the treatment team.

6. Patient assessment and clinical judgment should be used to determine safety needs throughout the patient's visit.

7. Refer to policy ED Practice Guideline for Triage.

Safety/Suicide Risk Classification

Examples listed under each safety classification are provided as a guide and point of clarification. They do not supersede clinical judgment that a patient's condition may warrant a higher classification. Judgment should error on the side of increased safety.

It may be helpful to collect information from other collateral sources such as police or law enforcement; to assess patient's most urgent psychiatric and medical needs, while continuously considering confidentiality concerns of the patient. The hospital must not require the disclosure of protected health information without obtaining a patient's consent.

The hospital may incorporate established evidence based practices.

The Regional ED Triage Nurse Behavioral Health Workflow (attached) shall be referenced for patient observational needs.

The ED 2020 BH Environmental Assessment and Mitigation Plan (attached) shall be referenced for room/area safety mitigation.

The policy named "Safety Management Plan" shall be referenced for general safety guidance.

The patient will be asked the CSSRS Screening questions. The patient's responses will guide the caregivers in the development of an observation status and mitigation of the treatment room/area.

1. Low safety/suicide risk: patient answers "no" to all CSSRS screening questions, does not complain of, or appear to be psychotic and is not an elopement risk. Patient can be seen in any room as "General Behavioral Health" status meaning patient does not require enhanced observation. A mitigated room should be used when possible.

2. Moderate safety/suicide risk: patient answers "yes" to CSSRS screening questions 1 or 2 and "no" to questions 3-6. Patient requires Q15' close observation until seen by Provider. If Treatment Team (including Provider) agrees close observation is not needed, alternative plan and/or discontinuation of close observation will be decided at that time and written as a Provider's Order.
3. **High safety/suicide risk:** patient answers "yes" to CSSRS screening questions 1 or 2 and "yes" to any of questions 3-6. *Requires 1:1 continuous observation until seen by Provider unless placed in a designated BH secured area such as PSV Red Pod. If Treatment Team (including Provider) agrees 1:1 continuous observation is not needed, alternative plan and/or discontinuation of constant observation will be decided at that time and written as a Provider's order.*

### Safety Observation

**General Behavioral Health** - Patients do not require enhanced observation.

**Close Observation** - The key element of an adequate close observation is *direct visual observation* of the patient every 15 minutes. Staff must be close enough to the patient to view respirations and observe the head and neck of the patient. Using a flashligh or approaching the side of the bed may be necessary to fully observe the patient. The identity of the patient must also be ensured.

**Continuous Observation** - Consider continuous observations for patients needing more frequent supervision than *15 minute observations*. Security officers can be utilized to assist *high risk* patients to ensure safety.

*Note:* PSV Red Pod and PPMC Team 5 are appropriate for any level of safety observation up to and including continuous 1:1 observation.

### Mitigation Considerations

1. Prior to patient's arrival in the treatment room, the room must be assessed and mitigated for safety. This includes removing ligature risks, sharp objects and other potential dangerous objects from the area when possible. This may be delegated to an Emergency Department Technician (EDT) or Behavioral Health Technician (BHT) by the receiving RN. Preparation of room safety should be charted once performed. *The ED 2020 BH Environmental Assessment and Mitigation Plan (attached) should be referenced for room/area safety mitigation.*

2. The patient must remain in constant observation until a handover to another caregiver has occurred. A handover does not change the level of observation. The level of observation can be changed by the ED Provider when appropriate. The change must be written as an order by the ED Provider if observation level is being downgraded.

3. The hospital must not delay a patient's discharge or transfer to another facility.

### Receiving Treatment Team Member

1. Upon arrival of all behavioral health patients to their room, the receiving RN completes (or delegates) and documents the following:
   a. Removal of all patient belongings.
   b. Removal of other items in the patient care area that can have the potential to cause injury/harm to patient or staff.
   c. Placement of patients into safe scrubs while observed by caregiver for safety.
   d. Documents actions taken to lessen the risk of violence/suicide within the patient's immediate environment.
Primary RN

1. Confirm removal of patient belongings and other items that may be used to induce harm.
   a. Confirm and document that the patient is in safe scrubs.
   b. Assess and document patient's level of safety risk.
   c. Determine and document observation needs of patient.
   d. Ensure and document patient's treatment room has been mitigated for safety.

2. Assess for possible medical conditions associated with, or independent of a behavioral health complaint presentation. Communicate to the Provider and document findings in the EHR.

3. Consider need for seclusion or physical restraint order if patient is at risk to injure self or others.

4. Refer to policy "Regional Nursing Minimum Documentation Reference" for charting guidance.

5. Reassess the patient's safety needs and response to intervention. This includes assessment of the desired or adverse effect of administered medication(s).

6. Add patient to the Safety Behavioral Health Tab in EPIC. This will allow caring contacts be automatically arranged within 48 hours of release from ED.

7. The RN will encourage the patient to designate a lay caregiver and sign authorization form ORC 240A (attached). The patient will be informed that they have the ability to rescind the authorization of the lay caregiver at any time. RN is to document in the Safety Behavioral Health Tab, the name and phone number of the patient's lay caregiver if patient desires their collaboration in discharge planning as part of the initial assessment. This should be completed within 2 hours of patient's admission to the Emergency Department.
   a. If the patient does not wish to name a Lay Caregiver, click the "decline" box next to Lay Caregiver in the Behavioral Health Tab.
   b. The RN will educate the patient and lay caregiver (if present) the benefits of involving a lay caregiver in the discharge plan for the patient. The Providence Information sheet should be given to the patient and lay caregiver if present at this time and charted as such in the Safety Behavioral Health Tab.

8. Complete a nursing note, with a complete set of vital signs every 8 hours (and more frequently as appropriate).

9. Complete and document an assessment, with vital signs, very 4 hours, if patient has received sedating medications (more frequently, if indicated).

10. Complete and document an assessment with a complete set of vital signs after any self-harm event. If patient refuses vital signs, document as such. Report the self-harm event to the Provider to determine next steps in patient care. Document the notification to Provider and all updates to treatment and/or discharge safety plan.

11. Complete a focused reassessment upon assuming care of the patient.

12. Complete a BARS assessment every 4 hours and as needed per changes in the patient's behavior.

13. Complete the Safety Assessment in EPIC every 1 hour and upon patient assignment to a new treatment room to assure room has been mitigated for patient safety and validates a safe
environment for the patient.


15. Disposition of patient
   a. The patient's immediate safety needs and the appropriate setting for treatment should be considered in disposition planning.
   b. Ensure the discharge planning is appropriate to the acuity of the patient, the needs of the patient and the abilities of the lay caregiver.
   c. A plan for ongoing needs should include patient's capacity for self-care and whether the patient can be properly cared for in the place the patient resides at the time patient is in the Emergency Department.
   d. RN must document patient's understanding of discharge instructions.
   e. If a patient:
      i. declines the safety plan and/or discharge instructions or
      ii. is unable to understand the safety plan and/or discharge instructions or
      iii. refuses to sign any documents required by policy or
      iv. refuses to be given a copy of the safety plan and/or discharge instructions alert the ED physician.

16. All abnormal vital signs should be reevaluated and made aware to ED Provider prior to disposition.
   a. Refer to the following policies in Policy Stat as needed:
      Emergency Treatment and Active Labor Act (EMTALA) Patient Transfers Between Facilities
      ED Practice Guideline Discharge Plan of Care and Education of Non- Behavioral Health Patients
      ED Practice Guideline Delayed Admission
      Releasing A Patient Following a Behavioral Health Crisis
      ED Practice Guideline Triage

**Risk for Violence/Suicide Risk Interventions**

1. Agitated but not physically aggressive:
   a. Reasonable methods of de-escalation and least restrictive measures should be used and documented prior to using physical restraints. Techniques such as reassurance, limit setting and negotiation may be employed, using simple, direct language.
   b. Use BARS as a tool to help assess the need for PRN medications.
   c. Consider pharmacological treatment of anxiety, agitation or psychosis after physician and RN assessment.

2. Escalation in aggressive behavior:
   a. Reasonable methods of de-escalation and least restrictive methods should be used and documented prior to using physical restraints. Techniques such as reassurance, limit setting and negotiation may be employed, using simple, direct language.
   b. Use BARS as a tool to help assess the need for PRN medications.
   c. Consider pharmacological treatment of anxiety, agitation or psychosis after physician and RN assessment.
Visitors

1. Provide patient visitors with a sticker identifying them as such. Visitor's belongings are to be secured or cleared by a caregiver. All visitors of behavioral health patients MUST check with the patient's primary nurse prior to entry. (Refer to policy "Visitors to Patients" for additional guidance or clarification)

ED Provider

1. Assessment
   a. Complete an emergency medical screening examination, including potential medical causes of presentation.
   b. Assess mental status and consider psychosis and suicidal ideation. The suicide risk assessment should include identification of factors and features that may increase or decrease risk for suicide.
   c. Continually assess and manage the safety needs and concerns of the patient.
   d. Assess the patient for the need for a Notice of Mental Illness and/or medication treatment, Director Hold or 12 hour Transport Hold depending on your ministries designation.

2. Interventions
   a. Proceed with interventions and orders as necessary, including but not limited to initiation of order for seclusion/restraints or Notice of Mental Illness and/or medication treatment, Director Hold or 12 hour Transport Hold depending on your ministries designation.
   b. In an emergency (situations of imminent danger to self or others), medications/treatment may be given without patient consent with an order from the Emergency Department Provider.
   c. Do not continue to administer medication or treatment after the emergency has subsided or
the patient has regained the ability to consent to the treatment, without obtaining the patient's informed consent.

d. Document in the EHR the specific nature of each emergency and the procedure that was used to deal with the emergency. If the patient is unable to give consent, document that fact in the EHR.

3. Disposition

a. The patient's immediate safety needs and the appropriate setting for treatment should be considered in disposition planning.

b. Consult with the psychiatric social worker (when available) to discuss plan of care, including disposition.

4. Admission and/or Transfer

a. Arrange and coordinate admission at a facility capable of providing the appropriate level of care if unable to offer the appropriate level care at your ministry.

5. Discharge

a. A plan for ongoing needs is developed by considering the patient's risk assessment and long term needs including patient's capacity for self-care and whether the patient can be properly cared for in the place the patient resides at the time patient is in the Emergency Department.

b. Outpatient treatment should be initiated to help transition the patients care to community-based providers, peer support, lay caregivers or others who can implement the patient's plan of care.

c. When possible have a follow-up appointment scheduled within 7 calendar days of discharge. If this is not possible, document the reason in the patient's chart if not performed by CIS.

d. Ensure the discharge planning is appropriate to the acuity and abilities of the patient and the abilities of the lay caregiver.

e. If a patient:
   I. declines the safety plan and/or discharge instructions or
   II. is unable to understand the safety plan and/or discharge instructions or
   III. refuses to sign any documents required by policy or
   IV. refuses to be given a copy of the safety plan and/or discharge instructions, pause and reassess patient. Engage the patient and lay caregiver (if available) to explain the clinical rational behind the plan. Ensure that care providers are aware that the patient has declined the safety plan and/or discharge instructions.

6. Reassessment of boarding patients

a. Reassess the patient at least every 12 hours or with change in patient's condition. Make adjustments to the treatment plan as indicated.

Psychiatric Consultant (when available)

1. Assessment

a. Conduct a behavioral health assessment using the CSSRS assessment in EPIC, including
but not limited to a risk for violence/suicide risk assessment. Include identified factors and features that may increase or decrease risk for suicide and violence.

b. Communicate safety risk to Treatment Team using safety classification.

c. Assess the patient's need for Notice of Mental Illness.

d. Reflect patient's safety risks on the Behavioral Health Safety tab.

2. Interventions

a. Proceed with interventions and orders as necessary, including but not limited to initiation of seclusion/restraints, Notice of Mental Illness and/or medication treatment.

b. Consult with the psychiatric social worker (when available) to discuss suicide risk, if applicable, and develop and implement an appropriate disposition plan.

3. Disposition

a. The patient's immediate safety needs and the appropriate setting for treatment should be considered in disposition planning.

4. Discharge

a. A plan for ongoing needs is developed by considering the patient's risk assessment and long term needs including patient's capacity for self-care and whether the patient can be properly cared for in the place the patient resides at the time patient is in the Emergency Department.

b. Outpatient treatment should be initiated to help transition the patients care to community-based providers, peer support, lay caregivers or others who can implement the patient's plan of care (case worker).

c. The Psychiatric Consultant will make a follow-up appointment for the patient scheduled within 7 days of discharge. If this is not possible, document the reason this is not possible in the EHR.

d. Ensure the discharge planning is appropriate to the acuity of the patient and the abilities of the lay caregiver.

e. If a patient declines the safety plan and/or discharge instructions, pause and reassess patient. Engage the patient and lay caregiver (if available) to explain the clinical rational behind the plan. Ensure that other care providers are aware that the patient has declined the safety plan and/or discharge instructions

5. Admission and/or Transfer

a. Arrange and coordinate admission at a facility capable of providing the appropriate level of care.

ED Clinical Intervention Specialists (CIS)/ED Social Work

1. Conduct a behavioral health assessment using the CSSRS assessment in EPIC. Include assessment of the patient's medical, functional and psychosocial needs that may include an inventory of resources and supports recommended by a behavioral health clinician, indicated by a behavioral health assessment, and agreed upon by the patient.

2. Include a risk for violence/suicide risk assessment and lethal means counseling. Identify factors
and features that may increase or decrease risk for suicide and violence. See BH Crisis Workflow (attached).

a. Communicate safety risk to Treatment Team using safety classification.

b. Assess the patient's need for Notice of Mental Illness.

c. Ensure patient has been added to the Safety BH tab so that caring contact arrangements will be automatically arranged within 48 hours of release from ED.

d. Reflect patient's risk on Behavioral Health safety tab.

3. Collaborate with care team to determine the observation needs of the patient.

4. Collect collateral information and involve lay caregiver in plan of care.

5. De-escalate agitated patients

6. Assist in Pre-code Grays and Code Grays

7. Perform crisis focused therapy

8. Reassessments:

a. Perform on-going assessment for appropriateness of inpatient hospitalization.

b. Repeat the suicide risk assessment:

   i. When there is a change in the patient's mental status (regardless of the previous level of suicide risk)

   ii. Every 24 hours if the previous assessment was rated moderate or high.

   iii. When the patient is discharged, admitted or transferred if the previous assessment was rated moderate or high.

9. Disposition:

a. The patient's immediate safety needs and the appropriate setting for treatment should be considered in disposition planning.

b. Lethal means counseling is to be documented using the CAF AVS smartphrase and added to the patient's discharge instructions.

10. Discharge:

a. A plan for ongoing needs is developed by considering the patient's risk assessment and long term needs.

b. Outpatient treatment should be obtained to help transition the patient's care to community-based providers, peer support, lay caregivers or others who can implement the patient's plan of care (case worker).

c. A follow-up appointment will be scheduled within 7 calendar days of discharge by the ED CIS/ Social Worker. If this is not possible, document the reason this is not possible in the EHR.

d. Ensure the discharge planning is appropriate to the acuity and abilities of the patient and the abilities of the lay caregiver.

e. If a patient:

   i. declines the safety plan and/or discharge instructions or
II. is unable to understand the safety plan and/or discharge instructions or
III. refuses to sign any documents required by policy or
IV. refuses to be given a copy of the safety plan and/or discharge instructions, alert the ED physician.

11. Admission and/or Transfer:
   a. Arrange and coordinate admission at a facility capable of providing the appropriate level of care.

12. If a clinician is not available to perform a behavioral health assessment, the ED caregivers will follow their chain of command.

**ED Mental Health Tech/ED Tech**

1. Assist with the following activities:
   a. Monitor and assist behavioral health patients in the department
   b. Continuous and close observation as applicable
   c. Assist with activities of daily living as needed
   d. Removal of patient belongings and placement of patients in safe scrubs.
   e. Prepare treatment room for patient using the Environmental
   f. Obtain vital signs

2. Report any change in the patient's behavior or concerns to the primary nurse and primary social worker (if available).

**Definitions:**

*The following is intended as general resource information which may not apply to each ED.*

**Restraint/Seclusion Documentation:** Complete on any violent, restrained patient, whether in seclusion or physical restraints. Restraints/seclusion can be initiated by RN, but needs a physician order immediately and a face to face within one hour.

**Mental Status Exam** – Assesses, mood, thinking, affect memory, etc.

**Notice of Mental Illness (NMI/Hosp. Hold):** Completed for a patient who is a danger to self or others AND requires emergent care or treatment for a mental illness. Initiated by ED physician and psychiatric social worker, filed with the court.

**Civil Rights Documentation:** Completed by the psychiatric social worker or RN who informs patient of Civil Rights when put on a Notice of Mental Illness (NMI) or Transport Hold.

**Behavioral Health Emergent Assessment Documentation (BHEA):** Used by PSA ED psychiatric social worker to document an assessment on all mental health patients seen in the ED.

**Behavioral Activity Rating Scale (BARS) -** A scale used for clinical communication and an objective scale to help determine whether PRN intervention is indicated.

**Columbia Suicide Severity Rating Scale (CSSRS):** suicide risk assessment through a series of simple, plain language questions; answers help identify risk, severity and immediacy of risk.

**Close Observation:** Documented 15 minute in-person observations of patients by caregivers to ensure patient safety.
**Continuous One-To-One Observation** - Documented, constant in-person observation by a caregiver with the sole responsibility of keeping the patient safe at all times. Caregiver should be free of all extraneous distractions.

**Self-harm Event** - The deliberate destruction or alteration to one's body tissue.

**Transfer Hold Documentation** - Completed by ED physician for patients being held involuntarily awaiting transfer to a psychiatric inpatient hospital. Hold is in effect for 12 hours at facilities certified by The State of Oregon as a Transport Hold Facility (i.e. Providence Willamette Falls and Providence Medford Medical Center.)

**Treatment Team** - The group of health care professionals caring for the patient. This may be comprised of the ED Provider, RN, EDT and ED Social Worker.

**Adult Informed Consent for Voluntary Admission Behavioral Health Services** - Consent signed by patient or legal guardian for voluntary psychiatric admissions

<table>
<thead>
<tr>
<th>ED Practice Guideline: Triage</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Practice Guideline: Delayed Admission</td>
</tr>
<tr>
<td>Regional Nursing Minimum Documentation Reference</td>
</tr>
<tr>
<td>Notification of Mental Illness</td>
</tr>
<tr>
<td>Code Gray-Pre-Code Gray</td>
</tr>
<tr>
<td>Restraints and Seclusion</td>
</tr>
<tr>
<td>Releasing A Patient Following A Behavioral Health Crisis</td>
</tr>
<tr>
<td>Safety Management Plan</td>
</tr>
<tr>
<td>Regional Nursing Minimum Documentation Reference</td>
</tr>
<tr>
<td>Emergency Treatment and Active Labor Act (EMTALA) Patient Transfers Between Facilities</td>
</tr>
<tr>
<td>ED Practice Guideline Discharge Plan of Care and Education of Non- Behavioral Health Patients</td>
</tr>
</tbody>
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**Approved by:**

Oregon Regional Emergency Clinical Collaborative September 2020

All revision dates:


**Attachments**

- BH Crisis workflow.pdf
- ED 2020 BH Environmental Risk Assessment and mitigation plan PSVMC-9-23-2020.xlsx
- HB 3090 Lay caregiver Broschure Handout.docx
- Regional ED Triage BH Workflow with Observation Algorithm - V 12.docx
Approval Signatures

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<tr>
<td>Angela Graves: Mgr-Ed Prof Prac/Dev/Sys/Qlty</td>
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Applicability

OR - Clinical Support Staff (CSS), OR - Connections, OR - Credena Health (CH), OR - Home Health (HH), OR - Home Medical Equipment (HME), OR - Home Services, OR - Home Services Pharmacy (HSRx), OR - Hospice (HO), OR - Providence Ctr for Medically Fragile Children, OR - Providence Hood River Memorial Hospital, OR - Providence Medford MC, OR - Providence Medical Group, OR - Providence Milwaukie Hospital, OR - Providence Newberg MC, OR - Providence Portland MC, OR - Providence Seaside Hospital, OR - Providence St. Vincent MC, OR - Providence Willamette Falls MC
Providence Health & Services is committed to the health and well-being of all patients who come to our emergency department with a behavioral health crisis. While in the emergency department, you will receive:

- A medical exam by a qualified medical provider.
- A behavioral health assessment by a behavioral health provider. This may include determining your risk for suicide and long-term needs that may affect the outcome of your visit.

In some cases, your visit to the emergency department may result in a hospital stay. More often, a plan can be put in place so you can safely return home.

During your visit, we will ask you to identify someone with whom we can share information about your diagnosis, treatment, and post-emergency department care planning. This person is often called a “lay caregiver” and can be a family member or a trusted friend. He or she will work with our staff to develop a safe care plan for your transition home, inpatient admission or lower level of care. We will ask you to sign a release of information for this person but you are not required to do so. Having a lay caregiver that we can share information with is important for positive outcomes and his/her involvement benefits both safety and discharge planning. Only the minimal information needed will be shared. You may revoke a release of information verbally or in writing at any time.

**Lay Caregiver Name & Phone Number:**

If it is determined that you can safely discharge, we will arrange for any needed follow-up care. In most cases, this is a follow-up appointment within 7 days to address the reason for your emergency department visit.

Your follow-up may include an appointment with:

- Your primary care provider.
- A mental health provider.
- A partial hospitalization program that provides therapy and skill building support.
- A walk-in crisis care clinic.

In addition, you may receive a phone call from a trained representative from Caring Contacts. Caring Contacts is a Providence program that provides support after you leave the emergency department.

If you would like a copy of our full policy on the discharge of patients in behavioral health crisis it is available at [www.providence.org](http://www.providence.org), select Oregon, select Releasing a Patient following a behavioral health crisis under Programs section at bottom of web page.