THE SULLIVAN GROUP

TSG NEWSLETTER

SAVING LIVES - REDUCING RISK

From The Editor

Psychiatric patients represent a huge risk to the Emergency Department team. Although psychiatric malpractice claims are not the most frequent or costly, they can be devastating when they occur. More importantly, psychiatric patients are at risk in the nation's EDs. The failure to manage these patients appropriately can lead to the patient's death as well as injury to others.

This month we present a case of 'systems gone wrong' that resulted in both suicide and homicide. The tragedy is that a review or root cause analysis of the case demonstrates that if staff had followed policy and/or if communication between ED team members had been better, multiple deaths could have been avoided. The case also raises some fascinating 'duty to third party' issues. As you read this case, you will be thankful you were not on this ED team. Wrong time, wrong place!

In addition, this quarter we provide an overview of the ABEM Assessment of Practice Performance, and demonstrate that the TSG EMRI Audit (**RSQ™** Assessment) meets the ABEM criteria for this recertification requirement. Several TSG clients have contacted ABEM and have received a thumbs-up on using the TSG clinical performance evaluation for recertification. See the specifics in this newsletter. ■

In This Issue...

Case Review

ED Visit #1

Triage

The patient was a 40-year-old male who presented to the ED at 1320. The triage nurse documented, "Suicidal ideation for 3 weeks. Considering hurting himself and his wife. Wants help."

The triage vitals were:

Temp	Pulse	Resp	BP	Pulse Ox
99°F (37.2°C)	80	20	140 / 86	98%
No current meds, No documented allergies.				

After the patient sat in the waiting room for 30 minutes, the triage nurse contacted the charge nurse; the patient was moved into an ambulatory treatment room at 1400. The primary nurse alerted the emergency physician (EP) to the nature of the presentation; they agreed that the patient would need a psychiatric evaluation. The primary nurse called for a consultation by the hospital mental health intake team.

The mental health intake team arrived within 30 minutes (at the bedside at 1430), before the EP had seen the patient. The mental health team made several important notations, including the following.

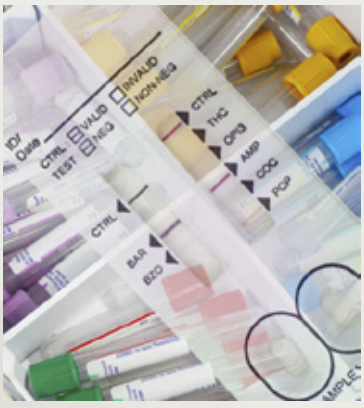
Mental Health Intake Evaluation

"Patient presents to the ED feeling depressed and paranoid about his wife. Past suicidal, homicidal and bizarre thoughts. Racing thoughts. Suicidal and homicidal thoughts within the last week. Homicidal thoughts focused on wife."

The intake worker noted the following under 'Presenting Problem': "40 year-old male with depressive symptoms, paranoia and possible delusions. Poor sleep, increased anxiety, obsesses about wife having an affair. Recent 'suicidal and homicidal ideation.'"

Under 'Preliminary Impression,' the intake worker wrote, "40 year-old male presented to the ED with depression, bizarre thoughts, insomnia, paranoia. Recommend inpatient treatment. Patient meets criteria for inpatient treatment and should be seen by a physician for an admission examination."

According to the nursing progress notes, the intake worker left the patient's room at 1455. The EP documented that he saw the patient at 1515. Between 1455 and 1515, there is no indication anywhere on the record that the patient was being monitored; there is no such order in the record and no indication of one in the nursing progress notes.



Prior to seeing the patient, the EP ordered a CBC, a basic metabolic profile (BMP), a drug screen, and an alcohol level. All were normal other than a mildly elevated serum sodium. No drugs were detected.

Emergency Physician Evaluation

In the 'History of Present Illness,' the EP documented that the patient was depressed and having auditory hallucinations. He noted that the patient complained of not thinking right, had thoughts of self-injury and insomnia, and was nervous and paranoid. He circled "suicidal ideation" on the psych disorder template. There was nothing significant on the 'Review of Systems' or 'Past Medical History.'

The physical examination was normal. In the neurologic exam, the physician documented that the patient "Denied suicide attempts." The neurologic exam was completely normal.

The EP documented a clinical impression of "Depression" and marked "Transfer to psychiatric facility" in the 'Disposition' section.

Nursing Progress Notes

There is a nursing progress note at 1700 stating, "Work up completed." At 1700, the nurse noted that she gave report to the incoming nurse. At 1740, the nurse noted, "Patient left without signing out. Not in the waiting room or first floor of hospital, not in front lobby." Disposition was documented as "Eloped."

Editor's Note: There are already a number of issues that merit discussion. There is not a single entry that relates to monitoring, observation, a sitter, security watch, or anything that would suggest that an effort was made to observe this patient for possible 'harm to self' while in the waiting room or the ED. You might imagine at this point that there is an obvious outcome to this case. But the case has an interesting twist.

ED Visit #2

The patient returned the following day to the same ED. The nursing triage note states, "Depression, seen in this ED yesterday for suicidal ideation, left without treatment before disposition by the MD."

The patient arrived at 0915. Vital signs were unremarkable. The patient was brought to a stretcher space immediately; the primary nurse noted, "Arrived ambulatory, patient contract made."

The EP's note is timed 0916. He utilized a Psych Medical Clearance T Sheet for this exam. He documented that the patient was depressed. The medical record is a paper T sheet, and the remainder of the writing in the HPI is completely illegible. In the 'Current and Associated Symptom' section, the EP circled "Depressed" and "Confused," and wrote a question mark next to "Hallucinat-

ing." He noted something about the patient's wife seeing other men, but the handwriting is barely legible in this section. He put a slash through "suicidal thoughts," "specific plan," and "gesture or attempt," indicating that these were all negatives.

In the 'Disposition' section, the physician noted, "Patient states not suicidal, not homicidal. Says he just wants something to help him know if his *(unable to read next several words)* wants help, but can't stay long."

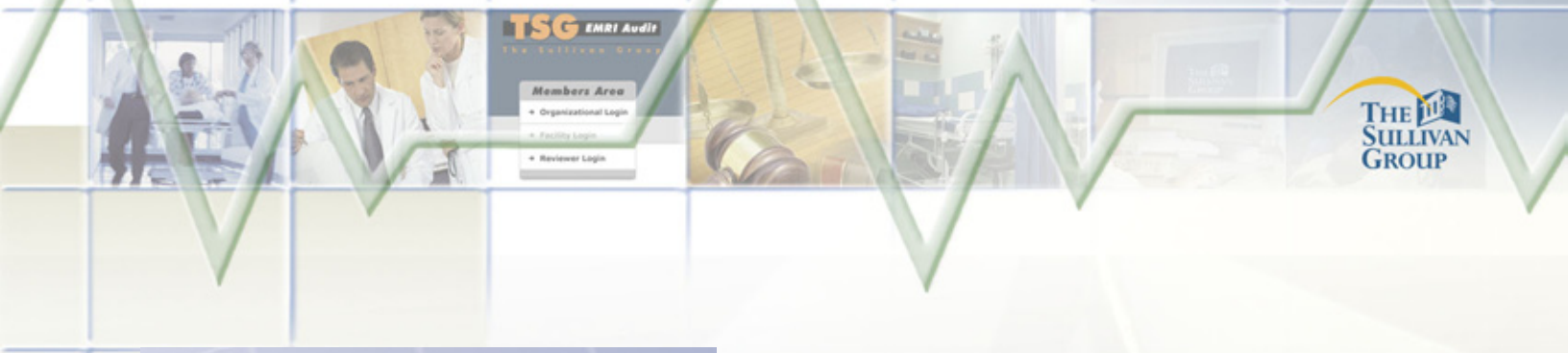
Thirty minutes later, the physician wrote another note in the 'Disposition' section: "Patient doesn't want to wait (psych intake service has been contacted but has not arrived). He just wants an antidepressant or *(unable to read word)* meds. Denies SI/HI."

The patient was discharged to home with an impression of "Depression," with no documentation of follow-up and no appointment for ongoing care. The patient never saw the psychiatric team during this visit.

The following day, the patient shot his wife in the head and then shot himself in the head. The cause of death on his death certificate reads, "Shotgun Wound of the Head."

Discussion

This is a tragic case. But what an unusual fact pattern! It was the first visit that raised all the red flags and alarms. After the patient eloped, you just had to believe that was when he would do harm to others or to himself. But that wasn't the case; he bounced back. This ED had a second chance. However, during the second visit, the emergency physician clearly documented (twice!) that there was no suicidal or homicidal ideation. It was after that discharge that the patient murdered his wife and killed himself. What an amazing set of facts.



The fascinating question is whether the documented lack of suicidal and homicidal ideation from the second visit absolved the sins of the first. Given all the missteps in the first visit, if the patient had gone straight home from that visit and killed his wife and himself, cause and effect would be clear. But after 24 hours, the clinical presentation had clearly changed. Or had it?

Whatever your thought process, this would not be a case that a defense attorney would want to argue in front of a jury. There were simply too many problems and too many issues. The case was settled on behalf of both emergency physicians for over $500,000. The hospital also settled the case for an unknown amount.

The case obviously presents a multitude of opportunities to improve patient care and reduce risk. For the sake of brevity, we will mention a few key issues.

1. **Supervision and Surveillance.** During ED visit #1, the patient needed observation from the moment he walked in the door, both in the waiting room and then in the ED. Following the evaluation by the psychiatric intake worker, there certainly should have been constant surveillance. There was no surveillance, nor was there any documentation by any of the providers that they had eyes on this patient. There was no mention of a psych room with a camera or anything about line of

sight. The team simply did not address this issue. There were actually hours that passed when this patient was alone.

2. **Duty to Take Steps to Find the Patient.** The patient eloped, and the ED team's response was to look around the hospital for him. They reported that he was not in the hospital. Given the overwhelming indication of suicidal and homicidal intent, what approach should the ED team have taken? What would have been enough to establish that the team had done everything possible to protect the patient and others in the foreseeable zone of harm? What would have been the reasonable response under the circumstances? Consider the following options:

- Call security immediately (no indication that security was called).
- Search the hospital.
- Search the grounds around the hospital.
- Call the patient's home.
- Call the police to go to the home.
- Call the family if unable to find the patient.
- Alert the authorities regarding the potential threat to the patient's wife.
- Alert the wife regarding the potential threat.

It seems that "All of the above" would have been the correct answer (see duty to third party discussion below).

3. **Duty to Third Party.** Did the physician and/or hospital have a duty to warn the patient's wife? This is a very interesting part of this case, and one that is not settled in all state jurisdictions. Without going into a summary of case law, the general approach is if the practitioner believes that an individual, outside the immediate patient-physician relationship, is in imminent danger or within a foreseeable zone of harm, then there is a duty to warn. This general approach follows several famous cases in this area, including the seminal case of Tarasoff v. Regents of the University of California[1].

What do you think in this case? Was the wife in imminent danger? Do you think she was in a foreseeable zone of harm? We believe that she was; we also believe that the emergency physician and the hospital had a duty outside the patient-physician relationship, a duty to a third party, and a duty to the patient's wife.

1 Tarasoff v. Regents of the University of California (17 Cal.3d425 [1976]).

Exactly what was the duty? Following case law, an effort to alert the authorities would have sufficed and was probably the step that should have been taken.

If you believe that a third party is in danger and you feel it is necessary to warn, contact the appropriate member of your administration. Don't fly solo when there is so much at risk. Allegations could result, including violations of HIPAA, confidentiality, right to privacy, and defamation, to name a few. Get help, preferably legal counsel.

4. **Significant Change in Condition.** What are your thoughts regarding the second visit? Remember that the patient was homicidal and suicidal at ED visit #1 the previous day, and everyone agreed the patient required admission. When that same patient came back the next day and denied homicidal or suicidal ideation, what was the correct approach? Can you take this patient's history at face value? Do you have to weigh ED visit #2 in light of the facts from ED visit #1?

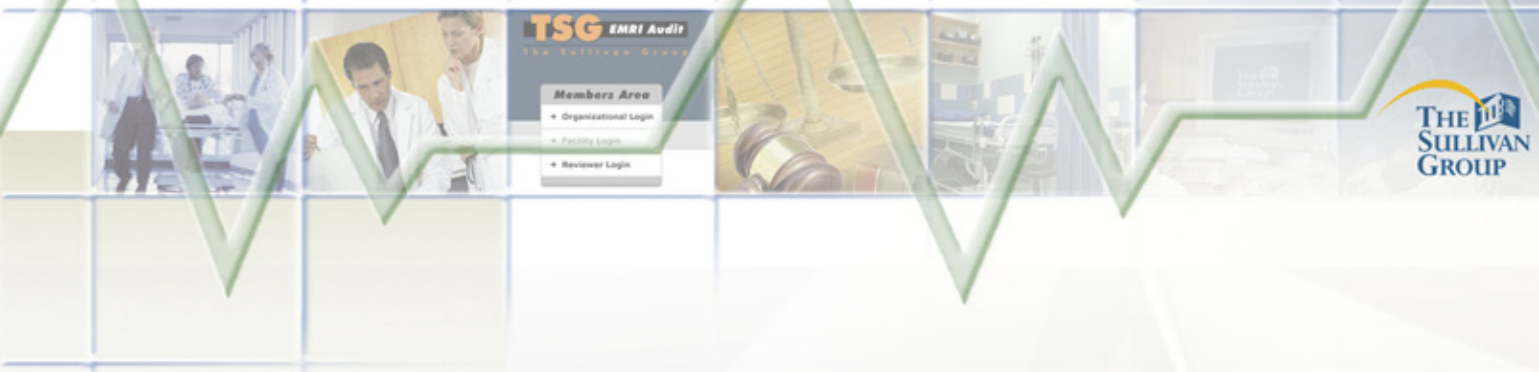
There are no easy answers here. These cases are complex, and you would be hard pressed to find a similar case that would establish a precedent.

It seems that the EP at ED visit #2 needed to do something more than he actually did. For example:

- Review all notes from the prior visit and document a thorough review. There is no indication in this chart that the physician evaluated the prior day's evaluation.

RSQ™ OB e-Learning Topics

- Anatomy of a Medical Negligence Lawsuit
- Appendicitis
- Case 07: A 27-Year-Old F with Abd. Pain
- Cognitive Errors Part 1
- Cognitive Errors Part 2
- Ectopic Pregnancy
- Medical Assault & Battery
- Neonatal Asphyxia
- Peripartum Cardiomyopathy
- Pitfalls & Liabilities in Labor
- Pitfalls & Liabilities in Prenatal Care
- Postpartum Hemorrhage Part 1
- Postpartum Hemorrhage Part 2
- Pregnancy Induced Hypertension
- Pulmonary Embolism Part 1
- Pulmonary Embolism Part 2
- Sepsis
- Shoulder Dystocia



- The patient did not want to wait. Do you comply with the patient's wish to be discharged because he didn't want to wait too long? Arguably, and based on the ED visit #1 evaluation, the patient had to have an evaluation by a psychiatric expert. This is no time to go it alone. It is critical to strike a balance here, but err on the side of caution. If the patient is competent and not suicidal or homicidal, then restraint for re-evaluation is considered to be battery. However, given the evaluation from ED visit #1, the prudent path in this case would have been to talk the patient into staying for evaluation by psych, and if necessary, restrain him against his will. It is far better to be the dedicated emergency physician trying to protect the patient than to be a defendant in a murder-suicide case.

If you practice emergency medicine as any part of the ED team, you know that this case hits very close to home. You may have policies in your department to protect the psychiatric patient; they may be great policies, but following them is a completely separate issue. To exacerbate matters, we as a society do not adequately protect patients with psychiatric disease. There are inadequate resources available, and patients with psychiatric presentations sit in our EDs for days and sometimes weeks. Some states are incredibly apathetic about this important patient group. The risks are exceedingly high, and this is an important area of focus for any patient safety initiative.

Editor's Comments and Recommendations

Every Emergency Department has created policies to protect patients who are suicidal or homicidal. However, there are a couple of common problems: the policies are inadequate; or the policies are great, but simply not followed.

During a recent visit to an ED that required an evaluation under a state and federal plan of correction for mishandling psychiatric patients, several issues emerged that apply to many EDs across the nation. As I read through the federal document listing the problems in psychiatric patient management, it felt like I was reading about every ED I have ever worked in:

- Inadequate policy on patient supervision
- Inadequate policy on supervision in the waiting room

If you'll be at the ASHRM Conference, please stop by and ask us how you can reduce medical errors & malpractice claims

Visit us at Booth # 604 at ASHRM

- Not following policy on psychiatric patient supervision
- Failure to evaluate for contraband
- Failure to follow policy on frequency of evaluation of patients in restraint
- Failure to follow seclusion and restraint policy
- Failure to perform performance improvement evaluation on psychiatric patients
- Failure to update policies on a regular basis

The list seemed endless.

Emergency departments need a team-based systems approach to the psychiatric patient. The following is a list of suggestions, but it is by no means all-inclusive; consider it a starter set of recommendations.

1. Review your policies. Make sure that you have a top-notch set of policies regarding the management of psychiatric patients. If there are any issues, address them. If you need to compare notes, contact colleagues or contact The Sullivan Group, and we can work together to create a set of psychiatric policies.
2. Do a mock psychiatric evaluation. Assume you are under review by a state or federal agency for mismanagement of psychiatric patients. You are likely to find gaping holes in your management of psychiatric patients or your documentation of the care provided. You will not know unless you take a careful look.
3. Evaluate your ED restraint policy.
4. Actually go to the ED and evaluate patients in restraint. Look at the medical records of patients in restraint to determine if the restraint policy has been adhered to. Look for statements such as the following:
   - Physician order to restrain
   - Re-order q __ hours based on state regulation
   - Appropriate nursing entries q ___ hours based on state regulation
5. Take ten charts of patients that were restrained and review them each month in team peer review. Evaluate and make action plans.
6. Evaluate the policy for patients that represent a danger to self or others.
7. Ensure that the intake or triage policy is appropriate for recognizing and acting to protect patients in danger.

8. Evaluate the policy for patients that elope, especially if they represent a danger to self or others.
9. Create a communication system between the psychiatric intake team and the ED staff.
10. Evaluate the charts of psychiatric patients to be certain that the communication system is functioning appropriately.
11. Determine who monitors or sits with patients that represent a danger to self or others:
    - In the ED.
    - In the waiting room. The observer in your waiting room is probably your security staff. Create a mock drill to determine how things are functioning and check response time.
12. Do an in-service on 'duty to warn.' When should you warn third parties outside the patient-physician relationship and how should you do it? This is a team approach that includes physicians, nurses, hospital administration and your legal team.

This case should serve as a wake-up call. Your psychiatric patients are at risk. In order to keep them safe, everyone on the ED team should be well versed on management of patients who represent a danger to self or others; they should know the policies that apply to psychiatric patients; and they should know to a certainty that the department is functioning at a high level in managing this high-risk patient population. ■

ACEP Scientific Assembly Lectures

by Dan Sullivan, MD, JD, FACEP

1. **Medical-Legal Risks in Times of Everyday Crisis**
   Sat., Oct. 15, 8:00 am - 8:50 am
2. **Taking the Stand: Real Malpractice Cases, Bad Outcomes - You Decide**
   Sat., Oct. 15, 12:30 pm - 2:20 pm
3. **Medical Liability: A Short Cut to Resolution**
   Sun., Oct. 16, 10:00 am - 10:50 am
4. **Become an Expert Witness**
   Sun., Oct. 16, 4:00 pm - 4:50 pm

The following e-Learning courses are available

1. The Psychiatric Patient: Danger to Self or Others: Medical Error and Risk Reduction
2. Duty to Warn Third Parties: Medical Error and Risk Reduction

Click on the course name to see the course description.

TSG's EMRI Audit (RSQ™ Assessment) Satisfies ABEM's APP Practice Improvement Requirement

ABEM is phasing in a new requirement called the Assessment of Practice Performance (APP) [ABEM Practice Care Improvement] for emergency physicians who want to maintain a "clinically active" status. This applies to all physicians whose certification expires in 2013 or later. But you can't wait until 2013. If you didn't begin your Practice Improvement (PI) component of the requirement in 2010, you need to start in 2011. The TSG EMRI Audit (RSQ™ Assessment) can completely satisfy the Performance Improvement requirement. That should be a comfort for those of you using the EMRI Audit (RSQ™ Assessment) since the data is safely stored and continuously available in the TSG database. ABEM will be auditing 10% of all APP submissions. It is critical that you have a system in place and the ability to verify the activity. If your designated "verifier" is unable to confirm your participation in the activity, then ABEM will be forced to convert your status to "clinically inactive" until the issue can be resolved.

The APP requires emergency physicians to institute a PI activity as defined below and to have the supporting data available in the event that you are asked to verify the activity. Diplomates must begin, complete, and attest to completion of one PI activity in years one through five of their certification and one PI activity in years six through ten. Refer to the ABEM web site for your specific timing requirements during the phase-in period.

1. Review patient clinical care data from ten of your patients. The data must be related to a single presentation, disease, or clinical care process. For example:

- Clinical care processes
- Patient feedback that relates to the clinical care given
- Outcomes of clinical care
- Access to care such as time for throughput, left without being seen, etc.
- Group data and data collected through a national, regional, or local practice improvement program in which you participate is acceptable.

2. Compare the data to evidence-based guidelines. Evidence-based guidelines are based on published research subject to peer review. Only if such guidelines are not available may you use guidelines set by expert consensus or comparable peer data. Guidelines set by expert consensus are published, accepted national standards; guidelines set by peer data are set by individuals who practice in like or similar circumstances.
3. Develop and implement a plan to improve the practice issue measured in Step #1. You may plan for an individual or a group improvement effort.
4. After implementing the improvement plan, review patient clinical care data from ten additional patients with the same presentation, disease, or clinical process as the first patient data review. Use this data to evaluate whether clinical performance has been improved or maintained.

Several emergency medicine groups have already begun utilizing the TSG EMRI Audit (**RSQ™** Assessment) to satisfy their recertification requirement for the APP. If you are interested in more information regarding the Audit and meeting the ABEM requirements, please contact us at **855.RSQ.INFO.** ■

Thank You.

We look forward to seeing you at ACEP and ASHRM!

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