There is no “I” in Emergency!

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No Conflicts to Declare
My *MOST* Difficult Patient

- One weekend minding my own business listening to CBC…….
Fiorito: Police give paramedics lesson in kindness

Sometimes, in a crisis, the helpers are not very helpful.

By JOE FIORITO Columnist
Mon., Dec. 17, 2012

Narges Joharchi works with people on the margins. She had a cup of coffee with a colleague on a recent morning, in a Tim’s on the corner of College and Spadina.

She said, “After coffee, we saw a commotion. A woman was sitting on the step in front of the 7-Eleven. Her top was off. Her back was naked, but she was covered — her jacket was on backwards.

“She was around 30 years old; short, chubby. I found out later she is diabetic. She was wearing pyjama pants.”

On the sidewalk, along with the passersby and rubbernecker,
A Brief Slice

• …long intermittent history but then she disappeared for 3 years;
• 2 years in psych facility then
• 1 year in corrections the….
• 5 weeks in the community;
  • 15 visits to 5 ED’s, 13 via EMS, 2 crit care admissions
  • Usually “out” < 6 hours
• Typical EMS arrival with 2 units and 2 police cars
Why SO “Difficult”?

- Unable to function/relate to others
- Seeks care/attention through self-harm – swallowing, inserting, OD’s (usually ASA!)
- Intermittently help seeking and rejecting
- All common/familiar behaviours BUT set limits and she will when able head to the nearest most public area (WR, sidewalk outside ED, Tim’s) and remove ALL of her clothes and start screaming “rape”
Stakes Rise

• Another 2 year admission, no talk therapy, drugs or other efforts work, spending most of her time in restraints
• Appeals to LHIN, MOH, MCSS all fail
• Trial of discharge to group home – ACT team/police/EMS/ED (iv access?) all involved, PSW 24/7
• Able to ditch PSW’s, OD or insert + travel….
• Civic authorities intervened – back in hospital
The Cycle Of impaired Patient-Physician Relationships

Difficult patients are often perceived by the physician to be making unreasonable demands (Fig. 128-1). Physicians react with negative feelings and may direct negative actions toward the patient. Patients are sensitive to these negative reactions, feel threatened with abandonment, and attempt to sustain the relationship by escalating symptoms. Physicians experience greater frustration at the maladaptive behavior of the patients, and so the cycle is perpetuated.

![Diagram of the Cycle of impaired patient-physician relationship]

The consequences of this impaired relationship for the patient include failure to identify the real problems, missing of medical diagnoses, "another poor experience" with the medical establishment, and premature or inappropriate discharge. The negative effect on the staff is manifested by frustration, a sense of failure and defeat, fear of litigation, and the development of unconstructive stereotypes and unrecognized prejudices, all of which may contribute to eventual professional burnout.
Another Story

• Frequent visitor with obviously voluntary ataxia, c/o cp, +/- HA, demand for admission
• Angry, attention seeking, almost always needs security to evict him
• Video evidence of malingering
• Apparently no mental illness till late middle age; son died, marriage ended, job lost in short period of time – behaviour emerged
• NO ability to engage, discuss feelings, make plans
Another Story cont’d.

• Just another typical presentation except – EKG shows STEMI!
Taking Care of the Hateful Patient

Abstract

"Hateful patients" are not those with whom the physician has an occasional personality clash. As defined here they are those whom most physicians dread. The insatiable dependence of "hateful patients" leads to behaviors that group them into four stereotypes: dependent clingers, entitled demanders, manipulative help-rejecters and self-destructive deniers. The physician's negative reactions constitute important clinical data that should facilitate better understanding and more appropriate psychological management for each. Clingers evoke aversion; their care requires limits on expectations for an intense doctor-patient relationship. Demanders evoke a wish to counterattack; such patients need to have their feelings of total entitlement channeled into a partnership that acknowledges their entitlement—not to unrealistic demands but to good medical care. Help-rejecters evoke depression; "sharing" their pessimism diminishes their notion that losing the symptom implies losing the doctor. Self-destructive deniers evoke feeling of malice; their management requires the physician to lower Faustian expectations of delivering perfect care.
Approach to the Difficult Patient

• Read the old chart
• Stay calm, professional
• Keep an open mind, explicitly assess the patient
• Set limits, address problem behaviors but resist any attack or denigrating of the patient
• WRITE GOOD NOTES!
• But…if they are back again? And again? And…..each time treated differently???
Interventions to Reduce Compulsory Psychiatric Admissions: A Systematic Review and Meta-analysis

Mark H. de Jong, MD; Astrid M. Kampersma, PhD; Margreet Droste, PhD; Stefan Rehbein, MD; Yvonne Brander, MD; Roland van Osch-Sande, PhD; Arnt R. Van Gool, PhD; Cornelis J. Mulder, PhD

Importance: Compulsory admissions, defined as admissions against the will of the patient (according to local legal procedures), have a strong effect on psychiatric patients. In several Western countries, the rate of such admissions is tending to rise. Its reduction is urgently needed.

Objective: To establish which interventions effectively reduce compulsory admissions in adult psychiatric patients in outpatient settings.

Methods: A systematic, computerized literature search was performed using EMBASE, MEDLINE, Web of Science, PsycINFO, CINAHL, PubMed (not yet indexed for MEDLINE), Cochrane Central, and Google Scholar. Every database was searched from its inception until April 30, 2015.

Study Selection: Randomized clinical trials (RCTs) that studied any kind of intervention designed to reduce compulsory admission rates in adult psychiatric patients (age range, 18-65 years) in outpatient settings were eligible. Eligibility was independently assessed by 2 of us.

Data Extraction and Synthesis: Two of us independently extracted relevant data. The Cochrane Collaboration’s tool was used for assessing risk of bias. Overall risk reduction (random-effects estimate) was calculated in the following 4 subgroups of interventions: advanced statements, community treatment orders, compliance enhancement, and integrated treatment.

Main Outcomes and Measures: Relative risk (RR) was calculated on the basis of the number of patients who had been compulsorily admitted.

Results: Our meta-analyses included 12 RCTs comprising 2970 psychiatric patients. The meta-analysis of the RCTs on advance statements showed a significant 22% (RR, 0.77; 95% CI, 0.60-0.98; 2 × 2.26) in an 110% risk reduction in compulsory admissions. In contrast, the RCTs on community treatment orders (RR, 0.95; 95% CI, 0.81-1.10; 2 × 0.0%) (n = 742), compliance enhancement (RR, 0.52; 95% CI, 0.11-2.37; 2 × 55.7%) (n = 250), and integrated treatment (RR, 0.71; 95% CI, 0.49-1.02; 2 × 49.0%) (n = 876) showed no significant risk reduction in compulsory admissions.

Conclusions and Relevance: The meta-analysis of the RCTs on advance statements showed a statistically significant and clinically relevant 22% reduction in compulsory admissions in adult psychiatric patients, whereas the meta-analyses of the RCTs on community treatment orders, compliance enhancement, and integrated treatment showed no evidence of such a reduction. To date, only 3 RCTs have used compulsory admissions as their primary or secondary outcome measure. This demonstrates the need for more research in this field.
Operationalizing Care Plans

- Heavy emergency department (ED) users consume a disproportionate amount of ED resources
- High prevalence of mental health and substance abuse issues
- Mismatch between needs and available resources
- Complexity and visit frequency lead to patient and staff frustration
- Obtained grant to address the issue through “care plans”
Objectives

• Interdisciplinary team to create “care plans” for heavy ED users with the goal of:
  • “Improved care”
  • Reduced frequency of ED visits
  • Reducing LOS in the ED
  • Supporting staff in provision of care under difficult circumstances
Methods - Patient Selection

• Original inclusion criteria
  • > 12 ED visits over the previous year, with ED visits in each of the last 4 quarters or
  • Mental health/psychosocial problems as the primary problem for > 6 visits/year and
  • Age > 18

• Modified inclusion criteria:
  • Any patient identified by staff as having difficult/erratic visit behaviour with frequent visits

• Analyzed behaviour for the three quarters prior to, and after care plan implementation
Patient Selection Problems
Care Plan Development

• Interdisciplinary approach: Social Work, ED Nursing, Psychiatry, Emergency Medicine
• Chart review to identify all known care providers and create a comprehensive problem list of “typical” reasons for visiting the ED
• Focused on patient’s medical, psychological and social needs
• Provide as much continuity and consistency of care as possible
Checklist for Developing Patient Care Plans –

1. Review patient chart and Cerner record looking for;
   a. Clinical problems
   b. Known social and economic problems
   c. Typical presenting complaints
   d. Known community contacts and caregivers
   e. Existing plans or common strategies employed
   f. Behavioural problems or known barriers to care

2. Check PRO (or cGTA) to see if we can add to lists above.

3. Check with CAMH regarding any further information and/or existing plans they may have

4. Contact key community providers to request additional information and/or existing plans.

5. Investigate programs or resources suitable to the patient not currently in place, check eligibility.

6. Draw up draft plan, review with team. Discuss communication plan with patient.

7. (Meet with patient, obtain their feedback on plan, willingness to engage in any required behaviours on their part, obtain their consent for sharing of plan with other providers.) – this is rarely necessary.

8. Finalize plan with team. Discuss appropriate roll out strategy including role of visit monitoring and/or automatic notification for any community partners.
Care Plan Implementation

- Front line staff alerted to the presence of a care plan using electronic flags incorporated into our patient tracking system
- Updated electronic copies of plans kept on secure server on hospital intranet
- Paper copies printed/appended to front of patient charts to alert attending staff of their presence
- “Guide” to use of care plans added – printed with each plan to address EMS/police concerns
Instructions for Using Patient Specific Guidelines

Attached is a guideline for a patient who has previously been a frequent visitor to the ED. Guidelines are typically developed for patients who have some combination of complex medical and/or psychiatric histories, challenging behaviours, or are suspected of deceptive or manipulative behaviour. They are meant as an aid to the ED staff. They are developed by a multidisciplinary team that includes emergency doctors and nurses, social work and psychiatry. The team reviews the patient’s records, and tries to identify (and where appropriate contact) their other health and social care providers in the community. A summary of their history is created, and key community contacts are listed. Where possible, some advice on the approach to their care in future visits is offered.

Like any guideline, it is meant as a reference tool for the staff, and must be applied in light of the specific clinical situation the patient presents with. Any patient may develop new illnesses or injuries and all cases must be approached with an open mind, but equipped with as much information as possible. Always note the date of the last update on the guide; information may become stale in time.

The guideline is not a part of the patient chart; it is more like a memo to staff. It should be placed in the shredder when the patient is discharged.

Occasionally you may encounter a patient you think is appropriate for a guideline, or obtain information that may be helpful in updating an existing guide. Please feel free to contact Rebecca Detje, Kate Van Den Broek or Howard Ovens with any suggestions or issues related to any guides.

Occasionally you may have a request to provide a copy of the guide to a patient or family member, or other professional including staff from outside the hospital such as police or Toronto Paramedic Services. We are happy to share the guide where appropriate but only in the proper context and with appropriate privacy controls. Thus, we would ask that any requests for copies of patient guides be directed to one of us and you can print this off to provide to the person requesting the guide.

Contact information for discussion of a guideline:
Results

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<td><strong>Psychiatric Diagnosis (%)</strong></td>
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<tr>
<td><strong>Substance Abuse/ Dependence Issues (%)</strong></td>
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</tbody>
</table>
Results

108 Care Plans Developed

92 Care Plans Implemented

- Visits Reduced (39%, n=36)
- Visits Not Reduced (35%, n=32)
- Unclear Effect (26%, n=24)
Results

- Overall, instituting care plans reduced ED visit frequency from a mean 9.58 (SD=9.74) to 5.98 (SD=6.46) \( p < 0.0001 \) during the study period.
- Cumulative LOS reduced overall from a mean 2930 min/pt (SD 3787) to 1617 (SD 2319) \( p<0.0001 \) – combination of less and shorter visits.
Results

• Care plans extremely well received by all ED staff who felt they were able to deal with these patients needs more effectively;
• Focus groups all positive, staff felt “supported”, “not alone”
• More confident wrt setting limits;
  • How much to investigate
  • Prescribing
  • Tolerating disruptive or uncooperative behaviours – refusing care under defined circumstances
• Indications for “forming” patients
Conclusions

• Our interdisciplinary approach to care plan development led to a significant reduction in ED visits, and overall LOS for a segment of this very challenging patient group

• Care plans requested by the staff;
  • High frequency of proposing patients for plans from broad range of staff based on flurry of visits and/or challenging behaviours
  • Over 400 plans presently, new ones 2-3/month
Sustainability

- SW does 1st draft, including contacting community providers where known
- MD review by me or 1 of several volunteers, include EM residents
- Psych consultant as needed (rarely now!)
- Update based on new info from staff, occasionally from community providers
- EMR icon is key to success (plan available almost immediately on registration)
“The strength of the team is each individual member. The strength of each member is the team.”
— Phil Jackson
Enhancing Teamwork

- A playbook helps;
  - Order sets
  - Protocols, algorithms
  - Checklists for procedural sedation, RSI etc…
- Practice helps;
  - Multi-disciplinary simulation and education/training
- Post-game learning helps;
  - Incident debriefs in real time
  - A culture of CQI….
BUT

• Q. Is there evidence that guidelines, protocols, order sets and such impact on our outcomes?

• A. Yes BUT
A Dilemma

• Experience and some published evidence of disappointing results show implementation of tools of practice is key
• Wasteful for every ED to duplicate work of expert panels
• Getting together, arguing over the evidence, agreeing on who does what, then making care more consistent, predictable builds teamwork and success
• Need to know best/most efficient approach to knowledge translation
TEAMWORK

MEANS NEVER HAVING TO
TAKE ALL THE BLAME YOURSELF