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MDS Alert

Psychosocial Assessment: When Should You Send a Resident to the Emergency Room for Suicidality?

MDS 3.0 gold standard nurse shares her experience.

Panel members participating in a CMS "Interdisciplinary Team Video" answered the following question: "The resident states they just want to die," said the webinar moderator, **Renee Henry,** a nurse and health insurance specialist for CMS. "This is not how they wanted to live their life. The resident is already followed by psychiatry. The facility policy states that if anyone voices these thoughts, they should be sent straight to the ER. Is this what was intended with the MDS 3.0 and, if not, how would you suggest that the situation be handled?"

In responding to the question, T**racy Montag, B**SN**, R**N**, RAC-CT,** an MDS 3.0 gold standard nurse, recounted a situation that she encountered when doing the PHQ-9 during the MDS pilot.

Montag reported that she first did the BIMS interview to assess the resident's cognitive status. Then she came to the PHQ-9 mood interview. Everything was going well with the interview, Montag said, until she asked the last question about "thoughts that you would be better off dead, or of hurting yourself in some way."

The resident's "whole mood changed and she answered very clearly: 'Absolutely. I absolutely would much rather be dead. I'd be better off dead,'" Montag reported. The resident, who was wheelchair dependent, went on to say that if she could, she'd go down to the nearby highway and "throw [herself] in front of a tractor trailer and end it all."

Montag said her "immediate response was panic," but she knew through training to talk to the resident about what she had disclosed. Montag went on to ask the resident about her preferences for customary routine and activities questions on the MDS 3.0. To provide background for those watching the webinar, Montag noted that the resident, a bilateral amputee, relied on the staff for her care, including getting in and out of bed.

Montag found out that "very clearly [the resident] was the last person to get up in the morning because of the way the staffing went, and they had to get her up with a mechanical lift. So she always had to have breakfast in bed. She very rarely got to put on her own clothes and she was left in a hospital gown."

The resident also said "she didn't like going to bed at six o' clock at night," which is when staff put her in the bed. "She wanted to sit up in the chair ... and to be outside her room."

After talking with the resident, Montag followed the policy and procedure where she had to report what she'd found out to the charge nurse and tell her "this lady feels she would be better off dead and, in fact, told us she'd like to go out and put herself in front of a tractor trailer."

The staff had no idea the long-time resident felt that way, Montag said. The staff called the social worker who came to the floor and asked Montag how she got the information. "We told them we asked the question." The staff "got into a little bit of a panic mode," Montag reported.

"So the first part of answering this question is not to panic," Montag said. "Use your critical thinking skills and try to find out ... the underlying issue. We were able to tell the social worker -- who then brought in the activities staff --" about what was bothering the resident. "Here are the things that have been taken away from her." The resident had "lost her whole sense of individuality because the nursing staff and activities staff -- everybody -- has planned her day." Montag then suggested to the facility staff what might help the resident.

Success: In following up with the resident on subsequent visits to the facility to do additional MDS assessments on

residents, Montag found that "she was much better because they had rearranged her schedule."

Key: "It wasn't necessary to send her off to the emergency room ... or do something in a panic mode," Montag said. "We knew what to do as far as referring [the situation] to the appropriate people at the facility. That's really what the MDS is talking [about] and the directions are for when you set up a policy in your facility... ." You want to "be able to ... figure out what's actually going on with the resident before you automatically ship them off."

Problem: Webinar presenter **Debra Saliba, MD,** noted that one challenge nursing homes sometimes face is that "staff can feel isolated. And the emergency room is sort of a default option to deal with that sense of isolation." In the question posed to the panel, the resident had a psychiatrist involved, she noted. "So don't hesitate to bring those people on board," said Saliba. But she thought Montag "hit it right on the head -- it's really about trying to figure out the resources for that individual."

"There are very rare occasions where the person may need an urgent intervention. And you may need to think about [sending the person to the ER] in severe situations where they really have an immediate plan moving forward," Saliba said. "But again, your protocols will help you figure out who those folks are that you are identifying," she added. "But I would really discourage a policy where you just ship someone off to the emergency room. The care they are going to get if no-one has communicated with a provider before sending them is not going to be the best ... ."

Saliba went on to say that "it's understandable where that impulse would come from and it feels like the safest policy but, in actuality, for some patients it's not the safest choice to be shipping them to the emergency room without communicating."

Consider These Additional Practices

Consultant **Marty Pachciarz, R**N**, R**A**C-C**T(who wasn't a webinar presenter) notes that "by completing the MDS 3.0 interviews and also asking the resident probing questions, the MDS 3.0 nurse in conversations with the facility team was able to help the facility modify the resident's care plan."

As a general "overall best practice," Pachciarz recommends that the person completing the mood interview "notify the care team/nursing about their finding and continue with further assessment," which includes identifying the resident's suicide risk. Staff should "provide one-to-one supervision and document it," adds Pachciarz, managing director of clinical services for the Polaris Group based in Tampa, Fla. Also "notify the physician of the resident's status," she adds.

When contacting the physician, "staff should be prepared to present subjective/objective information on the resident's comments, her overall behavior, current meds, other psychosocial factors etc."

"Based on the staff assessment, and physician input, the physician will then send the resident out for an evaluation, come see the resident and/or ask a mental health specialist to come in," Pachciarz says. The facility "should also notify the resident's family."

Depending on the resident's assessed suicide risk, "the facility may provide one-to-one supervision or frequent checks, e.g., every 15 minutes, and/or notify the police if the resident is dangerous to others also," Pachciarz adds.

"My list of suggested practices above says you should further assess the patient as the MDS 3.0 nurse relayed she did in the webinar. Through further assessment, you can decide if the situation is urgent. If you feel the person needs immediate intervention because they may be violent, for example, and you don't have an attending physician [or mental health specialist] to immediately evaluate the person, then you may have to send the person to the ER."

Pachciarz also notes that facilities need to develop their own policy, which will be "driven slightly by what is available on an urgent and non-urgent basis in the community." For example, "maybe there is no mental health provider available to see residents urgently except through the emergency room."

Editor's note: See the related article on page 106 of this issue.

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