JPS pride

JPS Health Network

Department of Psychiatry

JPS Health Network

- Founded in 1877
- JPS is licensed for 537 beds that includes advanced medical, surgical and neonatal intensive care units.
- JPS includes the county's first Level I trauma facility which is part of our recently completed five-story Patient Care Pavilion.
- JPS began our open heart surgery program in 2010
- Over 50 locations in Tarrant County with 19 SBC's
- JPS has more than 4,700 employees
- Over 1,000 credentialed providers including 39 specialties and sub-specialties
- We have 183 residents
- JPS is home to the largest family medicine residency program on one campus in the United States
- JPS patients are primarily indigent, uninsured or underinsured.

- Psychiatric Emergency Center
- Crisis Stabilization Unit
- Adult Inpatient Unit
- Adult Step Down Unit
- Adolescent Inpatient Unit
- Outpatient Clinics
- School Based Behavioral
- Integrated Medical Unit

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JPS Behavioral Health Services

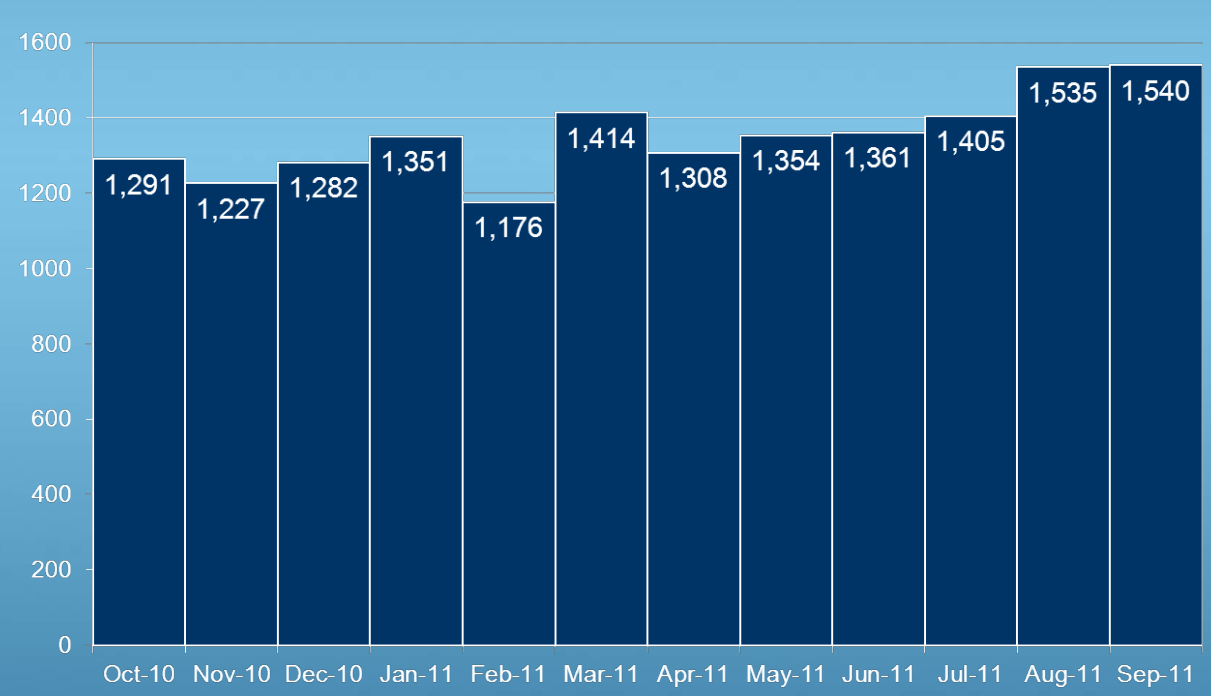
A team of physicians, nurses, social workers, and support personnel provide services 24 hours a day, seven days a week for both voluntary and involuntary patients in mental health crisis. This center provides triage, evaluation, and admission services. It also contains a walk-in medication clinic to assist those patients who are established patients but need additional medication or evaluation.

Services include:

- Psychiatric Triage
- Psychiatric Evaluation
- Short-term interventions including observation, stabilization, and monitoring
- Referral services
- Evaluation for Admission to JPS inpatient services
- Walk-in medication clinic to assist those who are established patients but need additional medication

JPSpride

Psychiatric Emergency Center



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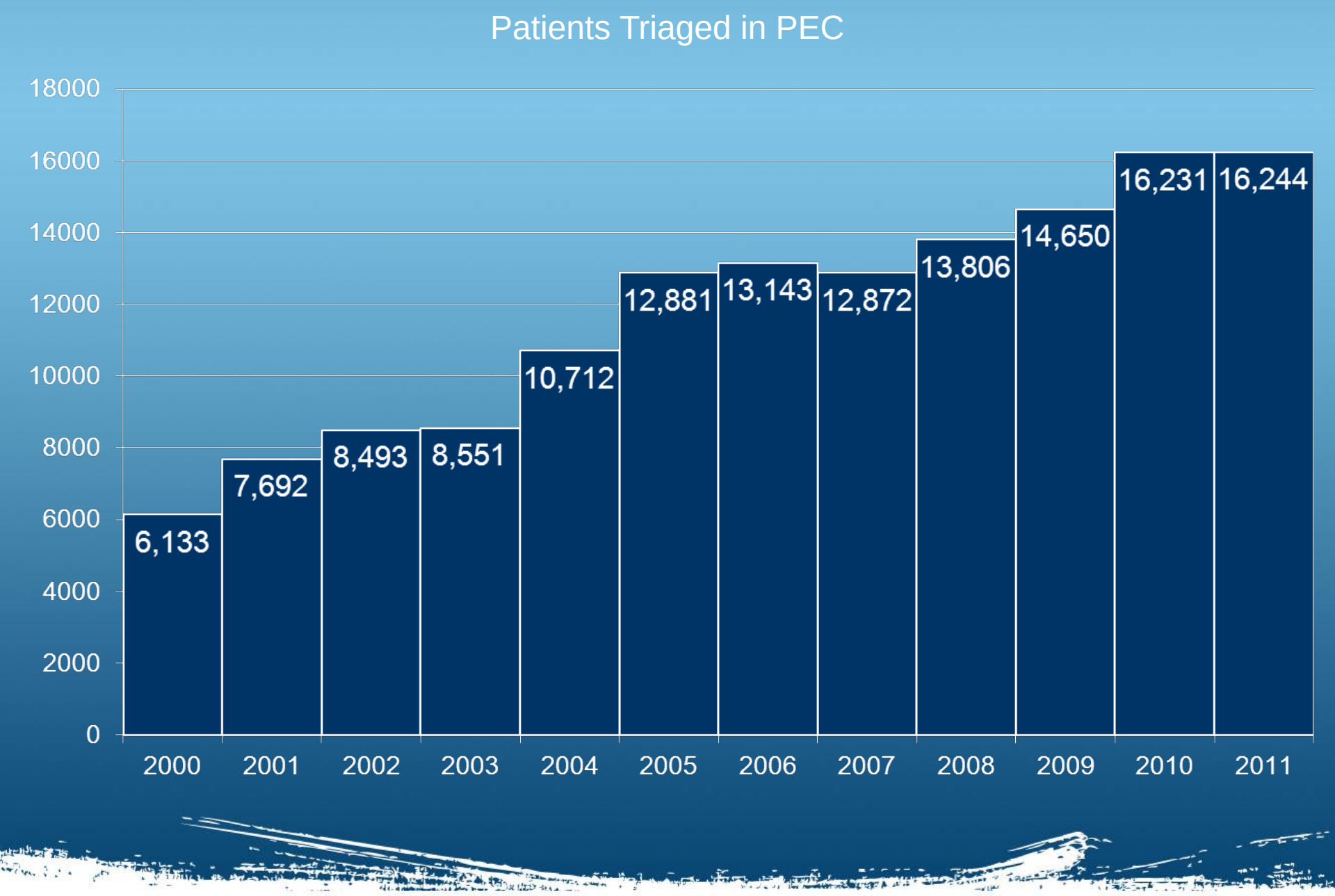
Psychiatric Emergency Center



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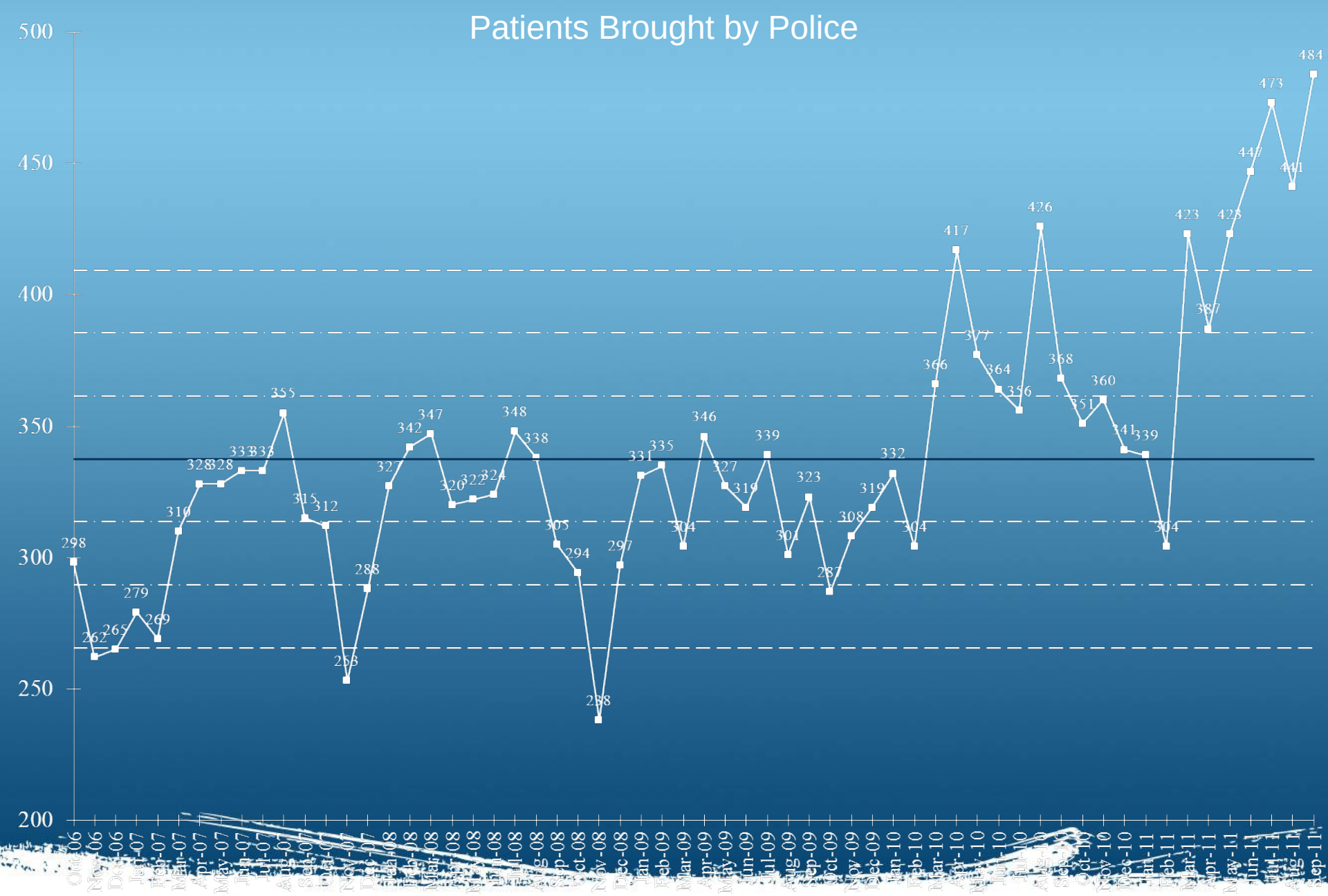
Psychiatric Emergency Center



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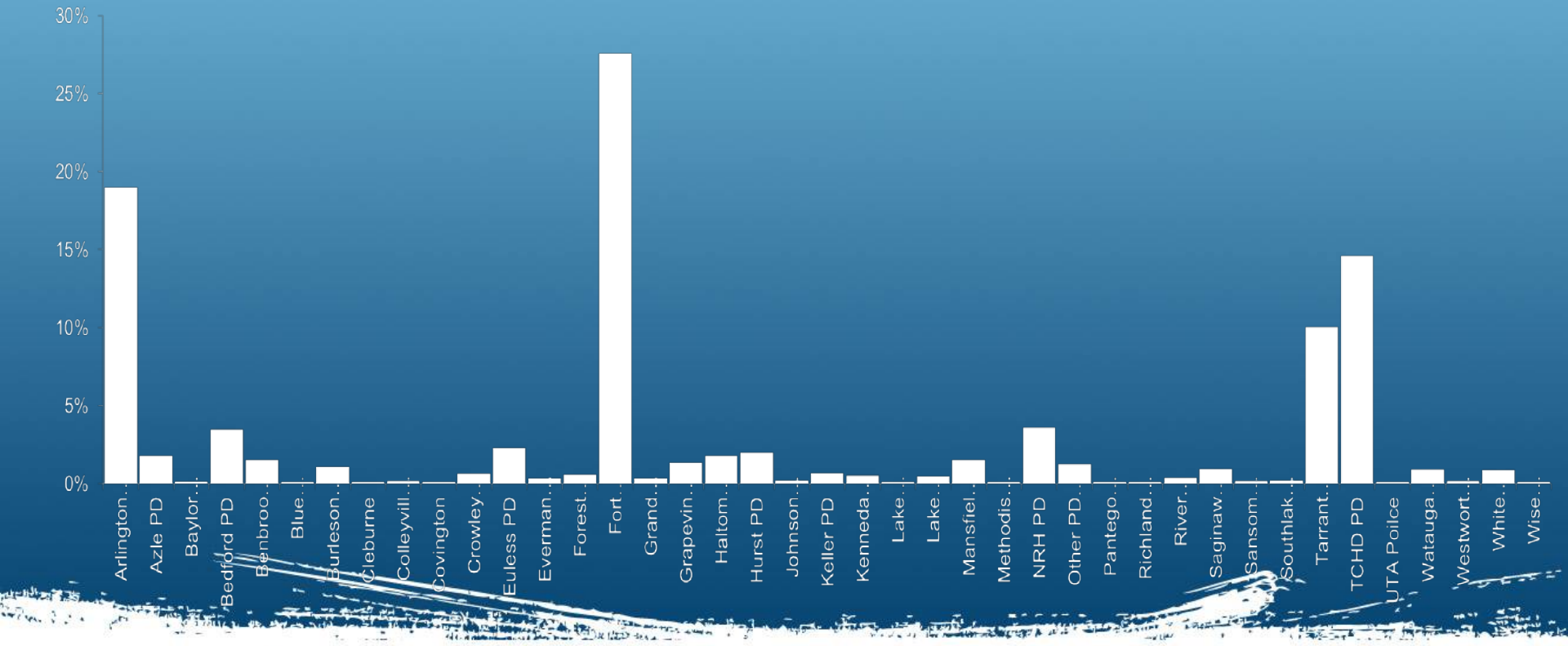
Psychiatric Emergency Center

Arlington PD	905	Crowley PD	29	Keller PD	31	River Oaks PD	16
Azle PD	83	Euless PD	108	Kennedale PD	23	Saginaw PD	44
Baylor Hospital PD	5	Everman PD	13	Lake Side PD	1	Sansom Park PD	7
Bedford PD	164	Forest Hill PD	25	Lake Worth PD	21	Southlake PD	8
Benbrook PD	71	Fort Worth PD	1315	Mansfield PD	70	Tarrant Cnty Sheriff	477
Blue Mound PD	1	Grand Prairie PD	14	Methodist Mansfield	1	TCHD PD	695
Burleson PD	50	Grapevine PD	62	NRH PD	169	UTA Poilce	2
Cleburne	1	Haltom City PD	84	Other PD not listed	57	Watauga PD	43
Colleyville PD	7	Hurst PD	93	Pantego PD	1	Westworth Village PD	6
Covington	1	Johnson Co SD	9	Richland Hills PD	1	White Settlement PD	41



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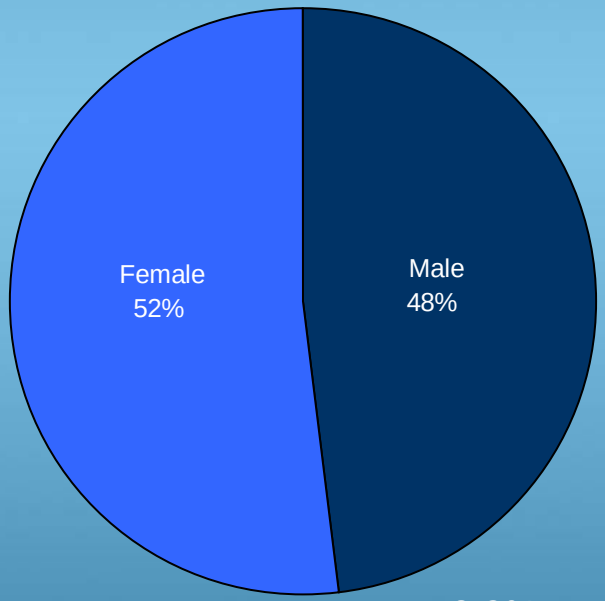
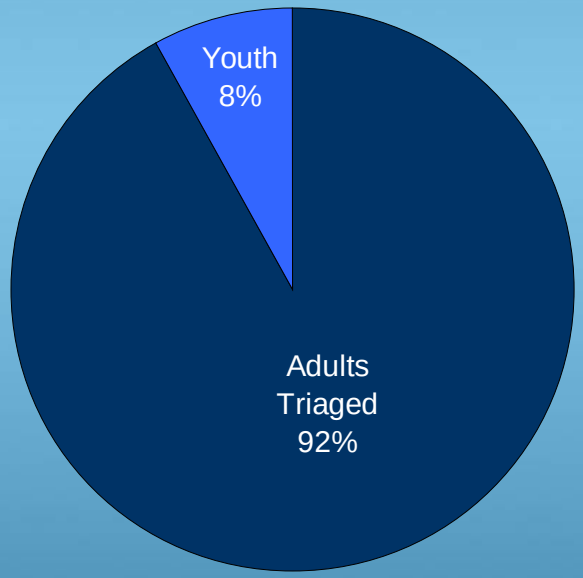
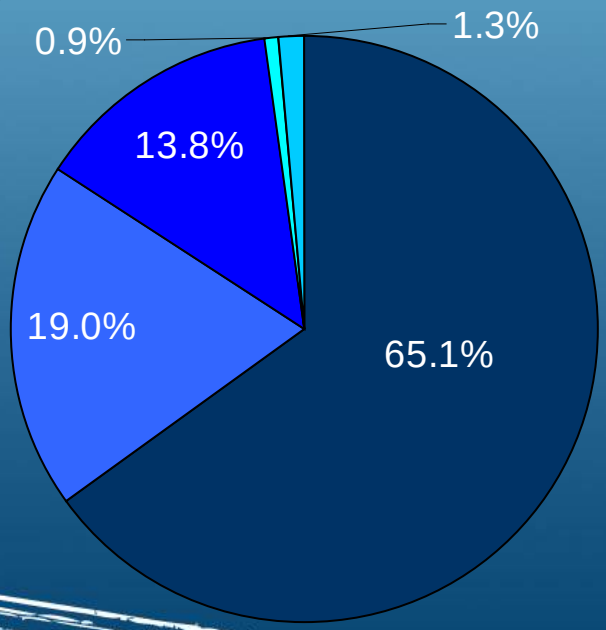
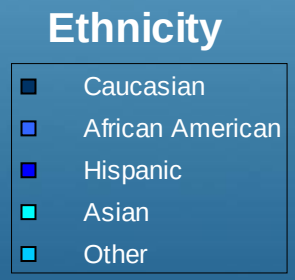
PEC Utilization by Law Enforcement









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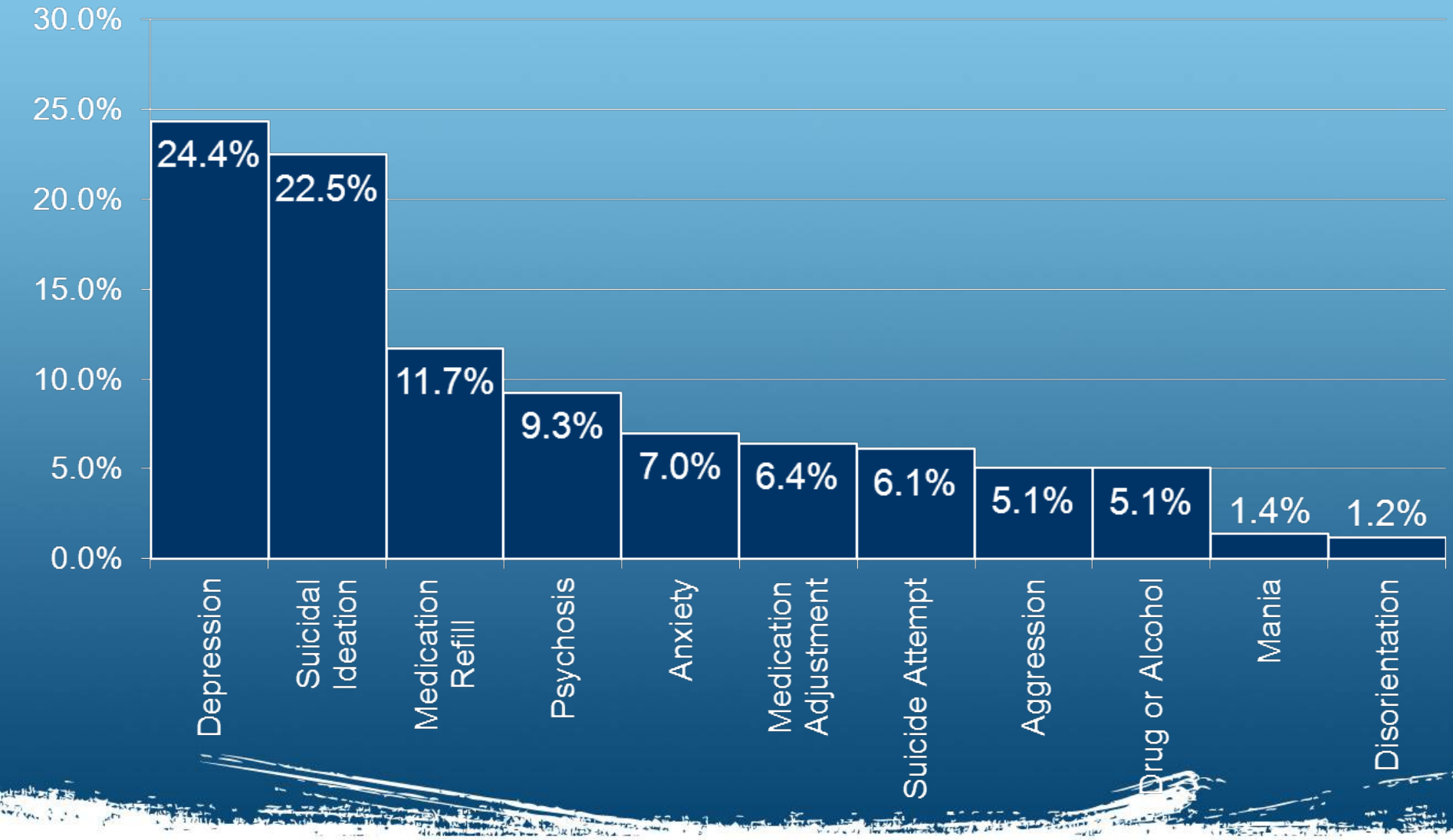
Psychiatric Emergency Center

PEC Presenting Problem

2000-08



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Psychiatric Emergency Center

The 12-bed CSU is a collaboration between MHMR of Tarrant County and JPS Health Network funded by a state grant aimed at increasing the crisis mental health services available in our area. The services offered in the CSU are short-term treatments aimed at reducing acute symptoms to avoid a deterioration in the patient's condition that might ultimately require admission into a psychiatric hospital. This unit is a part of a continuum of crisis services that also includes a mobile crisis team, a crisis respite unit, and a crisis residential unit all operated by MHMR.

Services often include:

- Process Groups
- Coping Skills
- Strength and Resource Identification
- Mental Health Education
- Medication Supervision
- Relapse Prevention
- Goal Identification
- Solution-Focused Group Therapy
- Individual Therapy
- Family Education
- Family Therapy
- Community Resources

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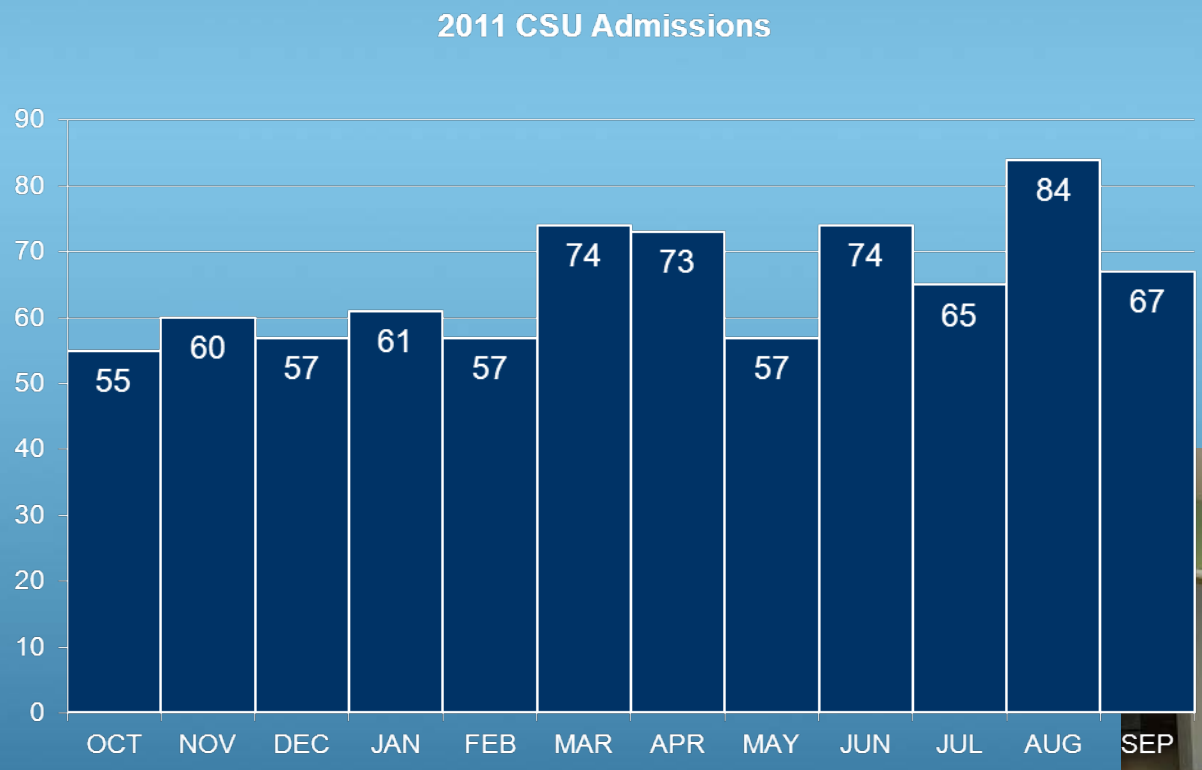
Crisis Stabilization Unit



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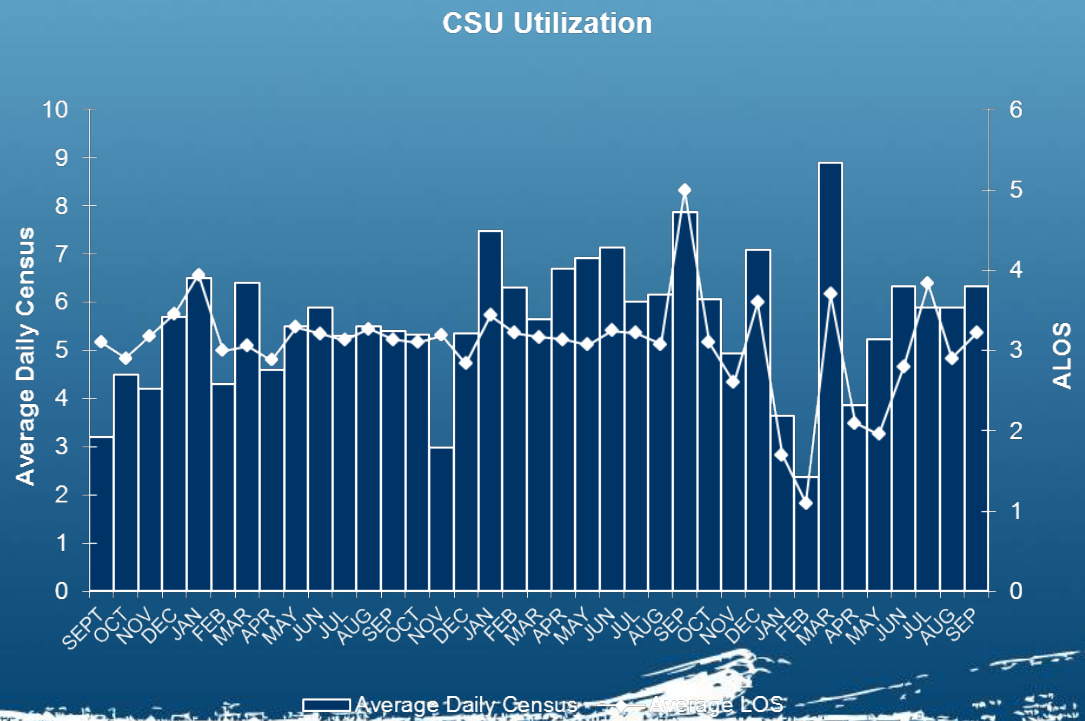
Crisis Stabilization Unit

MCOT comes to the CSU daily to complete intakes on all patients admitted to the CSU that are not initially referred through the crisis services. This allows for MHMR to capture the utilization information and provides access to a broader array of services for the patient.

In 2011, the CSU provided 2,209 days of service to served 784 people in crisis.



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Crisis Stabilization Unit

This 38-bed brief, acute program treats patients requiring comprehensive psychiatric evaluation and treatment to stabilize their psychiatric symptoms. Crisis intervention and individualized, structured treatment are provided to patients in need of an intensive and safe setting.

Services often include:

- Comprehensive and multidisciplinary biopsychosocial evaluation
- Case management and collaboration with the patient's outpatient clinician, physicians, family and community agencies to facilitate an integrated approach and establish comprehensive transition plans
- Psychological and brief neuropsychological assessment
- Crisis intervention & stabilization of acute psych symptoms
- Psychopharmacological evaluation and mgmt
- Activity therapy interventions

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Adult Inpatient Services

This 16-bed unit provides treatment for adults able to engage in therapeutic activities. This level of treatment emphasizes assessment, brief treatment, clinical case management and the initiation of rehabilitation. Treatment integrates biological, psychosocial and life skills approaches in treating the individual holistically and helps patients achieve their goals.

Services often include:

- Group therapies focused on symptom management and coping skills, acute life stressors, psychiatric disorders, medication and recovery
- Case management and collaboration with the patient's outpatient clinician, physicians, family and community agencies to facilitate an integrated approach and establish comprehensive transition plans
- Activity therapy interventions
- Comprehensive and multidisciplinary biopsychosocial evaluation
- Psychological and brief neuropsych assessment
- Psychopharmacologic evaluation and management
- Crisis-oriented family therapy and psychoeducation
- Crisis intervention and acute symptom stabilization

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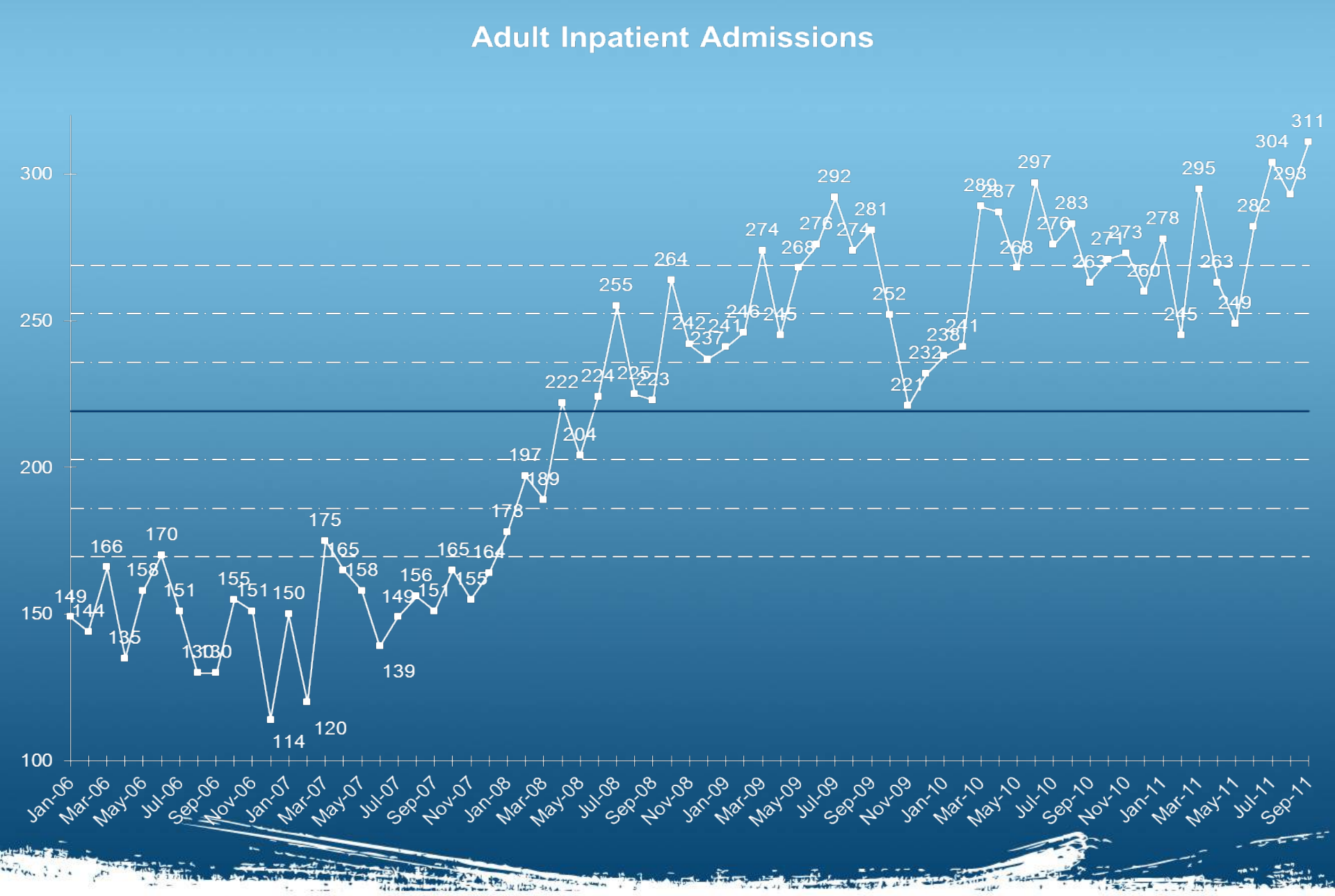
Adult Step Down Unit



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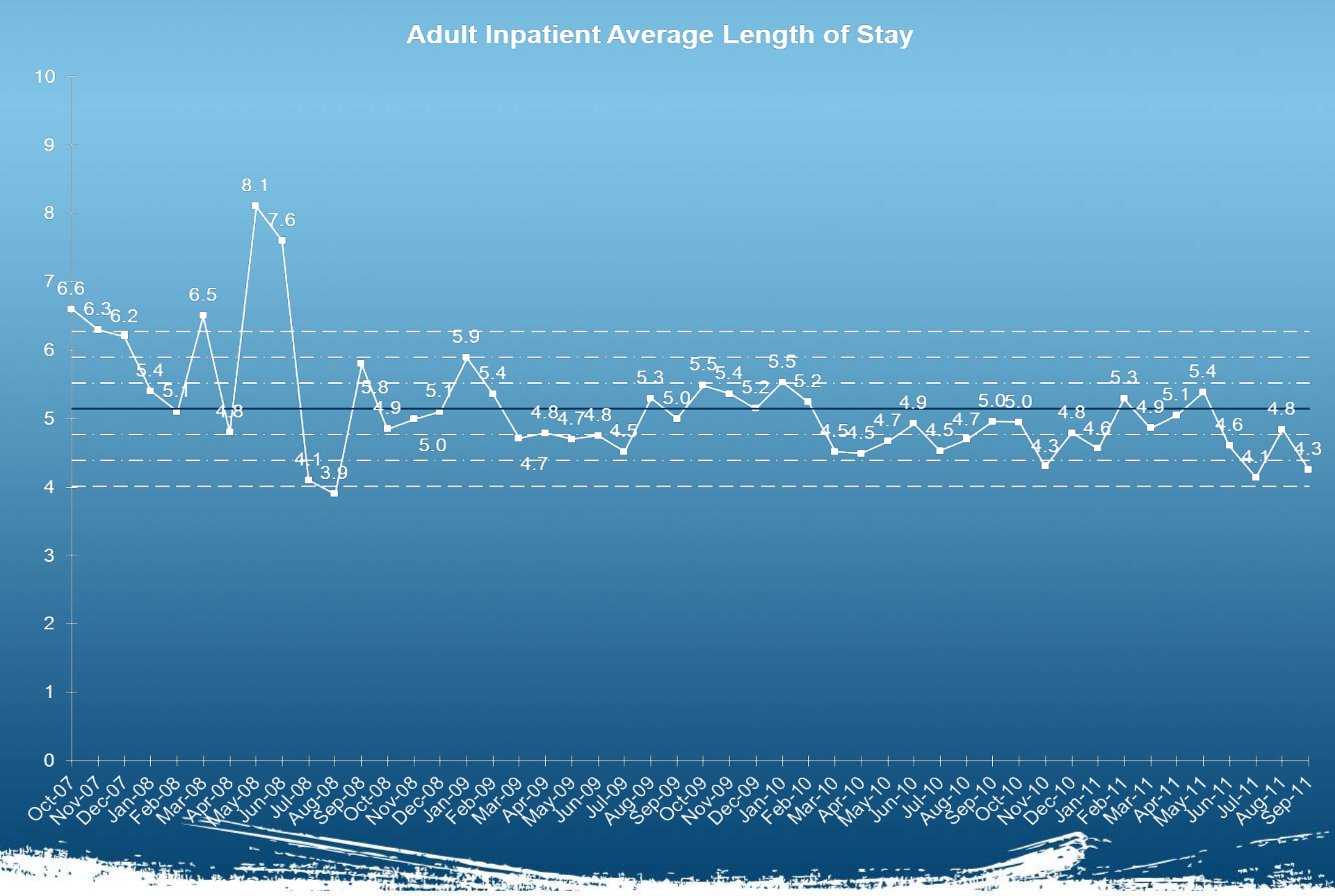
Adult Inpatient Services



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Adult Inpatient Services

The Adolescent Inpatient Unit is a 16-bed acute care unit. This co-ed unit contains eight double patient rooms and two common areas, comfortable furnishings and indoor areas used for recreational therapy activities.

Services often include:

- ***Crisis-oriented intensive family therapy***
- Psychological and brief neuropsychological assessment
- Psychopharmacologic evaluation and management
- Individual and group therapy
- Comprehensive and multidisciplinary biopsychosocial evaluation
- Academic services provided in collaboration with Fort Worth ISD
- Case management and collaboration with each adolescent's school, outpatient clinicians, family and other community agencies to facilitate an integrated approach, to establish comprehensive transition plans and to promote the adolescent's optimal functioning.

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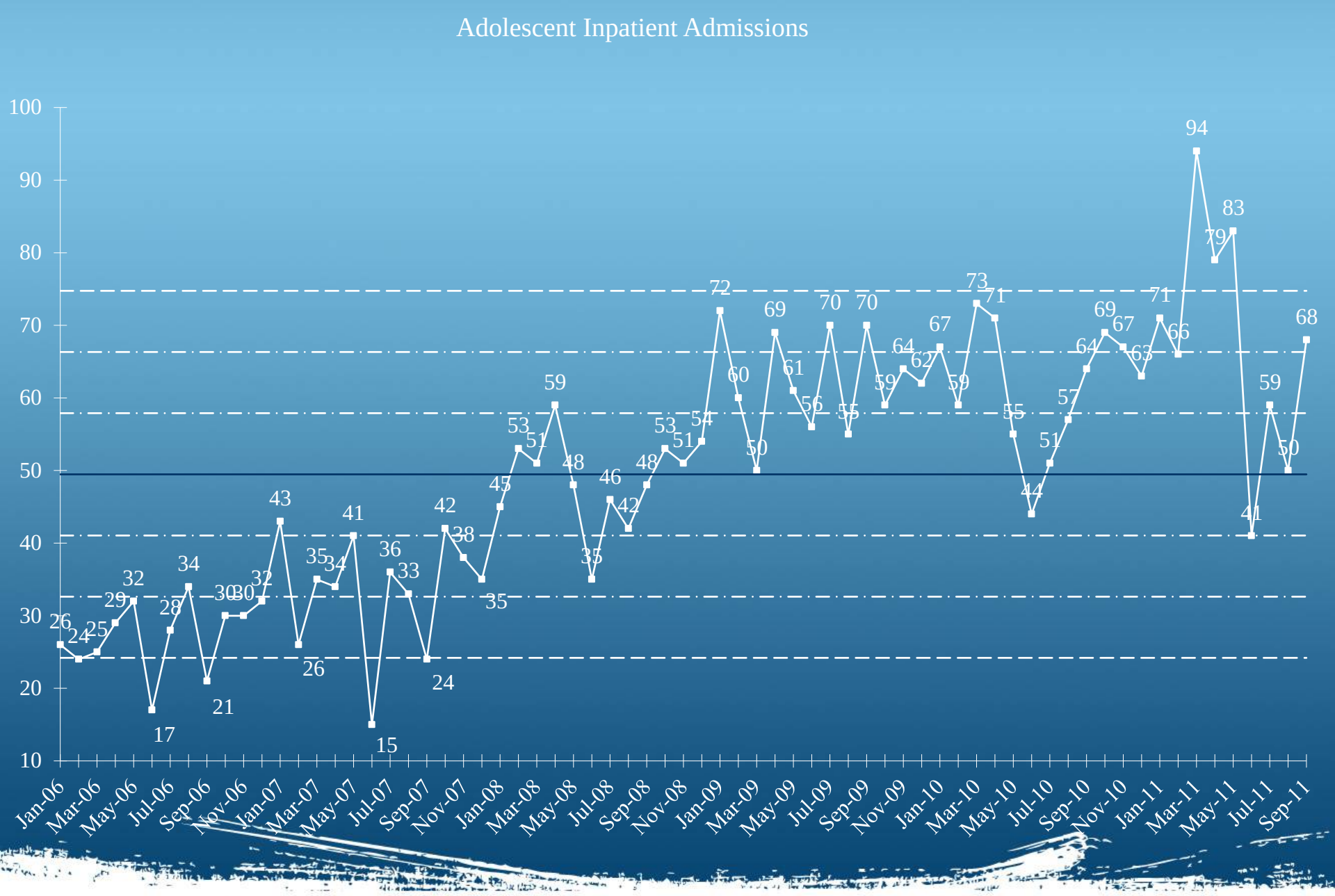
Adolescent Inpatient Services



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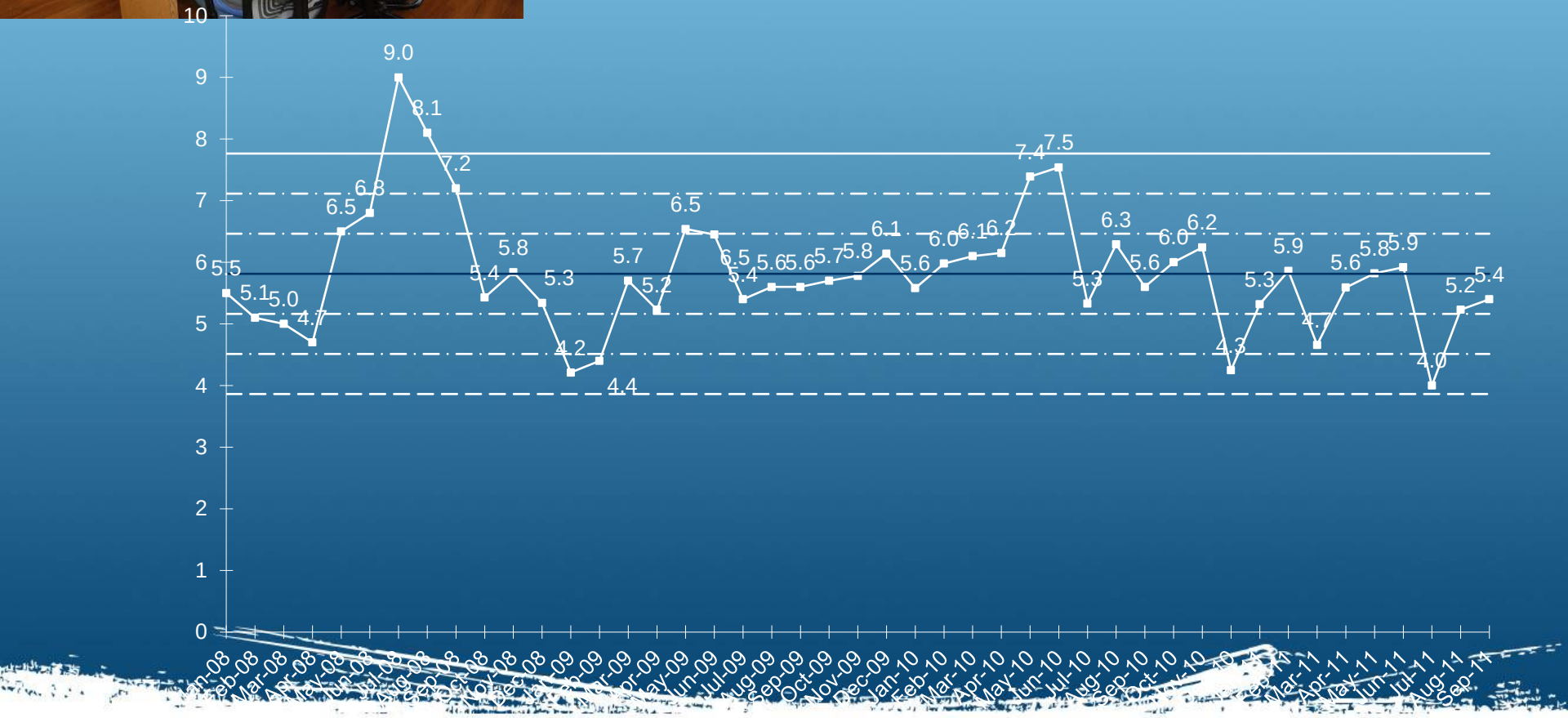
Adolescent Inpatient Services

Adolescent Inpatient ALOS



Adolescent Inpatient Services

JPS outpatient behavioral health services are integrated into strategically located JPS Health Centers. This integration allows for maximum coordination of care between patients' physicians while maintaining ease of access.

Outpatient Services:

- Evaluation
- Medication Management
- Limited Psychotherapy
- Limited Psychological Testing

Outpatient Clinics:

- JPS Health Center – Central Arlington
- JPS Health Center – Northeast
- JPS Health Center – Stop Six
- JPS Health Center – Viola Pitts

New Patient Appointments – 817-702-1456

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Outpatient Services

JPS has 19 school based clinics providing primary care services to school aged children and their siblings throughout Tarrant County. Two of those school based clinics have co-located behavioral health services on site. The services in these clinics are provided by a Family Psychiatric Nurse Practitioner and a Licensed Master Social Worker.

Services often include:

- Comprehensive and multidisciplinary biopsychosocial evaluation
- Psychopharmacologic evaluation and management
- Crisis-oriented intensive family therapy
- Individual and group therapy
- Case management and collaboration with each adolescent's school, outpatient clinicians, family and other community agencies to facilitate an integrated approach, to establish comprehensive transition plans and to promote the adolescent's optimal functioning.

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School Based Services

1. * Lena Pope Charter School - Chapel Hill
2. * HEB ISD-35 schools
3. Arlington ISD-74 schools
4. Birdville ISD-33 schools
5. Crowley ISD-20 schools
6. Castleberry ISD-8 schools
7. Eagle Mountain-Saginaw ISD-22 schools
8. Everman ISD-8 schools
9. Fort Worth ISD-144 schools
10. Grapevine-Colleyville ISD-19 schools
11. Lake Worth ISD-6 schools
12. Mansfield ISD-40 schools
13. White Settlement ISD-10 schools

Physical Locations of
Behavioral Health SBC's

HEB
HURST - EULESS - BEDFORD
Independent School District

Bulldog Pride
EISD
Everman Independent School District

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School Districts Served by BH SBC

1. * Lena Pope Charter School - Chapel Hill
2. * HEB ISD-35 schools
3. Arlington ISD-74 schools
4. Birdville ISD-33 schools
5. Crowley ISD-20 schools
6. Castleberry ISD-8 schools
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Physical Locations of
Behavioral Health SBC's

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HURST - EULESS - BEDFORD
Independent School District

Bulldog Pride
EISD
Everman Independent School District

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School Districts Served by BH SBC

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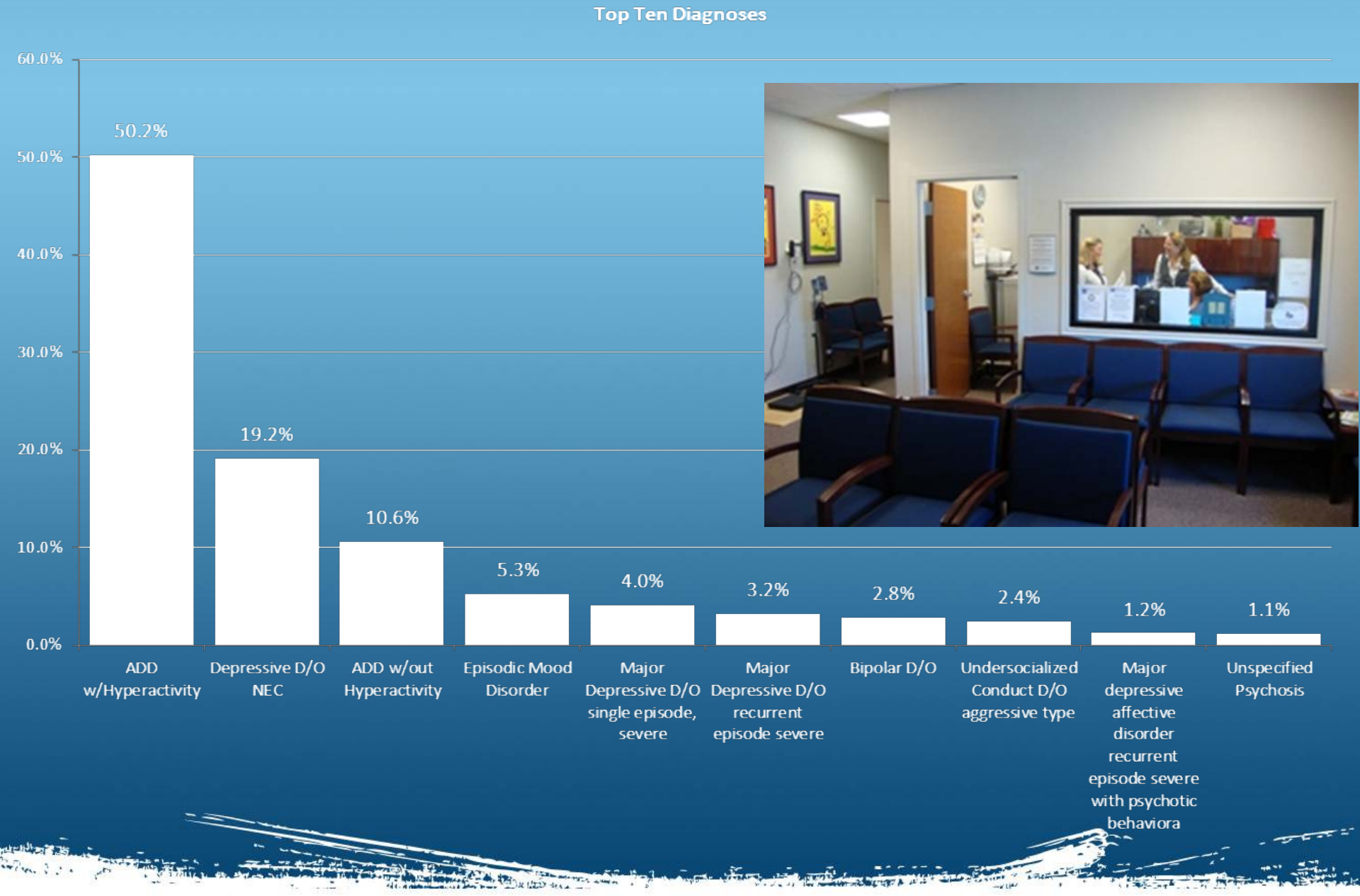
Behavioral Health SBC Visits



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Behavioral Health SBC Visits

	Inpatient Days	Inpatients
2NW	15,261	3,147
CSU	2,232	716
AIU	4,501	726
Total	21,994	4,589

	Outpatient Visits
PEC	16,231
VPC	8,435
NEC	5,509
SSC	4,901
CAC	2,413
SBC	237
Total	37,726

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2010 Total Service Volumes

Outpatient Clinic Schedules

Adult Psychiatric Clinics					
	Monday	Tuesday	Wednesday	Thursday	Friday
Stop Six	✓	✓		✓	
Northeast		✓	✓	✓	
Viola Pitts	✓	✓	✓	✓	
Central Arlington		✓		✓	

Adolescent Psychiatric Clinics					
	Monday	Tuesday	Wednesday	Thursday	Friday
Stop Six		✓			
Viola Pitts			✓		

School Based Behavioral Health Clinics					
	Monday	Tuesday	Wednesday	Thursday	Friday
Arlington SBC	✓	✓			
HEB SBC			✓	✓	

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Outpatient Services

Mental Health Court is held in TSP twice weekly. MHMR provides two staff members who serve as court liaisons between TSP, MHMR, the North Texas State Hospital, to ensure the transfer of patients and the commitment process occurs smoothly for all parties involved.

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Mental Health Court

Our multidisciplinary staff is able to address the many facets of psychiatric illness using a range of services including pharmacotherapy, case management, group therapies, skill-building groups and crisis intervention.

Treatment team members include:

- Psychiatrists
- Psychologists
- Nurse Practitioners
- Registered Nurses
- Licensed Clinical Social Workers
- Certified Therapeutic Recreational Specialists
- Licensed Professional Counselors
- Licensed Chemical Dependency Counselors
- Chaplains
- Physician Assistants

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Treatment Team

Residency Program

Our general psychiatry residency is a four year program which is fully accredited by the Accreditation Council for Graduate Medical Education (ACGME) and also by the American Osteopathic Association (AOA) and includes 4 resident slots per year for a total of 16 residents supported by 16 faculty members.

Clinical Rotations

First-year		
	Six months	Hospital Inpatient Psychiatry
	Two months	Neurology
	Two months	Inpatient Internal Medicine
	Two months	Outpatient Internal Medicine
Second-year		
	Three months	Psychiatric Emergency Center
	Five months	Hospital Inpatient Psychiatry
	Two months	Child & Adolescent Psychiatry
	Two months	Consultation Liaison
Third-year		
	Twelve months	Continuous Outpatient Psychiatry
Fourth-year		
	One month	Geriatric Psychiatry
	One month	Substance Abuse Treatment
	One month	Neuropsychiatry
	One month	Psychological Assessment
	Eight months	Outpatient Psychiatry & Electives

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Residency Program

		National Performance			JPS Performance			
		2009	2010	Percentage Point Change	2009	2010	Percentage Point Change	JPS vs National Performance
Admission Screening	Higher is Better	88.40%	92.00%	5.20%	42.27%	97.15%	54.89%	5.15%
Multiple Antipsychotic Medications*	Lower is Better	11.80%	11.20%	-0.60%	5.90%	5.39%	-0.50%	-5.81%
Justification for Multiple Antipsychotics	Higher is Better	28.30%	39.50%	11.10%	7.14%	29.73%	22.59%	-9.77%
Continuing Care Plan	Higher is Better	85.70%	90.80%	5.10%	57.37%	94.48%	37.11%	3.68%
Contining Care Plan Transmitted	Higher is Better	74.10%	80.60%	8.70%	43.13%	91.24%	48.11%	10.64%

		National Performance				JPS Performance		
		2009		2010				
		Median	Percent of Hospitals - 0 Hours	Median	Percent of Hospitals - 0 Hours	2009	2010	JPS vs National Performance
Physical Restraint (hours per 1,000 Patient hours)*	Lower is Better	0.11	8.60%	0.09	5.80%	0.0000	0.0000	-0.0900
Seclusion Restraint (hours per 1,000 Patient hours)*	Lower is Better	0.07	16.70%	0.06	16.80%	0.0001	0.0001	-0.0599

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HBIPS 2010 National Comparison

Trauma Informed Care

In recognizing the role trauma plays in our patients' illnesses and recovery, we have initiated several projects at improving our recognition and sensitivity to trauma.

Strategies:

1. Trauma Informed Care Workgroup
2. Enhanced Trauma Assessment
3. Groups regarding the impact of trauma
4. Education for Psychiatric Tech's by psychologist
5. Staff education by expert as a part of P^3

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Quality Improvement Project

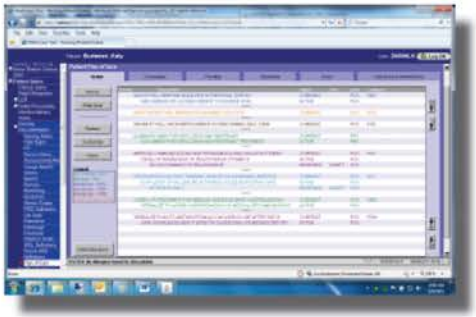
Department of Psychiatry: Process Improvement

Interdisciplinary Plan

On admission the interdisciplinary plan of care is started by the admitting nurse.

After reviewing assessments with the patient, identify strengths and liabilities.

Patient and nurse set initial goals.

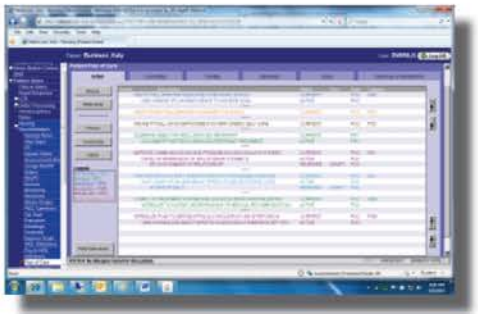


The interdisciplinary care team (consisting of the patient, nurse, physician, social worker, and adjunctive therapist) reviews and adjusts goals.

Establish an estimated length of stay and create a discharge plan.

All documentation includes patient signature, date and time of the initial plan of care.

Nurse reviews and updates plan as needed at every shift and charts to the goals.



All disciplines document patient/ family education and update plan of care as needed.

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QI Project

A Collaborative Multi-Tiered Approach to Psychiatric Emergencies

Lesley Smith RNC, BN JPS Health Network, 1500 South Main, Fort Worth, Texas

The JPS Department of Psychiatry offers behavioral health services that include the Psychiatric Emergency Center, an Adult Inpatient Unit, an Adult Step Down Unit, Crisis Stabilization Unit, and an Adolescent Inpatient Unit. We also offer four outpatient clinics and two school based mental health clinics located throughout Tarrant County providing psychiatric and therapeutic treatment.

Problem

Patients with psychiatric emergencies present with a broad array of problems, levels of acuity, and seriousness of mental illness. Timely response and easy access for patients with different needs and levels of crisis requires a multi-tier emergency mental health approach.

Findings

In 2006, the Texas Crisis Services Redesign Committee surveyed the spectrum of mental health professionals, other involved services, and consumers and identified the six core services needed by a mental health system. It also determined that in Texas these services were not consistently available or easily accessed.

Recommended Core Services

1. Crisis hotline services
2. Psychiatric emergency services with extended observation services
3. Crisis outpatient services
4. Community crisis residential services
5. Mobile outreach services
6. Crisis intervention team/mental health deputy/peace officer program

Literature Search

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Lee, S., Brunero, S., Fairbrother, G., & Cowan, D. (2008). Profiling police presentations of mental health consumers to an emergency department. International Journal of Mental Health Nursing, 17(5), 311-316.

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For more information and references contact: lsmith02@jpshealth.org

Collaborative Solution

Core services in operation prior to Crisis Redesign recommendations

Of the core services identified by the Texas Crisis Services Redesign, JPS Health Network, the county health provider, as part of its extensive psychiatric services already operated a 24 hour, seven day a week Psychiatric Emergency Center (PEC) with extended observation services, and the Acute Psychiatric Clinic (APC), a walk-in outpatient clinic.

Mental Health Mental Retardation of Tarrant County (MHMRTC), among its many services, already provided I-Care Call Center, a 24 hour, seven day a week Crisis Hotline and the Law Liaison program, providing telephone resources for peace officers.

Response to Recommendations

JPS Health Network and MHMRTC collaborated to create an expansion of mental health crisis services.

Together they created the Crisis Stabilization Unit (CSU), a 12-bed unit with a length of stay of up to 96 hours, designed and operated by JPS Health Network. CSU services include short-term, solution focused therapies aimed at reducing acute symptoms to avoid inpatient hospitalization.

The CSU is accessed directly through the JPS Health Network Psychiatric Emergency Center, Acute Psychiatric Walk-In Clinic, Behavioral Health Outpatient Clinics, and the MHMRTC Mobile Crisis Outreach Team (MCOT).

JPS Health Network realigned the PEC and APC to directly interface emergency services with the Crisis Stabilization Unit, creating a continuum of services for a broad array of individuals with varying levels of psychiatric emergencies.

MHMRTC implemented a Mobile Crisis Outreach Team (MCOT), accessed through the I-Care Call Center. This team of mental health professionals provides face-to-face assessment, intervention, and follow-up services to adults, adolescents, and children in their place of residence, school, and/or other community based locations 24 hours a day, 365 days a year.

MHMRTC also expanded the I-Care Call Center by increasing staff and gaining American Association of Suicidology certification, expanding the ability to provide immediate crisis screening and assessment.

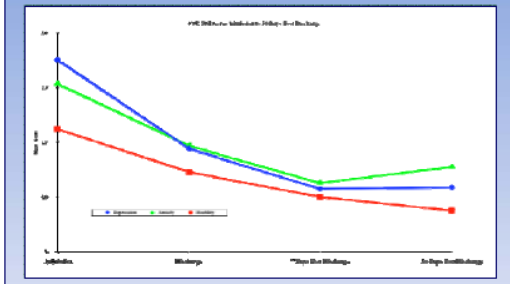
Additionally MHMRTC implemented Crisis Residential and Respite Units, the target population of which is any individual experiencing a crisis who has been seen by MCOT and is in need of a short-term stay until either the crisis is over or alternative living arrangements have been made.

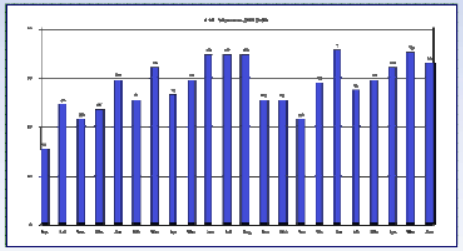
Collaborative Results

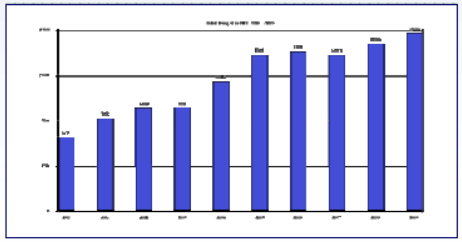
Through the efforts of JPS Health Network and MHMRTC, Tarrant County residents have benefited from an extensive mental health crisis system that provided multi-tiered care for patients with psychiatric emergencies. In response to the needs identified by the Texas Crisis Services Redesign Committee, JPS Health Network and MHMRTC worked together to extend their comprehensive mental health crisis system. Psychiatric emergencies cover a broad range of individual crisis and this system provides opportunities for each patient to receive the appropriate level of care for his or her psychiatric emergency. The immediate and growing utilization of these services show that they fulfill an important community need.

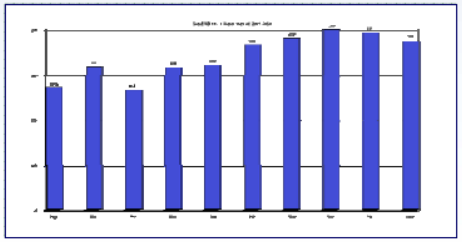
CSU Outcomes

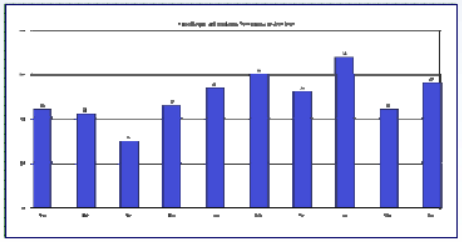
There is encouraging evidence that the main goal for establishing the CSU, avoiding inpatient admissions, is being realized. An extensive evaluation of the CSU found evidence that the program significantly reduced psychiatric symptoms theoretically associated with the reason for the admission. The Brief Symptom Inventory, a self-report measure of the experience of psychiatric symptoms, was completed by CSU patients on admission, discharge, 7 days post discharge, and 30 days post discharge. The results show a significant improvement in depression, anxiety, and hostility. The CSU evaluation of a sample also identified that only 16% of patients required inpatient admission within six months of CSU discharge.











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Poster Presentation

Psychiatric Emergency Center:
Meeting the challenge of rising mental health emergencies

Lesley Smith, RNC

JPS Health Network ♦ 1500 South Main Street ♦ Fort Worth, TX

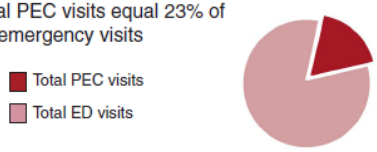
Problem

Psychiatric emergencies are a significant and frustrating burden on Emergency Departments (ED) and law enforcement agencies, creating a potential for non-optimal treatment for the mentally ill in crisis.

- ED capacity continues to be outpaced by demand. ED visits increase while the number of hospital EDs decreases. These factors lead to ED overcrowding nationwide.
- Mentally ill patients are resource intensive and have longer stays than medical patients.
- Psychiatric emergencies can involve patient aggression and violence that EDs are not designed to manage.
- ED staff are often not trained for psychiatric emergencies and find mentally ill patients to be challenging and frustrating.
- Adolescent mentally ill patients are especially challenging.
- Evaluation, treatment, and disposition may be less than optimal.
- Law enforcement officers experience long delays when escorting the mentally ill for admission, interfering with other public safety duties.
- The legal aspects of admitting voluntary and involuntary mentally ill patients are complex, requiring specific knowledge and procedures.
- Inefficiency in treating the mentally ill can lead to un-needed incarceration, affecting both the justice system and the mentally ill.

Total ED and PEC Visits 2007

- Total PEC visits equal 23% of all emergency visits



Solution

Establish a dedicated 24 hour, seven day a week facility for psychiatric emergencies.

Benefit for emergency departments:

- Diverts a substantial patient population requiring time and expertise not normally available in already overcrowded EDs.
- Removes disruptive patients from the ED to an appropriate clinical area.
- Reduces patient to patient and patient to staff violence.

Benefit for law enforcement agencies:

- Creates a dedicated 24/7 site for law enforcement officers to bring individuals in psychiatric crisis.
- The establishment of a system allowing rapid return of law enforcement officers to other duties.
- Reduces repeat crisis for the mentally ill, reducing repeat involvement with law enforcement.
- Diversion of the mentally ill from jail.

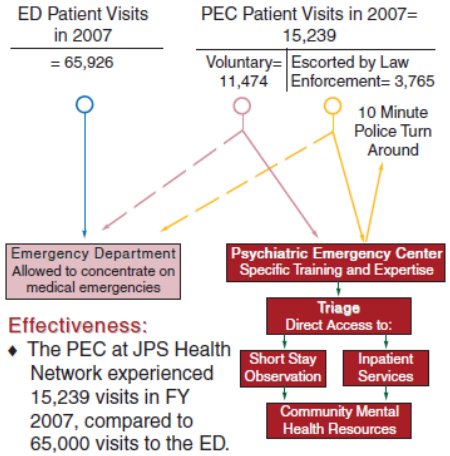
Benefit for the mentally ill patient:

- Staff with specific training and expertise.
- Rapid crisis stabilization
- Thorough assessment and evaluation
- Extended observation services
- Involvement of family in assessment and discharge planning
- Direct link from triage to treatment improves outcomes
- Access to inpatient and community resources
- Medication management and adjustment
- Secure, therapeutic environment
- Age specific treatment planning

The PEC at JPS Health Network

Implementation:

- Established in 1998
- Provides triage, assessment, observation, and crisis intervention for voluntary and involuntary patients 24/7
- Specific training and expertise allows rapid crisis stabilization, thorough assessment and evaluation using family input and support.
- Discharge planning is enhanced by direct access to inpatient services and mental health resources



Effectiveness:

- The PEC at JPS Health Network experienced 15,239 visits in FY 2007, compared to 65,000 visits to the ED.
- Law enforcement agents experience a 10-minute turnaround with the PEC.

Conclusion

- The number of patient visits to the PEC at JPS Health Network shows the potential a dedicated facility for patients in psychiatric crisis has to reduce the patient load on an ED.
- Without the PEC, the ED at JPS would be subject to a 23% increase in patient visits.
- Removing this patient group from the ED allows it to concentrate on medical emergencies
- A dedicated PEC has the potential for improved assessment, treatment, and outcomes for the mentally ill.
- The PEC has improved law enforcement productivity and diverted the mentally ill from inappropriate incarceration.
- Establishing a PEC with extended observation is an important component of the recommendations of the Texas Mental Health and Substance Abuse Crisis Services Redesign of 2006

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Poster Presentation

Comparison of Breathalyzer and Blood Alcohol Levels in Emergency Department Patients

Debbie Schmidt RN, MSN - Lesley Smith RNC - Charles Walker Ph.D., RN - Texas Christian University – JPS Health Network

Statement of Problem

Alcohol (ETOH) use among patients treated in Emergency Departments (ED) affects an estimated 10-20 million Americans and 15-20% of primary and hospitalized patients (Schumacher, Pruitt, Phillips, 2000).

Blood alcohol level (BAL) can provide a reading of the presence and amount of alcohol in a person's system when the patient denies or minimizes the amount consumed. Knowing the patient's alcohol level could alter the treatment or discharge plan.

BAL vs. Breathalyzer

BAL draws are invasive. Results may be altered if an alcohol swab is used for skin preparation prior to venipuncture. The charges for a single test can run over $100 and obtaining the results can take 30 minutes or longer.

Breathalyzers test BAL in exhaled air and are most often used in law enforcement. Breathalyzers are noninvasive, less costly, and yield instant results.

Purpose

The purpose of this study was to compare breathalyzer and blood alcohol levels in the ED setting. If breathalyzer results were found to correlate with BAL, then the breathalyzer could be used in the ED to obtain a quick, inexpensive, noninvasive alcohol level.

Research Questions

- Do breathalyzer readings correspond to BAL in ED patients?
- Is the breathalyzer a useful diagnostic tool in an acute care setting?
- Are there meaningful correlations among demographics and other variables when comparing BAL and breathalyzer results?

Correlation Table

	Breath	BAL	Difference
BAL	-.124	---	---
COPD	.080	.245	-.165
LIVER	-.120	.004	-.204
PAST BAL	.064	.885**	-.625
FREQUENCY	-.105	.096	-.169
SINCE	-.055	.373	.333
AMOUNT	.620**	.068	.297
LAPSE	.137	-.323	.328
WEIGHT	.396*	-.040	.230

*p < .05; **p<.001

Results

- Breathalyzer values did not correlate with BAL.
- Past BAL predicted current BAL measurement.
- Breathalyzer values correlated highly with self-reported amount of ETOH consumed and moderately with body weight.
- Caucasians reported more co-morbidities than non- Caucasians (r= .376, p < .05).
- Neither Breathalyzer nor BAL correlated with self-report of physical disease.
- Women reported more asthma and COPD than men (r = .377, p < .05).
- African American participants reported less frequent ETOH consumption than Caucasian or Hispanic participants (r = -.530, p < .01).

Mean BAL = 203 (SD = 115)

Mean Breathalyzer = .130 (SD = 0.07)

Time elapsed between measurements:

- Mean = 43 minutes
- SD = 1 hour , 46 minutes
- Range = 8 hours, 45 minutes

Acknowledgements
Funded by The Alma and Robert D. Moreton Research Award, Harris College of Nursing

Demographics

Sample size= 30
Gender: Male 77%
Ethnicity: Caucasian 67%, Hispanic 20%, African American 13%
Mean age: 36 years (SD = 9.86; range = 18-54)
Mean weight: 167 lbs (SD= 28.91)
Mean height: 68.5 inches (SD= 3.86)

Drinking Habits

Frequency of alcohol consumption:

- daily 63%
- weekly 21%
- less often 16%

Amount of alcohol consumed in last 8 hours:

- 0-3 drinks 36%
- 4-6 drinks 52%
- 7 or more 12%

DIFFERENCE between BAL and Breathalyzer was not explained by:

Time elapsed between measurements
Medical conditions (e.g. lung or liver)
How much ETOH was consumed
How long since the last drink
How often participants drank
Past BAL measurements
Demographic variables

Conclusions

Breathalyzer screening was an invalid measure of blood alcohol in this sample (N = 30).
Results from this study confirm findings from previous studies:

- Jones & Anderson (1996) – discrepancies noted
- Martinez & Martinez (2002) – off as much as 50%
- Sommers, et al (2003) – no single lab test suffices
- Cherpital, et al (2005) – poor screener preparation
- Pavlic, et al (2006) – susceptibility to individual factors

Sample and Context

- Convenience sample was used in this study.
- The sample was composed of individuals 18 years of age and older.
- Individuals presented to a county hospital seeking services in either the ED or Psych Emergency Center (PEC).
  - ED: Level II Trauma Center with average census of 5,000/month.
  - PEC: Average census of 1,100/month.

Method and Procedure

Brand of Breathalyzer – FC10 digital screener*
Data collected over an 8-month timeframe
Data collector training: Online, hands-on
Data analysis program used: SPSS
IRB approvals obtained
*C Series – Q3 INNOVATIONS, LLC., Eagan, MN.

Limitations

Difficulty quantifying self-reported ETOH consumption

- "a lot", "some", "several"
- "2 drinks"
- "one beer"

Inability to control variables affecting ETOH metabolism

- Gender
- Weight/height
- Food consumption, smoking
- Medical illnesses

Practical Obstacles

Time lapse between Breathalyzer and BAL samples
Access to participants in the ED setting
Breathalyzer recalibration
Data collector training
Other factors:

- Breath samples require active cooperation.
- Potential traumatic injury to the head or torso may inhibit adequate breath sampling.

Ethical and Legal Issues

- Obtaining two informed consents: for ED treatment and study participation.
- Participants may not realize BAL is drawn as part of routine lab work.
- Participant unwillingness to consent to breathalyzer if law enforcement is present.
- HIPAA: Information cannot be shared with law enforcement without additional consent.

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Poster Presentation

Strategies for Successful Transition of an Acute Inpatient Psychiatric Facility to a Non-Smoking Environment

Allison Mason, BS, RN

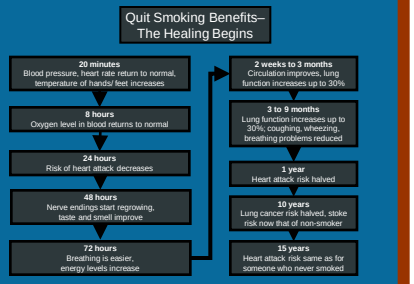
JPS Health Network, Fort Worth, Texas

Problem

- Cigarette smoking is the most preventable cause of premature mortality for all Americans, including the mentally ill.
- Psychiatric patients are twice as likely to smoke as the general population and those patients with a diagnosis of schizophrenia are almost three times as likely to smoke.
- Psychiatric patients who are smokers evidence statistically greater agitation and irritability compared with non-smokers.
- Psychiatric nurses and other staff have been reluctant to implement smoking cessation on inpatient psychiatric units despite the high use of tobacco by psychiatric patients.
- This is due to fears of increased physical aggression, increased episodes of seclusion/restraints and disruption of the treatment milieu.

Rationale

- The goal was to provide a healthy environment for patients and staff and to promote smoking cessation that continued beyond hospitalization



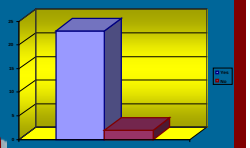
Planning and Strategies

- Through a multidisciplinary committee, an active education program was implemented to educate and prepare staff, patients and visitors for the change to a non-smoking environment
- A survey of staff was conducted to gain input regarding the subject of smoking cessation
- Staff were sceptical that it would be successful


Change is coming to TSP

Effective November 1, 2004 there will be No smoking or tobacco use for all patients during their stay at Trinity Springs Pavilion. This change has been made to provide our patients a healthier environment.

Staff who felt banning smoking would result in increased emergency medications and episodes of seclusion or restraint



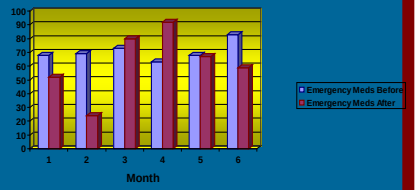
Implementation

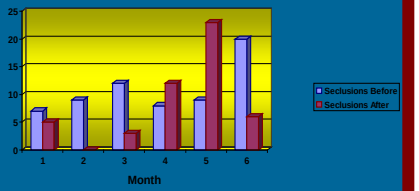
Steps taken prior to implementation of the no smoking policy:

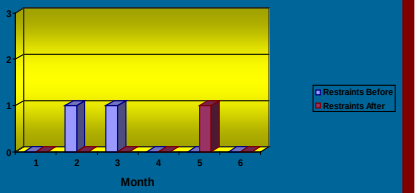
- Patients and families were notified by receiving educational handouts in the Psychiatric Emergency Center
- Signs regarding the change were posted throughout the Department of Psychiatry
- NAMI and other community mental health organizations were notified
- Educational material was given to discharging patients regarding smoking cessation support groups
- The unit schedule was adjusted eliminating scheduled smoke breaks and was replaced with outside activities and a smoking education group
- Nutritional Services was consulted to ensure patients would have access to appropriate, healthy snacks
- Pharmacy was notified to increase the stock of nicotine patches and gums in anticipation of the increased need

Results

Data Six Months Prior to and Post Initiation of a Non-Smoking Environment







Conclusions

- Successful initiation of a non-smoking environment in an acute inpatient psychiatric unit is possible with careful planning as well as multidisciplinary and administrative support
- The use of nicotine replacement therapy by patients is shown to improve success
- Increased vigilance is advised to monitor for smoking contraband
- Clear communication to patients, families and visitors beginning at the point of entry is essential to managing expectations

Implications for Nursing Practice

- Multidisciplinary collaboration and coordination including alternative activities, dietary options and clear and consistent protocols are essential
- A didactic group led in collaboration by psychiatrists and RNs supporting smoking cessation was added to the unit programming
- Patients are provided with education and information regarding smoking cessation support groups in the community upon discharge

Follow-Up

- Three other local psychiatric facilities have implemented smoking cessation on their units after successful implementation at JPS
- Implementation in the psychiatric environment has prompted the acute hospital at JPS to follow in a smoke free environment

References

Prochaska, J., Goldman M.D. Process of Smoking Cessation: Implication for Clinicians. *Clin Chest Med*, 1991;12:727–735

Lippolis, C. Smoking Cessation, What are we to do? Grand Rounds Presentation, JPS Health Network, January, 2008.

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History of Violence Screening in a Psychiatric Emergency Center

Lesley Smith RNC

JPS Health Network 1500 South Main Street Fort Worth Texas

Problem

Patient violence against mental health workers is frequent and increasing

Mental health professionals are six times more likely to be victims of violence than any other occupation

Evidence

Violent Patient Characteristics

A history of violence is the most important predictor for future violence

Substance abuse is a significant contributor to patient violence

It is important to note that 90% of the mentally ill are a low risk for violence

Supporting evidence for History of Violence Screening Tool

Patients with a history of violence are 20 times more likely to be violent to staff

NIOSH recommends history of violence screening

Similar tools have been shown to be successful

Patient self reporting of previous violence has been shown to be accurate

Evidence for Concise Screening Tool

A simple system has been shown to be accurate

There is greater nursing compliance when using a concise assessment tool

Complex models of assessment can be unreliable

The tool avoids negative ethnic or cultural assumptions

Therapeutic Considerations

Violence interferes with therapeutic care

Staff may see 'potentially violent' as 'violent'

A violent label may impede effective care

Include patient perspective in treatment planning

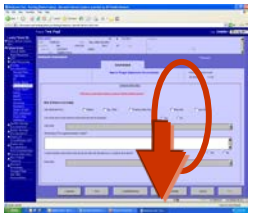
Implementation of History of Violence Alert in the Psychiatric Emergency Center

Patient Presents to the Psychiatric Emergency Center (PEC)

Triage Assessment

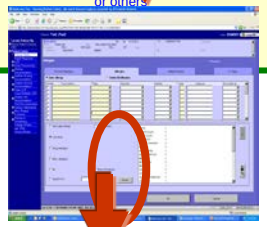
Asks the patient, family, law enforcement if the patient has exhibited any degree of physical violence to others or property

Asks what helps patient to regain or maintain control



If the patient meets criteria for history of extreme violence:

- Injury to staff, patient, or others that requires medical treatment exceeding first aid.
- Willful destruction of hospital property
- Use of weapons to threaten staff or others



Patients positive for a history of violence have a red triangle sticker placed:

At the top of the PEC chart

On the workstation name board

Alert follows the patient to inpatient unit

The nurse documents 'risk of violence,' creating a JPSJPS Health Network wide, online violence alert in both the critical factors screen and rounds report

Alert shows on each future episode of patient contact until removed by psychiatry

Evaluation of History of Violence Screening

In a Canadian study 71% of violent patients were successfully flagged

An Oregon study showed substantial reduction in violent attacks

In the PEC had a 29% reduction of staff injuries in the 23 months following implementation of the history of violence screening and alert protocol

Recommendations

Use a simplified process to ensure compliance

Expand the use of the tool to include some clinical factors such as substance abuse

Risk assessment should respond to clinical change in the patient

Continuing staff education is key to reducing patient violence

Respond to the patient perspective on contributing factors in the environment

Conclusion

The history of violence screening tool contributes to the reduction of patient violence against the staff in the PEC and in other organizations

A simple assessment can be more effective than a complex one

A history of violence tool alone will not eliminate violence

Any assessment and alert system must be part of a larger framework that addresses all aspects of patient violence prevention

For more information and references contact: lsmitho2@jpshealth.org

Questions????

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Thank You