Quantifying Psychiatric Acuity to Improve Quality of Care

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Background:

- Difficulty found in clearly communicating psychiatric acuity among the treatment team
- Little evidence-based practice on psychiatric acuity tools but proven usefulness in other patient care areas
- Need for a quantitative description of patient and unit acuity

Purpose:

To quantify psychiatric acuity on the Adult Psychotic Disorder unit of Vanderbilt Psychiatric Hospital as a means of improving the quality of patient care delivered.

Objectives:

- To appropriately allocate nursing resources
- To assist with fair patient assignment loads
- Provide an objective snapshot of patient acuity on the unit at a given time

Methods:

- Unit staff feedback obtained on what "drains" nursing staff resources above the expected workload
- Multidisciplinary group of MD, RN, MHS, and Director of Patient Quality and Safety developed an acuity scale to be implemented on the unit based on feedback
- Acuity tool included both a psychiatric and medical acuity scale
- Staff educated on tool use and implemented on unit for day (7a-3p) and evening (3-11p) shifts

Psychiatric Acuity Tool

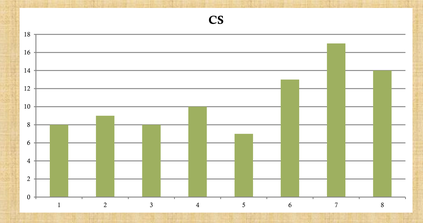
Score:	0	1	2	3
Protocols	• No protocol	• Monitoring and symptom management • CIWA • CNS-DP • COWS	• Scoring on protocol such that requires more frequent monitoring • CIWA • CNS-DP • COWS	• Loading on a protocol • CIWA • CNS-DP
Aggression • Suicidality • Self-injury • Agitation • Homicidality	• No history of aggression • No suicidality, or suicidality without plan or intent • No homicidality, or homicidality without plan or intent	• History of aggression, suicidality, self-injury, agitation, or homicidality • Suicidal ideation or homocidal ideation with a plan outside of hospital	• Concern for aggression, self-injury, agitation • Concern that patient may have suicidal or homicidal intent, or act on ideation in the hospital	• Impulsive behavior putting the patient at risk of physical harm • Temper and lack of control resulting in physical or threats of physical altercations with others • Others are intimidated, threatened or incited by patient • Active suicidality and/or homicidality with intent and plan/attempt while in hospital
Unpredictable Behavior • catatonia • disorganization • altered mental status	• No evidence of delusions/hallucinations • No evidence of impulsive behavior	• Psychosis- hx of delusions or bizarre behavior associated with psychotic d/o • Some problems with impulsive/distractible behavior • History of sexually acting out behavior • Readily redirectable	• Current delusions/hallucinations associated with psychotic d/o • Impulsivity and distractible behavior impairing function • Behavior indicating intent toward sexually acting out or manipulation of others while in hospital • Difficult to redirect	• Delusions/hallucinations that place others at risk of harm • Manipulation of others or sexually acting out/attempts to engage others in hospital • Uncontrolled impulsive behavior such as exhibited with developmental delay • Redirectable only with constant intervention
Precautions (above q15) • eyesight • 1:1's • Elopement	Q 15 min	Q 15 min, but "on the verge"	• Eyesight OOR • Elopement risk	• 1:1 • Eyesight • Off-unit appointments • Seclusion/restraint
High Utilizer • Frequently symptomatic • PRN frequency • Non-adherence • Visitation • Oppositional behaviors • Intensive Family needs	Not a high utilizer Occ PRN Non-acute requests	• Recent onset of defiance type behavior • Inconsistent compliance with treatment regimen • Lg groups of visitors or including small children	• Anxiety associated with frequent needs for reassurance and numerous demands • Defiant behavior causing emotional harm to others • Partial or complete resistance to taking medications. • Frequent requests to address symptom management, multiple PRNs	• Anxiety associated with frequent needs for reassurance and numerous demands and impairs ability to function • Oppositional behavior involving threat of harm to self or others • Medication non-compliance, can result in TRC • Constant request for symptom management and/or prn requests exceeding normal administration parameters

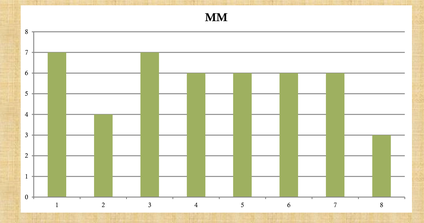
Medical Acuity Tool

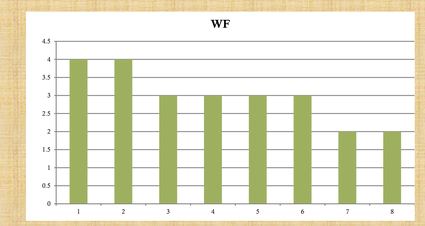
Score:	0	1	2	3
Fall Risk	No Risk	Low Risk	Moderate Risk	High Risk
ADLs	Independent w/ ADLs	Needs frequent reminders but requires minimal staff assist	Requires assist with some of the following: toileting, bathing, transfer or feeding	Requires full assist with toileting, bathing, transfer or feeding. Frequent incontinence.
Wound Care	No wound	Patient performs self-care, nurse to assess	Nurse to perform simple dressing changes and wound care/education (established trach)	Extensive wound care including frequent dressing changes. (i.e. SI GSW, burn)
Skilled Care/ Equipment Use	No accu-cheks, IV, feeding tube, catheter or O_2 use BG checks with insulin administration.	Patient self caths. Saline lock IV. O_2 use. .	Foley cath w/I&Os. uncontrolled DM requiring close monitoring of BG and diet	IV infusions, symptomatic Cardiac symptoms requiring close monitoring

Results:

- Staff feedback assisted in changes to scoring criteria to better fit patient population
- Acuity scores typically decrease from admission to discharge
- MDs reported better understanding of patient status throughout admission







Patient Samples:

- A look at patient scores over a one week period
- Provides objective view of patient progress

Education of Use:

- RNs to complete acuity tool near the end of each shift
- Psychiatric acuity total score is added to the total medical acuity score to give each patient a total acuity rating
- Acuity distribution: Mild (0-4) Moderate (4-8) High (>8)

Implications/Next Steps:

- Continue to assess validity
- Monitor staffing changes with unit acuity
- Assess use on other psychiatric units within VPH
- Integrate tool into HED and OPC
- Continue to obtain staff feedback on relevance

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