Behavioral Health Guidelines
For
Medical Isolation

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Contents

The goal of the Nebraska Behavioral Health Guidelines for Medical Isolation is to assist Nebraska hospitals in meeting the behavioral health needs of patients who are subject to in-patient isolation precautions. The isolation experience can be stressful for the patient, their families and caregivers. It can also evoke strong community reactions when there is a highly transmissible, widespread, or deadly agent involved. This document provides background information related to stress and isolation precautions and guidelines for providing services to patients in isolation, their families, staff, and the community. The appendices include a template policy that can be adapted to meet the specific requirements of Nebraska hospitals and resources for use within hospital settings.

Background

Patients admitted to isolation units have higher rates of anxiety and depression than other hospitalized subjects and rate themselves lower in the areas of self-esteem and sense of control (Gammon, 1998; Davies & Rees, 2000).   For that reason, it is important to triage each patient for mental health issues, continue to provide on-going assessment throughout hospitalization, and provide opportunities for the patient to participate in decision-making and self-care as appropriate. Effective support, provided by the entire healthcare team, can ease the anxiety experienced by many patients in the isolation environment.

> *"Anxiety increases the demand on the individual. It competes for time and attention and draws on already taxed resources – coping, listening, emotional reserves and courage. The individual is left drained and vulnerable as stressors occur. Anxiety can cause secondary, unrelated illnesses, e.g. angina, ulcers, hypertension and, more pertinently…. it can decrease resistance to infection by suppressing the immune system."* (Gammon, 1998)

Hospital staff can reduce patient anxiety by providing information to the patient about common reactions (e.g., feeling anxious) to isolation or to their symptoms. Predicting for patients that behavioral health symptoms may occur can help the patient understand their reactions through the course of their illness.

> *"[During the SARS outbreak] several patients who experienced waxing and waning anxiety throughout their stay in hospital reported that peaks of anxiety coincided with feeling feverish or learning of an elevated temperature. One patient with a pre-existing panic disorder experienced episodes of panic during spikes of fever. Other patients reported feeling discouraged and frightened by the return of fever after an afebrile period."* (Maunder, 2003)

Patients under stress may regress to lower levels of functioning. They "may become annoyingly assertive or demanding, and be prone to fussiness with outbursts of temper when crossed" (Denton, 1986). Understanding this process and learning specific communication skills to use in these situations prepares hospital staff to calm and de-escalate the anxious or agitated patient. Patients can feel out of control while under isolation precautions. Not all patients react to this perceived lack of control in the same way. Some patients prefer to maintain control; some prefer to relinquish control (Cohen, Ley, & Tarzian, 2001). Hospital staff should recognize this difference between patients. Helping those who need more control to regain a sense of power over their own care can decrease their stress. This may include controlling the number of visitors that are allowed. Patients sometimes request that they be left alone by family and friends, however some "later regretted the results when family, friends, and nursing staff complied with their request" (Cohen et al, 2001). For that reason, it is important to remember that requests of this type should be reassessed over time.

Several studies have noted that nursing and medical staff often spend less time in the room interacting with the isolated patient than they do with other hospitalized patients. When staff must gown and glove before entering a room, it greatly decreases the amount of time they have available to interact with patients. It can also cut down on staff's impromptu visits with patients. Patients may not understand the difficulty in maintaining isolation, but instead perceive it as "a reluctance of some staff members to enter the room" (Kelly-Rossini, Perlman, & Mason, 1996). Denton (1986) recommends that caregivers "Isolate the organism, not the patient: this is surely the prime tenet of the nurse who is involved in caring for patients in isolation, whether the isolation is for the benefit of the patient or the public."

Patients who enter isolation with a pre-existing behavioral health diagnosis will need to continue treatment under the guidance of their behavioral health provider as directed by their attending physician. Some patients may have a pre-existing illness, but may not be under the current care of a behavioral health provider. Patients who have been triaged and need further evaluation and possible treatment, should be referred to a psychiatrist, psychologist or other licensed mental health professional. Physician preference along with hospital policy and resources will dictate whether this referral is to in-house or community behavioral health services.

People under stress often do not completely understand directions or information. It is important when approaching a person under stress to make a statement of empathy within the first 30 seconds of approaching them. This statement of empathy allows the person to de-escalate enough to hear the rest of your message (B. Reynolds, Centers for Disease Control and Prevention, personal communication, January 23, 2007). Directions and information may need to be repeated and, perhaps presented in more than one form (for example, verbal and written information). Hospital staff can use good communication skills to help patients who are having difficulty processing information. It is important to remember people who speak English as a second language may lose some of their English-speaking skills under stress. Their understanding may be enhanced if it is communicated in their preferred language by a professional interpreter. Although this is standard procedure in most hospitals, it takes on particular importance in situations when isolation precautions are associated with highly transmissible, widespread, or deadly agents. It is the responsibility of hospital staff to ensure that the message being sent is the message received by the patient and his/her family. At its most basic level, staff must use good listening skills to ensure that the teaching provided to the patient is understood. Information should be provided in a culturally and developmentally appropriate manner. Staff can enhance their confidence and competence in communication by reviewing or learning psychological first aid. The Nebraska Psychological First Aid (2004) training is available either on-line (http://www.bordersalertandready.com/catalog/module.php?subjectid=11) or in-person training through Nebraska Regional Behavioral Health Authorities (http://www.disastermh.nebraska.edu/regional.html).

Families of patients can experience their own "particular isolation and experience feelings of guilt, pity and role strain" (Wu, Mu, Tsay, & Chiou, 2005). Some families may develop a coping pattern in which they avoid typical social interactions with friends and family. The family is a primary support mechanism for the patient and often the patient's link to the outside world. Most hospitals have policies and procedures in place that guide staff interactions with patient families. The unique stressors associated with visiting and supporting a family member under isolation precautions include concern about transmissibility; restrictions on contact; possible use of personal protective equipment by family members; and potential stigmatization by community members if the illness is highly contagious, widespread, or deadly. The importance of briefing family regularly and encouraging them to practice healthy behaviors will help them cope successfully with the situation. This, in turn, assists the patient by keeping his or her support system functioning. Family involvement is particularly important in situations that involve children being separated from a parent.

In situations with the possibility of large-scale infections (such as SARS) or a bioterrorism event, it is likely that the community will be interested and affected indirectly by hospital isolation precautions. Often, community members who present at the emergency department as concerned about their level of exposure are referred to as "the worried well." This implies that there is nothing wrong with the person, and the best treatment for them is to "go home" as their presence appears to hinder the "real work" of the hospital. Viewing these community members as psychological casualties instead of simply worried defines the problem differently. This may lead to an intervention other than sending them home.

Outreach to the community by hospitals may be appropriate when isolation precautions are used in high-profile situations. This outreach can include provision of information to the media about what is being done to keep the patient, patient families, and staff safe. Easing the community's fears of contagion will decrease the stigma that may attach to staff and their families and may also mitigate development of psychological casualties in the community. Hospitals can provide more in-depth or technical information to community healthcare providers and hotlines. This may decrease the demand for hospital based service by giving concerned community members access to information through their preferred or trusted healthcare provider. Decreasing fear and increasing knowledge in a community can also be accomplished by equipping teachers, faith leaders, and other informal leaders with basic information that can be

disseminated to their constituents. These community leaders can be trained to identify basic signs and symptoms of stress or disease for those with whom they come into contact. Gentle insistence can guide community members to the appropriate caregivers early.

Community members may be concerned because they fear that hospital staff and volunteers are carriers of contagion. This is particularly important with highly transmissible, widespread, or deadly agents. This perception may affect anyone who works at the hospital, not just those in direct care with patients in isolation. During the SARS outbreak in Canada, Maunder and associates (2003) reported that "staff was adversely affected by fear of contagion and of infecting family, friends and colleagues. Caring for health care workers as patients and colleagues was emotionally difficult. Uncertainty and stigmatization were prominent themes for both staff and patients." The hospital can reduce stress for all workers by practicing good risk communication through regular releases to media about the real risks and precautions being taken to protect workers. Hospitals can decrease stress for staff working directly with isolation precautions by planning and providing mental health and social service supports. The Centers for Disease Control and Prevention (2004) suggests that in situations like the SARS outbreak, arrangements be made to make mental health counseling available for healthcare workers and their families, along with other services that allow staff to concentrate on their work like child care, shopping services, transportation, lodging, and in some cases economic support.

In some isolation situations, staff identified as non-essential may be sent home from the hospital. Hospitals may want to consider pre-identifying roles for staff who occupy this category that allow them to continue contributing to the resolution of the emergency, staying connected to the hospital, and providing support for their co-workers who remain in service. There may be support roles that they can perform off-site such as providing support to families of staff who must remain at the facility.

> *"Nonessential staff reported feeling isolated and ineffective in contributing meaningfully to the crisis. The term nonessential may have contributed to this sense. Some were called back to work in re-deployed roles and indicated that it was psychologically more satisfying to work than to stay home."* (Maunder et al, 2003)

The patient will benefit from hospital efforts to keep the stress level to a minimum for staff working on isolation units. Honest communication between staff, supervisors, and administrators helps everyone feel less stress, even if the news is not good. This can be accomplished through regular, multidisciplinary staff meetings.

Arranging for and mandating breaks for staff working with isolation precautions can increase effectiveness of staff. Respite or breaks can include the availability of peers trained to listen and provide support; food and drink in a peaceful environment; massage; private space for confidential phone conversations; and space to rest comfortably. Maunder and his associates (2003) noted that senior staff "acted as role models" by appropriately taking breaks in the designated break areas during the SARS outbreak in Canada. Nebraska CISM medical peers or trained in-house medical peers can also assist in monitoring and acting to reduce staff members' stress or distress. Information on accessing the Nebraska Statewide CISM Program is available online (http://www.cism.nebraska.edu/).

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Behavioral Health Guidelines for use with Hospital Isolation Precautions

These guidelines include actions to enhance coping while decreasing stress for patients subject to isolation precautions, hospital staff/volunteers, patient families and the community at large. Each section contains suggestions to inform, support, triage, and treat that population. These four major actions and accompanying suggestions are also presented in tabular format for quick reference.

Section I: Patients

Inform (Patients)
- Provide information on the illness, treatment, and procedures of the isolation unit (for example, it should be clear whether the patient can leave the room and who has permission to enter, etc.) The information should be made available in the patient's primary language, and at a level they can understand.
    - Use a variety of communication methods to convey information to the patient (written material; videotapes/DVD's; verbal).
    - Repeat presentation of information in a variety of formats to enhance patient understanding.

- If the patient speaks English as a second language, or does not speak English fluently, a professional interpreter should be used for all communication regarding health care information and decisions. Avoid the use of family members as interpreters if at all possible and never use children to interpret for parents.
    - Interpreting services may be available by contract with outside agencies (such as AT&T) if the hospital does not have access to professional interpreters in-house (either in-person, or phone).

Support (Patients)
- Ensure that time spent in the room does not appear rushed. Use pleasantries, make eye contact, express encouragement and understanding.

- Remind patients that their wants and needs will change over time as their health changes.

- Patients indicating a religious or spiritual preference should be given the opportunity to express their faith as much as possible in the isolation setting, and to meet with appropriate clergy or faith leaders.

- Allow and encourage patients to bring in pictures from home.

- Teenagers especially need to maintain contact with their friends. In addition to phone contact, providing computers with internet access can help patients maintain ties with friends. While all patients across the age-range may benefit from internet access, it is expected that teens especially will feel less isolated if they have access to this means of communication.

- Answer call lights promptly to lessen patient perceptions of abandonment.

- Bring in and remove food trays promptly; use these occasions as an opportunity for "small talk."

- Provide choices and variety in menus to increase the patient's sense of control.

- Patients have reported gaining benefit from massage, not only in terms of relaxation, but in feeling less isolated and abandoned. If touch is not contraindicated, offer massage daily.

- Provide exercise opportunities (per physician discretion) for those patients who are well enough to exercise.

- Ensure that isolation rooms have a view, if even just to the hallway to decrease the sense of physical isolation.

- If possible, allow family members to bring in outside food to promote connections to home and the outside world. Home-cooked meals or meals from favorite restaurants can often help to stimulate patient appetites.

- When in-person visits or even window visits aren't possible, video-conferencing may be the next best solution. This may also be the best solution when the patient is a child, or the patient has children who cannot visit.

Triage (Patients)

Psychological/emotional status of patients should be assessed upon initiation of isolation precautions using a standardized protocol or instrument (see Appendix III). This may be performed by nursing staff, the attending physician, psychologists or social workers. The assessment information should be faxed to the consulting psychiatrist/psychologist or relayed to them over the phone. Assessment should be repeated regularly as patients may develop symptoms over time, depending upon the severity of their condition and the length of isolation. Triage should take into account the developmental level and culture of the patient.

- Perform a basic assessment of psychological/emotional status upon initiation of isolation precautions.

- Determine the patient's preferences about visitation and intervene as appropriate to limit visits according to patient preference.

Treat (Patients)

Hospitals can enhance behavioral health treatment to patients in isolation by pre-identifying affiliated behavioral health professionals that can be trained to function in isolation units. This may include fit-testing masks and familiarizing them with isolation precautions and protocols.

- Emphasize to patients that there are a wide variety of common reactions to the abnormal situation of requiring placement in a hospital isolation unit (see Appendix IV). Provide verbal and written information about these reactions.

- Provide a referral to a psychiatrist or licensed mental health practitioner (preferably those who have received training in isolation procedures) when symptoms interfere with functioning, if a pre-existing condition is indicated, or when the patient expresses suicidal or homicidal ideation.
    - o If possible, include a psychiatrist or licensed mental health practitioner as part of the treatment team to assess or screen isolated patients on a routine basis.
    - o Psychotherapy and/or psychiatric services may be provided via teleconference or videoconference if in-person services are not possible or are unavailable.

- Consider implementation of suicide precautions protocol as indicated (See Appendix II).

Section II: Staff

Inform (Staff)
- Provide information about the risks of working with the patient, in both verbal and written formats.

- Include direct care staff in daily multi-disciplinary staff meetings/briefings.

- Keep staff informed of scenario updates, procedural changes, and basic information on the illness and its effect on the hospital environment.

- Expressions of praise and gratitude from administrators or supervisors to individual workers remind staff that their work is appreciated.

- Release or discuss emerging hospital media reports to staff before they hear it on the news.

- Monitor rumors among the staff or in the community and address them through in-person meetings with staff or through release of factual information. Addressing rumors immediately will help prevent misinformation from spreading further.

Support (Staff)
Staff coping may be enhanced if they feel they are receiving adequate support from administration and peers.

- Provide a staff break area away from the isolation unit for respite. If possible, provide soothing music, comfortable chairs and snacks, and space suitable for confidential conversations with peers.

- Consider instituting mandatory breaks for staff working on the isolation unit.

- Consider instituting staffing patterns that provide adequate time away from the hospital for rest and reconnecting with family and friends.

- Hold regular daily staff meetings for those working directly with isolation precautions.

- Consider including mental health support in staff meetings for those working with isolation precautions.

- Access Nebraska's Critical Incident Stress Management Program or in-house stress management resources. Such programs can provide medical peers to monitor stress level of staff via maintaining a presence in the respite area, or be available to facilitate stress management sessions on an individual or group basis.

- Encourage staff to maintain contact during their shift with their own family by providing private phone time.

- Consider enlisting confidential phone support from in-house or community mental health professionals.

- Include Psychiatry and Psychology Department staff or similar professionals on the command team to provide support to the institutional leadership.

- Periodically make psychiatrists and/or other mental health providers or chaplains available at nursing stations and at staff meetings to assist in providing unobtrusive support to workers.

Triage (Staff)
Triage for staff working on isolation units includes regular monitoring for signs of stress or distress.

- Use Nebraska CISM medical peers (see http://www.cism.nebraska.edu/) or trained in-house medical peers, administrators, or supervisors to monitor direct care staff members' stress and distress.
    - Formal and informal assessments can be done during staff meetings, staff breaks, or via more formal stress management sessions.

- In large outbreaks with high acuity, fitness for duty assessments may be done for staff providing direct patient care.
    - Fitness for duty is an evaluation to determine if an employee is mentally or physically capable of performing the essential functions of a job without risk of injury to the worker, co-workers or patients.

Treat (Staff)
- Staff requiring behavioral health treatment beyond normalizing reactions or basic support, may be referred to an employee assistance program, an affiliated behavioral health provider, or a community behavioral health provider of the employee's choice.

Section III: Family
Patient families are often the primary support for patients in isolation. The patient's stress and ability to tolerate isolation may be linked to their family member(s) ability to cope successfully with the situation. The role of hospital staff with the family is primarily to monitor their stress, and provide support and information and referrals if necessary.

Inform (Family)
- Obtain a release of information from patient (as applicable) so family can be informed of patient progress.

- Provide accurate information about isolation precautions, illness, and risks to patient and others.

- Provide information about common responses to isolation and about what the family can expect to experience.

- Consider informing family prior to releasing information to media, particularly in high profile situations.

- Consider providing family access to web pages that serve as a mechanism to keep friends and others informed of patient progress. This can decrease the number of times the family is asked to repeat information about the patient's progress.

Support (Family)
- Inquire about the family's spiritual needs and/or enlist the assistance of a chaplain or faith leader.

- Encourage family members to take frequent breaks from the hospital setting.
    - Consider ways to keep family informed while they are away from the hospital (e.g., scheduled phone updates, pagers, etc.).

- Encourage family members to accept help from other family members and friends as appropriate. The family should also be empowered to limit contacts with others if desired. Normalize this desire and suggest that family turn off cell phones and let home calls go to an answering machine.

- Create space for family members to gather away from media, particularly in high profile situations.

- Encourage family to get adequate sleep and nutrition.

Triage (Family)

Hospital staff will be focused on caring for the patient in isolation, but will have frequent contact with the patient's family. This places hospital staff in a unique position to monitor how the family interacts with the patient and how that affects the patient. In regard to family members, triage relates to monitoring the general coping of family members and how their coping affects the patient.

- Monitor stress and expressions of distress by family members.

- Inquire about religious beliefs and arrange for an appropriate chaplain to contact the family.

Treat (Family)

Hospital staff may encounter family members who are under the care of a behavioral health professional (mental health or substance abuse) or who could benefit from this type of professional support.

- Provide a referral to a behavioral health professional if concerns arise about family functioning or about an individual family member's mental health or substance abuse.

- Encourage family members to tend to their personal mental health as a way to support the patient more effectively.

Section IV: Community

Community members may be especially interested in what the hospital is doing to treat people who are affected by agents that are high profile, highly contagious, deadly, or that are a result of widespread transmission. The hospital's interest is in preventing unnecessary surge to the hospital and ensuring that patient families and workers are not stigmatized by community members.

Inform (Community)

- Provide frequent updates to media with accurate, timely information about risks to the public, staff, and others. Include information about isolation precautions and how the public can be protected.

- Provide information on common psychological/emotional reactions (e.g. fear, anger, a need to protect loved ones, etc.)

- Follow good risk communication practices.
    - Hospital public information officials can access behavioral health message maps and fact sheets through the Nebraska Health and Human Services System (402-471-9108) or local public health district.

- Release technical information about the agents or illness to community health professionals and hotlines that can be disseminated to community members concerned about transmissibility.
    - Ensure that hospital operators have hotline numbers and resources to direct callers to.

- Release translations of media information to reach non-English speaking populations.

- Release information to public about how they can be most helpful to those affected by isolation precautions.
    - Post information on hospital web sites, media releases, and on visitor handouts available at the hospital.

- In some situations the hospital may wish to hold a community forum that includes public health and behavioral health information/resources to provide a safe place for concerned community members and families and friends of staff and patients to ask questions of officials away from media.

Support (Community)
- Consider arranging for a location outside of the hospital for community members to gather if needed or desired (e.g., to show support, hold a prayer service, etc).

- Provide opportunities for community members to support each other through hospital sponsored educational forums, support groups, health screenings, or other appropriate health activity.

- Publicly thank community partners and patrons as appropriate.

Triage (Community)
Behavioral health triage for community members may take place at the emergency room or via community agents trained to detect symptoms. Preventing psychological casualties can be accomplished through release of good public information, screening for distress in schools, workplaces, faith communities, etc. Plan ahead for the type and timing of the information you plan to release. If you plan to withhold information, be clear why you are withholding the information. The fewer facts the media have, the more likely they are to make their own interpretations. Providing facts lessens the possibility that the media and community will begin to make guesses about what is happening.

- Consider providing behavioral health screening and referral training to community members in a position to detect stress or distress in others (e.g., teachers, clinic nurses, faith leaders).
    - Augment training with instruction on physical signs and symptoms that indicate a need to refer for medical screening. Sometimes providing concrete information will be enough to alleviate concerns about personal safety. Delivery by a trusted source can prevent unnecessary emergency room use.

- Provide handouts to emergency room personnel for distribution that includes common reactions and resources to alleviate personal distress.

- Work with community partners or in-house psychology/psychiatry/social work resources to ensure that psychological casualties who are not admitted to the hospital receive a follow-up contact.

Treat (Community)
Behavioral health treatment for community members can be facilitated by hospitals through timely dissemination of information about available resources and how/when to appropriately access them.

- Provide a list or description of potential referral sources to media for dissemination to the public along with information about when to seek help for behavioral health concerns.

- Provide information in waiting areas of the hospital, the emergency room, in affiliated clinics and other places that people gather about what to expect when seeking treatment for behavioral health concerns.
    - Hospital communication that frames treatment for mental health or substance abuse issues in the same way treatment resources are presented for health issues can decrease stigma surrounding seeking help.

Summary of Behavioral Health Guidelines for use with Hospital Isolation Precautions

	Inform	Support	Triage	Treat
Patients	• Provide information about common responses to isolation • Provide information in native language • Use a professional interpreter if needed • Use multiple modes to communicate information about stress and isolation	• Immediately (within 30 seconds) use pleasantries; make eye contact • Provide a supportive environment and relationship with the patient • Provide basic supportive counseling (psychological first aid) • Periodically assess visitor restrictions • Allow and encourage reminders of home • Provide access to communication means • Respond promptly to call lights • As appropriate encourage exercise; visits; favorite foods	• Assessment of mental status upon initiation and periodically throughout isolation	• Refer to psychiatrist or licensed mental health practitioner for further assessment or treatment • Employ suicide precautions as applicable • Be aware of common reactions to isolation and the potential to develop depression/anxiety symptoms
Hospital Staff/Volunteers	• Provide information about risks of working with patients • Frequent updates to staff about upcoming media reports or press releases • Praise and thank workers • Hold daily multidisciplinary staff meetings • Control rumors by dispensing regular, accurate information to all staff	• Provide break area away from isolation unit for respite • Consider mandatory breaks • Hold regular staff meetings • Include mental health support in staff meetings • Access Nebraska's CISM resources • Encourage contact with own family via phone • Consider enlisting confidential phone support from in-house or community mental health professionals	• Supervisors regularly assess stress level, coping, and fitness for duty of workers	• Provide referral information for in-house or community resources (e.g., Employee Assistance Program)

	Inform	Support	Triage	Treat
Patient Families	• Obtain release of information from patient so family can be informed of patient progress • Provide accurate information about isolation precautions, illness, and risks to patient and others • Provide information about common responses to isolation • Consider informing family prior to releasing information to media • Consider providing family access to internet pages as a way to keep friends and others informed of patient progress • Consider ways to keep family informed while they are away from the hospital	• Inquire about spiritual needs • Encourage family members to take frequent breaks from hospital setting • Encourage family members to accept help from others • Create space for family members to gather away from media • Encourage family to get adequate sleep and nutrition	• Monitor stress and expressions of distress of family	• Provide referral information (for community or hospital resources that the family may access as needed)
Community Members	• Provide frequent updates to media • Follow good risk communication practices • Release technical information to community health professionals and hotlines • Release translations of media information to reach non-English speaking populations • Release information to public about how they can be most helpful to those affected by isolation precautions	• Consider arranging for location outside of hospital for community members to gather if needed or desired	• Consider providing intervention/referral training to community members in a position to detect stress or distress in others (e.g., teachers, clinic nurses, faith leaders)	• Provide a listing of potential referral sources to media for dissemination to the public along with information about when to seek help

Appendix I

TEMPLATE
POLICY AND PROCEDURE

Subject: Patient and Family Behavioral Health Needs Associated with Medical Isolation Precautions
_____

I: **Purpose:**
Provide guidelines to identify and address behavioral health needs of patients and their families impacted by medical isolation precautions.

II: **Policy:**
It is the policy of this Hospital to use facility and community resources to provide information, support, triage, and treatment as necessary to address behavioral health needs of patients and patient families impacted by medical isolation precautions.

III: **Procedures:**

[Insert guidelines that have been customized and adopted by your hospital.]

Example:
A.   Patient
1.   Hospital staff will review common behavioral health reactions to isolation with the patient and/or patient's family upon initiation of isolation precautions. A copy of the information will be left with the patient.
2.   Determine the patient's preferences about visitation and intervene as appropriate to limit visits according to patient preference.
3.   The patient's emotional health will be assessed by hospital staff or the attending physician upon initiation of isolation precautions and daily thereafter throughout the course of isolation.
4.   The primary physician will be consulted about the need for referral to a psychiatrist or licensed mental health professional if mental status interferes with patient functioning or indicates the patient may be suicidal or homicidal

B.   Family members
5.   Hospital staff will monitor stress and expressions of distress by family members
6.   The Hospital will inform family members prior to releasing information to the media about general precautions, concerns, or education related to the reason their family member is in isolation

[Note: These are generic examples. Specific procedures should be formulated using the background information provided that incorporates local resource information]

TEMPLATE
POLICY AND PROCEDURE

Subject: Hospital Staff and Volunteer Behavioral Health Needs Associated with Medical Isolation Precautions
_____

I: Purpose:
Provide guidelines to identify and address behavioral health needs of hospital staff and volunteers affected by medical isolation precautions.

II: Policy:
It is the policy of this Hospital to use facility and community resources to provide information, support, triage, and access to treatment as necessary to address behavioral health needs of staff and volunteers affected by medical isolation precautions.

III: Procedures:

[Insert guidelines that have been customized and adopted by your hospital.]

Example:
1.   A designated break area away from the isolation unit will be available for staff and volunteers working with isolation precautions.
2.   Medical peers from the Nebraska Critical Incident Stress Management Team (CISM) will be requested to provide informal stress management and support in the break area by the nursing supervisor when the isolation situation is due to a highly transmissible, widespread, or deadly agent.
3.   Isolation unit staff meetings will be held daily.
4.   All staff working directly with isolation precautions when a highly transmissible, widespread, or deadly agent is involved will undergo a fitness for duty assessments after three weeks of service.
5.   Hospital personnel will receive copies of press releases related to the isolation precautions that can be shared with their families.

[Note: These are generic examples. Specific procedures should be formulated using the background information provided that incorporates local resource information]

TEMPLATE
POLICY AND PROCEDURE

Subject: Community Behavioral Health Needs Associated with Medical Isolation Precautions
_____

I: **Purpose:**
Provide guidelines to identify and address behavioral health needs of the community impacted by medical isolation precautions when a highly transmissible, widespread, or deadly agent is involved.

II: **Policy:**
It is the policy of this hospital to provide information and outreach to the community to address concerns of community members impacted by medical isolation precautions when a highly transmissible, widespread, or deadly agent is involved.

III: **Procedures:**

[Insert guidelines that have been customized and adopted by your hospital.]

Example:
1. The designated hospital public information officer (PIO) will provide frequent updates to media with accurate, timely information about risks to the public, hospital staff, and others.
   i. Information will be made available via the hospital web-site
   ii. Hospital personnel/volunteers answering public phone lines will be briefed with latest information as it is available
   iii. Hospital personnel/volunteers answering public phone lines will be given names and numbers of personnel who can assist with difficult calls
2. The hospital will hold timely educational forums to inform the community.
3. Clinic A's large meeting room will be designated as the primary location for community members to gather in support of those affected by isolation precautions.
4. Emergency room personnel will distribute handouts about common stress reactions and resources to alleviate distress.

[Note: These are generic examples. Specific procedures should be formulated using the background information provided that incorporates local resource information]

Appendix II
Sample Suicide Precautions Protocol
(From: Health Care Professional's Network, http://www.wlm-web.com/hcnet/index2.htm)

Purpose
To reduce the risk of harm to self and/or others for the patient in crisis or severe depression.

Supportive Data
Interventions for safety are of primary importance for patients whose behavior may be destructive to themselves or others. The goal is to provide protection for the patient in the least restrictive environment that allows for necessary level of observation and/or physiologic monitoring. Interventions range from periodic and regular observation to 1:1 contact in an observation room or secluded area.

The level of precautions needed may be ordered by the attending physician, resident physician, or initiated by nursing staff. Should the nursing staff initiate any level of observation, rationale for this decision is recorded in the medical record and the patient's physician notified as soon as possible. If the physician concurs, an order must be written. Orders for "suicide precaution" must specify which level of observation is intended. Level of observation can be reduced only by physician order.

Observation must be provided by an RN, or by LPN or PCT under the direct supervision of an RN. Use of family members and/or significant others as observers is determined by attending physician and nursing staff (case-by-case basis) only after careful assessment of these individuals; the physician must document approval of family/SO in medical record.

The need for suicide precautions must be re-evaluated every 24 hours by the physician and nursing staff; discontinuations or change in level can be made by the attending physician or consulting psychiatrist; current clinical state and reason for continuing, modifying or discontinuing precautions must be documented by physician.

Psychiatric consultation should be requested on all patients requiring suicide precautions.

Assessment

1. Assess for presence of destructive, suicidal, or homicidal behavior, thoughts, verbalizations and/or intent at least every 8 hours or as condition changes.
2. Assess for need to assign a "Precaution" level to provide unobtrusive surveillance at least every 8 hours or as condition changes.
3. Assess risk for suicide using "Suicide Clues & Behavior Rating Scale" of patient on Suicide CareMap®.
4. Monitor need to move patient to a more controlled environment to decrease stimuli which may be influencing moods, behavior or emotions.
5. Mental Health Unit (MHU): Assess for need to assign Elopement precautions using elopement criteria on Admission Database.

Levels of Observation

6. Assign one of the following "Precaution" levels for the protection of the patient:

   a. Watch Closely - observe every 30 minutes for patient safety; initiate frequent verbal contact (indications: expressed vague suicidal ideation without a plan; no demonstrated self-destructive behavior; may have chronic suicidal thoughts; exhibits poor impulse control).

b.   PSR (possible suicide risk) - observe every 15 minutes (indications: patients admitted for medical stabilization following suicide attempt; active suicide ideation with or without suicidal plan).

c. SSR (serious suicide risk) - observation with 1:1 contact at all times (indications: verbalizes clear intent to harm self; has concrete/specific plan; exhibits disorganized and/or psychotic behavior; also indicated for medically stabilized patient following suicide attempt)

d. Mental Health Unit only: Elopement (patient at risk of leaving unit) - observe every 30 minutes. Patient placed in locked observation area on the Mental Health Unit.

Consult with Physician

7.   Obtain physician order for appropriate "Precaution" level as soon as possible.
8.   Contact physician regarding obtaining behavioral health consult when suicidal statements, self-destructive behavior, or threatening comments about others occurs. Consult should be completed within 24 hours.
9.   Consult with Mental Health Unit staff/CCM for assistance with Precaution level determination and/or identifying specific, helpful interventions (supportive statements; statements to avoid).

Report To Physician

10. Report to physician/other care team members the effectiveness of interventions (behavior/mood changes, any increase or decrease in suicidal ideation, verbalization of positive self/future planning) and discuss need to increase or decrease the level of the precaution at least once daily.

Interventions

11. Communicate initiation of Suicide Precautions and level of observation to care team members.
12. Initiate Suicide Attempt CareMap® if actual suicide attempt has been made.
13. Provide for patient safety by removing potentially harmful objects or contraband from patient and environment (e.g., sharp objects, glass items, belts, straps, ties, drugs, hair dryer, curling iron, purse, cosmetics in glass containers). Itemize items removed and give to family as soon as possible; call Security to dispose of contraband.
14. Allow only cordless razors.
15. Search any object or package brought to patient by visitors.
16. Consider serving meals on paper plates, using only paper/plastic containers, plastic forks and spoons; have USR order "isolation tray" (necessary for SSR).
17. Observe patient when he/she uses shower; observe SSR patient using bathroom or shower.
18. Do not allow patient to leave unit for any reason without staff escort. If patient becomes resistant or belligerent, call Security and/or Supervisor for assistance. (Consult with Supervisor regarding involuntary admission to Mental Health Unit).
19. Refrain from criticizing actions or minimizing patient's feelings; avoid offering solutions; avoid statements like "I know how you feel".
20. Facilitate discussion of factors or events which precipitated the suicidal thoughts/destructive behavior; respond with active listening; demonstrate concern.
21. Offer to contact Pastoral Care for spiritual guidance.
22. Inform patient/family of availability of Behavioral Health Services.

Teaching

23. Explain "Precaution" level, associated restrictions, and rationale to patient and family.
24. Inform family/visitors that potentially harmful items (glass, scissors, etc.) are not to be given to the patient.
25. Explain to patient/family that suicidal thoughts are a common symptom of depression.

26. Encourage support of patient by family/friends.
27. Instruct family about possible warning signs or pleas for help patient may use. Notify Mental Health Unit regarding availability of educational materials.

Documentation

28. Assessment findings.
29. Suicide precautions maintained; level of precautions and observation intervals; effectiveness of interventions.
30. Physician notification.
31. Items removed from patient or environment.
32. Patient/family teaching and response.

References:

Hogarty, S. & Rodaitis, C. (1987). A suicide precaution policy for the general hospital. *Journal of Nursing Administration, 17*(10), 36-42.

Lego, S. (1996). *Psychiatric Nursing: A Comprehensive Reference*. Philadelphia: Lippincott.

Tucker, S. M. (1996). *Patient Care Standards: Collaborative Practice Planning Guides*. St. Louis: Mosby.

Appendix III
Screening Resources

The following resources can be considered for use by hospital personnel for screening or triage of patients in medical isolation or for adults who present at the emergency room as a psychological casualty.

Emotional health
Many of the brief screening tools and psychosocial screening protocols available for use in hospital settings are proprietary and cannot be reproduced in this document. In general, nursing protocol should include routine conversation with and observation of the patient related to their emotional health and well-being while under isolation precautions. Questions are included here that hospital personnel can use to ask about emotional or psychological health.

1. How are you holding up emotionally right now?
   (Common responses include anger, anxiety, or sadness. Patients that answer "I'm fine" may benefit from provision of information about common emotional reactions to help normalize how they might be feeling. Pushing people to respond to this question may not always be advisable. Moving to the next question may help the person identify how they have coped successfully with stressful situations in the past.)

2. Tell me about a time when you were in an unfamiliar or stressful situation and how you got through it.
   (Listen for ways the patient has coped successfully in the past that can be applied to this situation)

3. What mood would you say you are in most of the time? Happy, mad, sad, crabby or worried?
   (Listen for their description and notice if it matches their behavior.)

4. Have you been feeling down or sad most of the day? (If yes, continue to question a)
   a. How long have you felt this way?
   (It is not uncommon for people in isolation to feel sad. It is potentially concerning if this feeling of sadness is pervasive and unrelenting. Notice if the feelings of sadness preceded isolation precautions. Ask the patient or family about how they successfully dealt with these emotions in the past.)

5. Have you found yourself wishing you were dead or thinking everyone would be better off if you were dead?
   (It would not be unusual for a person in medical isolation to think about death. Allow the patient to talk about their feelings. Just because they may wish they were dead does not necessarily mean they are actively trying to end their life. Follow up with the next question about suicide.)

6. Have you been thinking about hurting yourself in any way? (If yes, continue to ask questions a – d)
   (Asking about thoughts of suicide does not cause someone to be suicidal. Most experts believe that asking directly about these thoughts gives the person permission to talk about them and may actually be beneficial. Consider the use of suicide precautions if clinically indicated.)
   a. What has kept you from killing yourself?
   b. Who are the people who you feel closest to?
   c. What have you thought about doing?
   d. What helps you when you feel this way?

7. Do you ever hear or see things other people say they don't hear or see?
   (The goal of asking this question is to see if the person is experiencing any type of hallucinations. The cause of any hallucinations may be related to the physical condition of the patient and not indicative of a psychological problem. It is important to help the person understand that regardless of the cause of these symptoms, there is hope for their resolution.)

<u>Drug and alcohol screening tools</u>
Screening for drug and alcohol problems at admission to the hospital or to the isolation unit is recommended. Two quick tools are included in this appendix, the **CAGE & Consumption** questions for adults and the **CRAFFT** for adolescents. In addition to these brief screening tools, a number of other instruments available in the public domain are listed below:

Alcohol Use Disorders Identification Test (AUDIT), available at:
http://libdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

Drug Abuse Screening Test (DAST), available at:
http://www.projectcork.org/clinical_tools/pdf/DAST.pdf

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), available at:
http://www.who.int/substance_abuse/activities/assist_v3_english.pdf

Alcohol Screening and Brief Intervention for Trauma Patients: COT Quick Guide, available at:
http://sbirt.samhsa.gov/documents/SBIRT_guide_Sep07.pdf

Consumption + CAGE Questions

Description: This screening method combines 3 alcohol consumption questions that identify a patient's current drinking pattern with the CAGE questionnaire.

The CAGE utilizes 4 questions to identify patients with alcohol dependence syndrome;
1. Have you ever felt you should **C**ut down on your drinking?
2. Have people **A**nnoyed you by criticizing your drinking?
3. Have you ever felt bad or **G**uilty about your drinking?
4. Have you ever had an **E**ye opener first thing in the morning to steady nerves or get rid of a hangover?

Together, the consumption questions and the CAGE identify patients whose drinking puts them at risk of having alcohol problems in addition to identifying the likelihood of dependence.

The consumption questions are:
1. On average, how many days per week do you have a drink containing alcohol?
2. On a typical day when you drink alcohol, how many drinks do you have?
3. How many times in the past year have you had x (x=5 for men; x=4 for women) or more drinks in a day?

Use: This method can be administered in about 2 minutes by an interviewer or completed by the patient on paper or by computer. In interview or computer format, questioning can stop if the first question is 0 or none and if the response to question 3 is 0. Preface the screening by explaining that the consumption questions relate to drinking in the prior month and what constitutes a drink, i.e., one beer, one glass of wine (5 oz.), or one standard mixed drink (one shot or 1.5 oz. of 80 proof spirits). Note that the four CAGE questions refer to the patient's lifetime drinking experience.

Cutoff Scores: The patient is considered positive if:
• The product of responses to questions 1 and 2 produces a total number of drinks per week exceeding the recommended weekly guidelines (7 for women and anybody older than 65; 14 for men under age 66);
OR
• The response to question 3 is more than 0;
OR
• The patient answers "yes" to 2 or more of the 4 CAGE questions.

This material is taken from: Alcohol Screening and Brief Intervention for Trauma Patients: COT Quick Guide

Original Source: Ewing, J. A. (1984). Detecting alcoholism, the CAGE questionnaire. *Journal of the American Medical Association, 252*(14), 1905-1907.

CRAFFT

Description: This instrument was specifically designed to screen for alcohol and drug problems in adolescents. Rather than asking direct questions about quantities and frequencies of alcohol and drug consumption, it asks 6 questions about behaviors that are reliable indicators of consumption and risk.

Use: No prior explanation to the patient is required.

Cutoff Scores: Two or more positive answers indicate a possible problem.

Advantages: The instrument was designed especially for adolescent

1. Have you ever ridden in a **C**ar driven by someone (including yourself) who was high or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to **R**elax, feel better about yourself, or fit in?
3. Do you ever use alcohol or drugs while you are by yourself **A**lone?
4. Do you ever **F**orget things you did while using alcohol or drugs?
5. Do your **F**amily or **F**riends ever tell you that you should cut down on your drinking or drug use?
6. Have you ever gotten into **T**rouble while you were using alcohol or drugs?

This material is taken from: Alcohol Screening and Brief Intervention for Trauma Patients: COT Quick Guide

Original Source: Knight, J. R., Sherritt, L., Shrier, L. A., Harris, S. K. , Chang, G. (2002). Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Archives of Pediatrics & Adolescent, 156*(6), 607-614.

Appendix IV
COMMON STRESS REACTIONS[1]

BEHAVIORAL
• Increase or decrease in activity level
• Substance use or abuse (alcohol or drugs)
• Difficulty communicating or listening
• Irritability, outbursts of anger, frequent arguments
• Inability to rest or relax
• Decline in job performance; absenteeism
• Frequent crying
• Hyper-vigilance or excessive worry
• Avoidance of activities or places that trigger memories
• Becoming accident prone

PHYSICAL
• Gastrointestinal problems
• Headaches, other aches and pains
• Visual disturbances
• Weight loss or gain
• Sweating or chills
• Tremors or muscle twitching
• Being easily startled
• Chronic fatigue or sleep disturbances
• Immune system disorders

PSYCHOLOGICAL/EMOTIONAL
• Feeling heroic, euphoric, or invulnerable
• Denial
• Anxiety or fear
• Depression
• Guilt
• Apathy
• Grief

THINKING
• Memory problems
• Disorientation
• Slow thought processes; lack of concentration
• Difficulty setting priorities or making decisions
• Loss of objectivity

SOCIAL
• Isolation
• Blaming
• Difficulty in giving or accepting support or help
• Inability to experience pleasure or have fun

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[1] U.S. Department of Health and Human Services. (2005). *A guide to managing stress in crisis response professions* (DHHS Publication No. SMA 05-4113). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.