Wake Forest Baptist Medical Center
ED PSS Protocol

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This protocol details how to screen for patients, how to intervene with patients and how to complete necessary paperwork. This protocol document acts as a detailed guide for how peer support is implemented at Wake Forest Baptist Medical Center. Peers are expected to adhere to all aspects of this document in their daily work.
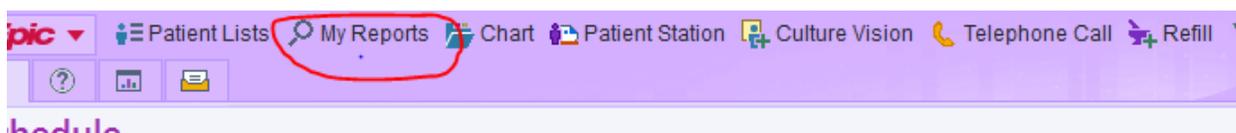
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SCREENING PATIENTS & ENTERING ASSESSMENTS AND FLOWSHEETS

STEPS FOR DAILY SCREENING

1. Log in to WakeOne with the same username/password as your Wake Health email

2. Find the "My Reports" button on the top of the window

3. Once you've selected My Reports, it will take you to a new page where all the reports you have favorited will be visible. If this is your first time logging in and you have not saved the ED PSS report yet, you will click on the "Library" tab on the left hand side and search for "WH ED Peer Support"
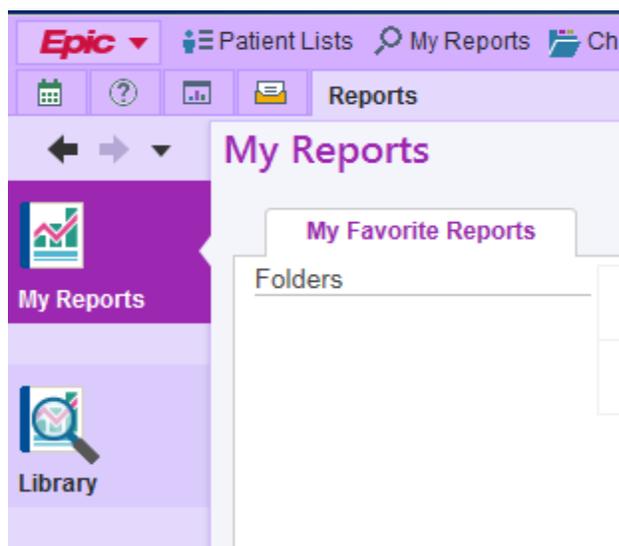
   a. Once you've found the report click the star on the left next to the report to save it as a favorite for the future

4. Double click the report to run it, once it opens it will have the list of current ED patients along with different information about the patient such as their admitting concern/primary diagnosis, labs that were done (i.e. blood alcohol level, urine drug screen)

   a. This report and the information included in it will be how you screen patients and determine which patients will be priority to receive Peer Support Specialist services (some of this information will also be useful and is included in the intake assessment that will be done with patients through Redcap)

HOW TO SCREEN PATIENTS

1. There are a number of different ways to find information about patients and determine if they have any substance use issues and could benefit from PSS services

   a. **Admitting concern:** overdose, withdrawal, intoxication, and hallucinations and altered mental status (these it's helpful to look through notes to determine if they are substance induced or not)

      i. Any obvious indications of substance use like this would screen a person on to our service

      ii. It can also be helpful to quickly look through notes to see if there is any mention of substance involvement

   b. **Medical History:** this can be found under the History tab on the left side of screen once you've opened up a patient's chart. Often if a patient has a diagnosis or prior history this will be listed under the "medical" tab in history

      i. You'll see things like "alcohol abuse" "polysubstance abuse" "opioid dependence" etc. (*any of these would automatically screen a person onto our service)

      ii. Other diagnoses to look for are health conditions frequently caused by prolonged substance use such as: pancreatitis, alcoholic cirrhosis, hepatitis, endocarditis, and osteomyelitis

   c. **Substance History:** this is another tab found under the History section in a patients chart. Here you will find pre-screen information usually taken by nursing staff regarding a patient's alcohol and drug use

      i. Any patient reported drug use would screen them on to our service

      ii. For alcohol:

         1. If a male patient reports 14 or more drinks in a week or 5 or more drinks in one sitting they screen on to our service

            a. For male patients 65 years and older, 7 drinks or more in a week screens them on as well

         2. If a female patient reports 7 or more drinks in a week or 4 or more drinks in one sitting they screen on to our service

            a. For female patients 65 years and older, 4 drinks or more in a week screens them on as well

   d. **Labs:** patient lab results is a column in the report, however, they can also be found inside a patients chart if you go to Chart Review and then click the Labs date (just be sure to check that the labs are from the current admission)

   **i.** For labs, any positive BAL (blood alcohol level) or UDS (urine drug screen) will screen a patient on to our service

A PATIENT SCREENS ON IF…

- They have a substance-related admitting concern or primary diagnosis
- Some form of substance use or illness is listed in their medical history
- They pre-screen yes to **any** drug use
- They pre-screen to 14+ drinks a week (men)/7+ drinks a week (women) OR 5+drinks in one sitting (men)/4+drinks in one sitting (women)
- They have a positive BAL and/or UDS

## ADDING SCREENED-ON PATIENTS TO THE EPIC LIST

Option 1:

1. In Epic under the Shared Patient Lists found on the left hand side you will find the list titled "ED PSS Visits Active"
2. This list is where all screened-on patients will be put for you to know who needs to be seen each day
3. To add a patient onto this list that you have screened, you will go to the **Demographics** tab found within the patient's chart
4. Once there, you will select the second tab option that says **Clinical Information**
5. Here, you will see a space that says **Patient Lists** and in that space you will type in "ED PSS Visits Active" to add them
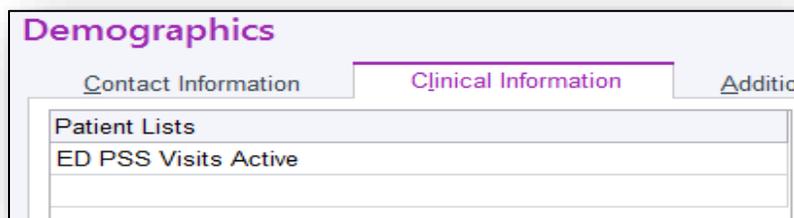
Option 2:

1. In the patients chart, copy their MRN (medical record number) found in the top left of their chart under their name
2. Go to the "ED PSS Visits Active" list found in your patient lists under shared lists
3. Once in that list, click the "add patient" button near the top
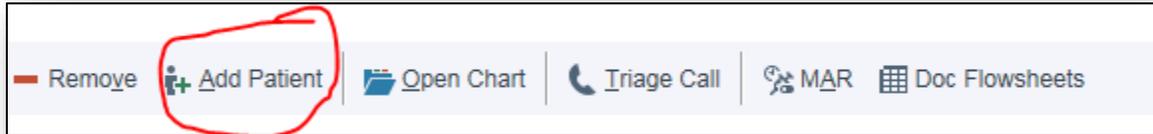
4. A window will pop up with different search options, paste the MRN into the correct search bar and hit enter or click the "find patient" button

5. The patient's name will pop up, verify that is the correct patient, and then hit enter or press the select button in the bottom left corner and they will be added to the list

PRINTING THE "ED PSS VISITS ACTIVE" LIST

1. You will print the list as a convenient reference and to write notes for yourself on which patients to prioritize seeing first *(all paper must be put in the shred bin or filed in the locked patient files)*
2. To print, be sure that you are currently in the Epic list, go to the upper right hand corner of the list and click on the downward pointing arrow icon that is directly below the X
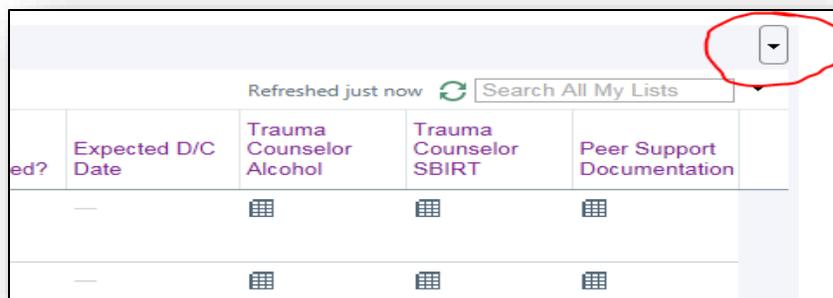
3. Click "Print Patient List" from the drop down menu. A window will pop up to select the printer you want to print from. It will also give you options for "Columns to Print"
   a. Be sure to select "custom" and select all of the columns you want to include
   b. It also gives you an option to print a blank column to write comments
4. *Double check you are printing to the correct printer so patient information isn't printed out somewhere else for others to find
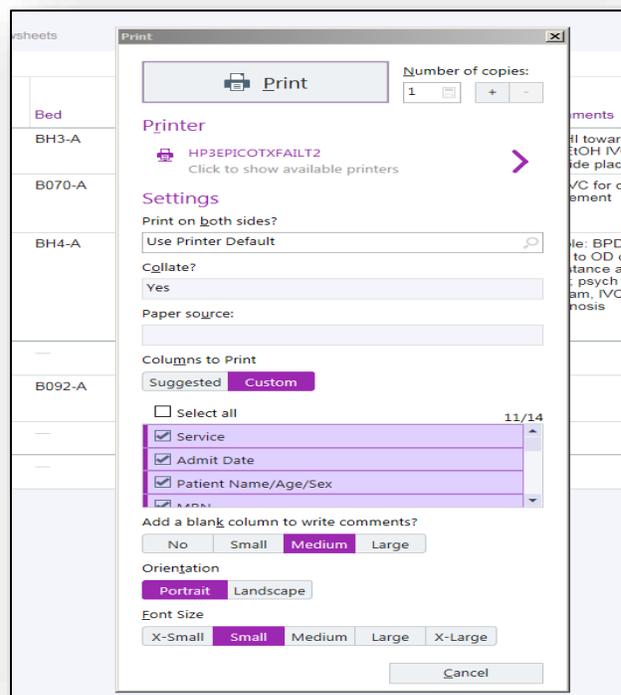
INTERVENING WITH PATIENTS

While our peer support specialists can provide services to all patients, we prioritize patients with substance use disorders or who misuse substances. ***Dr. Shilling must approve any deviation from this.***

In the ED, peers prioritize patients with opioid use disorders unless otherwise instructed by a supervisor (Drs. Veach and Shilling, Olivia Smith, and Liz White). At this time, peers are not providing services to patients in the ED who have a psychiatry consult, are on the psychiatry service or are in any psychiatry unit in the hospital (excluding the med-psych floor on North 9).

The process for intervening with patients goes as follows:

- Peers identify patients using the methods above.
- After identifying the patients and printing a list, the peer goes to the ED and approaches the attending physician to discuss the patient. **Peers are required to share with the attending physician the reason(s) for wanting to see a patient and receive confirmation that the current timing is appropriate for seeing the patient.**
- Upon confirmation from the physician that the timing is appropriate to see the patient, the peer approaches the patient and introduces himself/herself.
    - Introductions should take into account who is in the space and the patient's approachability. Peers are encouraged to ask if it's alright to speak with the patient alone if someone else is in the space. If the other person, or people present do not leave and the patient consents to them staying, the peer needs to address the fact that confidentiality cannot be guaranteed.
    - Introductions can include information about being a peer if it seems appropriate or can be more general about being a part of a team that provides support to patients.
- The peer intervention includes first and foremost relationship building. The primary purpose of peer support is to develop rapport with the patient.
    - Once rapport is developed, the peer needs to keep in mind collection of information required for the NCHA grant as detailed in the next section.
    - The intervention should be tailored to the patient's needs and be responsive to those needs.
    - Interventions may include
        - Supporting, demonstrated by listening and reflecting
        - Connecting the peer to resources like housing, etc

- Developing or discussing the development of crisis or wrap plans
- Assisting with advocacy needs
- Advocating for the patient
  - A primary task of the intervention includes connecting with the patient and learning the best way to get in touch with the patient once they leave the hospital. During this discussion, do not mention discharge at all to the patient.
- Once an encounter with a patient is completed, the peer documents this information in redcap (ED only) and in the flowsheet. A flowsheet entry is required for every time a peer meets with a patient.

STEPS FOR ENTERING & COMPLETING ASSESSMENTS IN REDCAP

1. Go to: **https://redcap.wakehealth.edu/**
2. Enter your Wakehealth login and password information
3. You will see a "My Projects" tab, select that and click on the ED Peer Support Project to open it
4. To add a new patient record or select an existing record, click on "Add/Edit Records" on the left side of the page
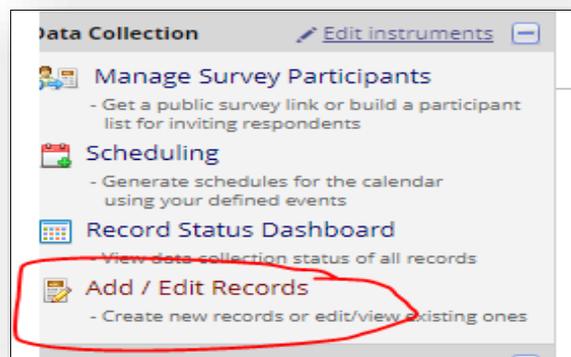
5. Then select the "add new record" button

6. Once you've clicked the "add new record" button, it will take you to a page where you will select what instrument you will be using, if this is a new patient who has not been seen, you will select "ED PSS Intake Assessment" (click the round button under initial intake assessment)

7. Once clicked, the assessment page will be pulled up. The Record ID should automatically create the correct number, however, there is a second field that allows you to type in the ID number, please enter the same number that is listed above that was automatically populated

ED PSS Intake Assessment

Adding new Record ID **1**

Event Name: **Initial Intake Assessment**

Record ID	1
Record ID	[ ]
Is this an initial intake assessment or a follow-up assessment? * must provide value	○ Initial Intake Assessment ○ Follow Up Assessment reset Please select if this is the intial intake assessment with a patient or the 30-60 day follow up assessment
Date/Time of PSS Assessment Encounter * must provide value	[ ] 📅 [Now] D-M-Y H:M
Declined PSS services? * must provide value	○ Yes ○ No reset
Assessment Completed? * must provide value	○ Yes ○ No reset
Visit Length * must provide value	[ ] Please input the visit length in minutes only
ED PSS Team Member Name * must provide value	[ ] Please put your name or initials here
Form Status	
Complete?	[Incomplete ▾]
	[Save & Exit Form] [Save & ... ▾] [-- Cancel --]

8. As you fill in information in the assessment, more options will drop down depending on what you have selected. If a patient does not decline PSS services, the rest of the assessment will appear for you to go through. All of the information that DOES NOT have the asterisk and red writing stating "must provide value" is information that can be pulled from the "WH ED Peer Support Patient Screen – Winston Campus" and can be entered after your visit with the patient (or by the Project Coordinator if you're not able).

9. All of the items that you will be asking the patients are phrased in a way that you can read directly from the assessment until you get more comfortable with what information we are collecting. Any questions near the end of the assessment that are not phrased in a way directed at the patient are for you to fill out after you've completed your session with the patient.

10. Once you've finished the assessment and encounter with a patient, you will select a Form Status. If you are not able to input the demographic and Lab information that is at the top of the assessment that can be pulled from the Epic report, please select **Incomplete** from the drop down menu so the Project Coordinator knows that more info needs to be added.

11. If you have entered all information in the assessment, select **Unverified** from the drop down menu and click the "Save & Exit Form" button to save and leave that file.
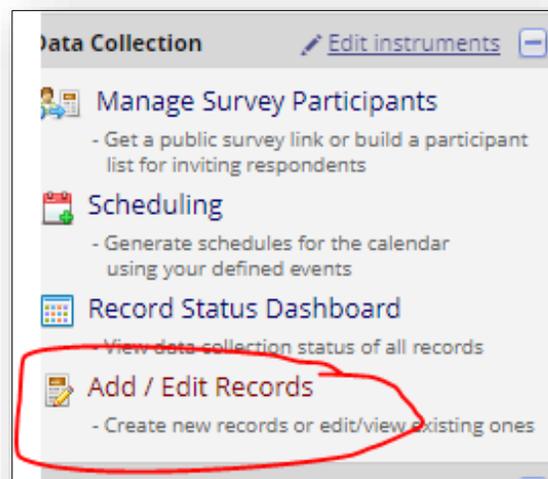

ENTERING A FOLLOW-UP ENCOUNTER IN REDCAP

1. Follow-ups are typically conducted within 24-48 hours after the patient has been discharged and are usually over the phone
2. Log in to RedCap and select the ED Peer Support Project
3. Go to the "Add/Edit Records" on the left hand side
4. To add a follow up encounter to an existing record, select the correct record ID number from the drop down menu
5. If you do not remember the record ID number that corresponds to the patient you are following up with, you can use the "choose a field search" which is located on the same page to find them.
   a. In the drop down menu, you will select "name_and_mrn (Patient Name/MRN)" and type in their name to search

6. Once you've selected the correct record, you will be taken to the same page where the different instrument tools are listed

7. Select the "ED PSS Follow Up Encounters" button
8. As with the initial assessment, for the Follow up encounters tool further options will drop down depending on what you select. All information in this tool are required (*note that not all fields for this tool are displayed in the image below*)

9. Once you have finished filling out the information for the follow up encounter, please select **Unverified** for the Form Status and click the "Save & Exit Form" button to complete your entry.

ENTERING THE 30-60 DAY FOLLOW UP ASSESSMENT

1. Each patient will receive a follow-up assessment 30-60 days after they have been discharged. This assessment is almost identical to the Initial Intake Assessment, the only difference is it does not have the Demographics and Labs portions
2. Go through the same steps to complete this assessment with the patient

KEEPING TRACK OF WHEN TO FOLLOW UP WITH EACH PATIENT

1. Based on when a patient was seen and their initial intake assessment was conducted, the Project Coordinator will create a calendar for the patient to calculate when they will be due for the 24-48 hour follow up encounter as well as the 30-60 day follow up assessment
2. To access your calendar to view when these are due, select the "Calendar" option on the left hand side tool bar once you've entered into the ED Peer Support Project in RedCap
3. See example of the calendar
4. *The Project Coordinator will also keep track of when follow ups are needed for patients and will contact you accordingly, but the calendar is another tool for you to be able to see for yourself the follow

STEPS FOR ENTERING A FLOWSHEET IN EPIC

1. Once you have seen a patient, you will also need to enter a Flowsheet entry in Epic, to do this, go back to the "ED PSS Visits Active" list in Epic
2. Once there, find the appropriate patient. On the far right side, you will the final column on the list is titled "Peer Support Documentation"
3. Double-click on the icon and the flowsheet window will pop up
4. Enter all of the appropriate information (be sure double check that the date and time are correct). *Note that next to each option there is a page icon, if clicked, this icon gives you a small window to add additional notes if desired

*Note: this image doesn't show all the information in the flowsheet

5. **Be sure to include your initials where indicated, as well as time spent with a patient**
6. Once you've added all the information, click the **Accept** button and it will save and close the window