

**Diverting Psychiatric Crises in
Emergency Departments:**
*An innovative model of shared care
delivery*

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The Challenges

- Individuals who present to ED in need of psychiatric services have a unique set of needs which are quite different from individuals with physical illnesses.
- These individuals tend to require more time and expertise from staff in an environment that is most often chaotic and overcrowded.



The Constraints

- Fiscal concerns
- Increased demands & higher acuity
- Stigma
- Shortages of primary care physicians
- Limited access to specialized in-patient and community psychiatric resources
- Time consuming consultations
- Unsecured & unsuitable space in ED environments
- Unpredictable availability of beds
- Lack of skills, knowledge & confidence of ED nurses (Happell, Summers & Pinikahana, 2002)



The Response: Overview of the Literature

- A scan from the British, Australian Canadian & US literature reveal some common themes:
 - Psychiatric nursing expertise is essential in ED;
 - The point of access to specialty service does make a difference;
 - The role and reporting structure of the psychiatric nurse must be clearly defined;
 - Triage tools and education of ED staff is critical.





Literature: Models of Care

- **Psychiatric Nurses work as part of the ED team** (Sinclair, Hunter, Hagen, Nelson & Hunt, 2008).
- **Psychiatric Liaison Nurse in ED** (Ryan, Clemmett & Snelson, 1997)
- **Psychiatric Emergency Nurses with advanced practice roles in ED** (Clarke, Hughes, Brown & Motluk, 2005)
- **Psychiatric Nurses as Gatekeepers in ED** (McArthur & Montgomery, 2004)



Models of care: Survey of 10 local General Hospitals

- **Psychiatric Crisis Teams (PCT) reporting to Mental Health Departments and available as consultants in ED. In 1 hospital PCT nurses provided care.**
- **Only 1 hospital offered 24/7 coverage. Others offer 16 hour coverage ranging from 07h00 to 01h00.**
- **Staffing variations: MSW, psychologists, RN, CYW.**
 - **Most PCTs had RNs with allied health support.**



Models of care: Survey of 10 local General Hospitals

- **Psychiatric coverage: role varies from staff psychiatrist to consultant. Hours of coverage also vary from daytime hours, to 16 hour coverage to “by request” only.**
- **ED nurses triage patients, seek medical clearance & then refer to PCT.**
- **ED nurses also decide if patients are “*fast tracked*”: skip medical clearance before referral to PCT.**



Models of care: Survey of 10 local General Hospitals

- **Most hospitals offer follow-up through a continuum of care within their MH programs**
 - Urgent clinics
 - Same psychiatrist and PCT nurse will follow patient as they navigate through the system
 - All discharged patients referred to Mobile Crisis Team & designate support staff
 - Follow-up by residents and clerks
 - Follow-up clinics



North York General Hospital (NYGH)

- **Community Teaching General Hospital & Schedule 1 facility**
- **Located beside the busy 401 highway in Toronto**
- **Averages about 3360 psych ED visits/year**
- **Peak hours: 15h30 to 24h00**

NYGH: Current State

■ Psychiatric Crisis Team:

- All RN Team
- Reports to the MHP
- Provide consultation and intake services in ED from 07h00 – 23h00, 7 days a week for adult and child & adolescent individuals
- ED nurse triages patient and ensures medical clearance before referring to PCT
- Psychiatrist is contacted by PCT nurse once assessment is completed. Psychiatrist may or may not see patient but a disposition is decided.

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NYGH: Current State

■ Follow-up services

- Outpatient urgent appointments
- Outpatient follow-up clinic
- Adult/adolescent day hospital programs
- Emergency diversion partnership with St-Elizabeth Mobile Crisis Team
- Referral to SAP – RN from SAP on site to assess & provide links to community programs immediately

NYGH: The Constraints

Individuals presenting with a mental health illness/crisis are treated like all other individuals seeking physical care and go through the same initial process



The Strategic Alignment Model

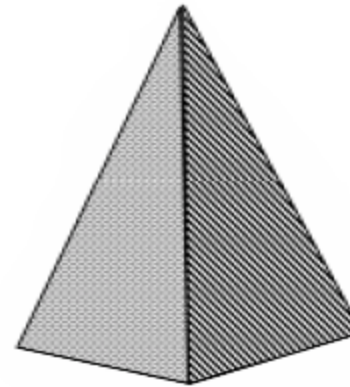
Mission

Strategy

Skills

Structure

Culture



The Strategic Alignment Model

- System design tool used to create and maintain strategic alignment.
- To achieve strategic outcomes you must align its structure, culture and skills to the strategies it puts in place to realize those outcome



The Mission

To deliver efficient crisis mental health services to designated individuals in the ED



The Strategy

- Develop an early partnership between psychiatric nurses with advanced preparation and ED nurses
- Utilize a triage tool that includes mental health complaints & risk assessments
- Based on level of acuity psychiatric nurses will develop management plans, coordinate necessary resources, educate and support ED nurses.



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Skills: Technical & Analytical

Current State:

- ED nurses triage all individuals using the Canadian Triage & Acuity Scale (CTAS).
- It is unclear whether the CEDIS Mental Health complaints & second order modifiers are utilized and interpreted
- ED nurses arrange for medical clearance based on competing demands
- After medical clearance individual is referred to PCT
- PCT nurses assess individuals and makes recommendations without any standardized tools.



Skills: Technical & Analytical

The issues:

- ED nurses believe they have limited skills and knowledge to effectively triage these individuals. They tend to see this population in stereotypical ways thereby reinforcing stigma. (Clarke, Hughes, Brown & Motluk, 2005; McArthur & Montgomery, 2004)
- Individuals with MH conditions in crisis tend to receive a lower priority rating which increases wait times (Wynaden, Chapman, McGowan, McDonough, Finn & Hood, 2003)
- No Mental Health Triage Scale tool to standardize acuity of presenting problem. (MHTS) decrease wait times in ED. (Broadbent, Jarman & Berk, 2004; Happell, Summers & Pinikahana, 2003)
- PCT mental health & risk assessment form is generic and prone to individual interpretations
- Disposition based on consultation between the PCT RN and psychiatrist.

Skills: Technical & Analytical

The solutions:

- PCT: Registered nurses with advanced knowledge and skills to assess for organic contributors to the presenting problem in ED (Clarke, Hughes, Brown & Motluk, 2005)
- PCT and ED staff require ongoing education
- Develop *Fast Track* protocols for individuals known to hospital. Seeking psychosocial support: finance, housing, legal. (Coristine, Hartford, Vingilis & White, 2007)
 - Medical clearance will be coordinated with ED physician during visit
- Standardized mental health triage tool
- Standardized mental health & risk assessment tool used





Skills: People & Communication

The issues:

- PCT consultant role in ED is unclear for both the ED nurse & the PCT nurse
- Communication with the individual & families is inconsistent
- Communication about the care of the individual & family is inconsistent
- Clear formal processes for change of shift reports among PCT are missing

The solutions:

- Negotiate and develop clear role definitions for the PCT
- Assessment results, management & care plans recommendations will be communicated by PCT to clients/families & ED nurses both verbally & in writing as applicable
- PCT nurses will be available to educate & support ED nurses in the delivery of care.
- Education & support will also be given to clients/families.
- Develop formal guidelines & structures for change of shift reports

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Structure

- PCT nurses will partner with ED nurses at the point of triage for designated individuals. Medical clearance will be arranged during ED visit.
 - Higher risk individuals will be further triaged and assessed by PCT promptly. Care recommendations will be developed and communicated efficiently to ED
 - Lower risk individuals presenting with psychosocial issues will be “*diverted*” to designated services and resources (i.e. SW, CYW, Crisis worker)
 - Individuals referred to PCT by primary care physicians with no reported medical concerns will be “*fast tracked*” and by-pass ED triage



Structure

- Individuals will be assessed, supported and managed in a designated area of ED
- PCT will act as a liaison & communicate referrals & admission needs to other members of the MHP
- PCT will ensure that individual has a set follow-up appointment before discharge
- PCT staff 24/7; overnight on call residents
- PCT will identify & report gaps in resources



Strategy Outcomes

- Based on the literature having the PCT nurse at the point of triage:
 - Significantly reduced wait times (Wynaden, Chapman, McGowan, McDonough, Finn & Hood, 2003)
 - Reduced pressure & anxiety of ED nurses & placed individuals on an equitable footing with clients presenting with physical illness & injury (Broadbent, Jarman & Berk, 2004)
 - Reduced overnight stays
 - Diffused volatile situations & violent behaviour
 - Reduced number of individuals leaving without being seen
 - Reduces stereotyping
 - Increased client satisfaction



Culture

- The proposed partnership with ED staff coupled with ongoing education targeting *stigma* will serve to remove barriers for individuals presenting with mental health conditions & complications while promoting a positive culture of:
 - Respect & compassion;
 - Free of stigma &
 - Enhanced therapeutic relationships.

QUESTIONS

