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Triage Guidelines for Providers Interfacing with Mental Health Patients Presenting to the
Emergency Department

DNP Project
Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

St. Catherine University
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Abstract

This QI Project was inspired by a concern and belief that a hospital emergency department (ED) can more effectively respond to and manage the mental health patient population by improving its triage process. When a patient in mental health crisis presents to the emergency department (ED) for care, the triage process often results in patients having multiple encounters with various staff asking the same questions over and over. Many times, staff query patients about issues that are considered non-essential. Patients are often frustrated by this repeated questioning and therefore, the ability to develop or maintain a positive therapeutic relationship is compromised. Patients often shut down, become increasingly agitated, are mistrustful, and even walk out of the ED without receiving care. The following initiative focuses on identifying and addressing system level barriers that impede the ability to triage mental health patients seeking care in the ED. At the conclusion of this QI project, practice changes include the reduction of door to doc time, enhanced communication between staff and clarification of assigned roles and duties, and a streamlined workflow process.

Keywords: mental health patient, emergency department, triage, admission workflow

Introduction

Patients presenting to the emergency department (ED) with mental health concerns are often required to interact with a variety of individuals during the admission process. Anecdotal evidence suggests that many find these encounters exasperating due to the same questions being asked by multiple staff, resulting in systematic barriers to care. Patients presenting to the ED often express frustration with their experience which can compromise the patient-provider therapeutic relationship. Perhaps more importantly, inefficiencies in the rooming process often result in delayed care and less than timely access to necessary services.

This quality improvement (QI) project is based on the premise that all patients deserve to be treated with respect and dignity and to feel as though their needs are being addressed in a fair and equitable manner. The needs of mental health patients are no less urgent or important than a patient presenting to the ED with a medical concern. The following article describes a quality improvement (QI) project designed to examine the current admitting process for mental health patients seeking care at a Midwestern, rural emergency department. The question guiding this project is, “For mental health patients presenting to the emergency department, what is the effect of a mental health triage algorithm compared with standard care on the 'door to doc' time metric?”

Background

The prevalence of mental illness in our country is significant and healthcare organizations continue to respond to an increasing demand for services (Zhu, Singhal & Hsia, 2016). The number of emergency room visits has increased 32% from the years 1999 to 2009 and has resulted in an increase wait time for services from 46.5 minutes to 58.1 minutes (Hing & Bhuiya, 2012). According to the Agency for Healthcare Research and Quality (2010), it is estimated

that one out of eight emergency room visits involve a mental health and/or substance use condition (Owen, Mutter & Stocks, 2010). According to this study, people requiring a mental health intervention wait longer than those presenting with medical concerns, the availability of in-patient psychiatric beds contributes to delayed care, and many ED departments are not prepared to handle serious mental health issues (Wright et al, 2012). Anecdotal evidence, as well as research findings suggest that several challenges exist when working with this population, including greater safety concerns, role ambiguity, and stressful working conditions (Hitchcock et al, 2013). While several variables contribute to this practice problem, the need to address various system-related barriers related to the triage process for this patient population is clear.

Emergency departments typically use an admission process referred to as triage that determines assignment of acuity and urgency of care related to a patient's presenting chief complaint. In general, triage processes are medically-based and aren't necessarily transferable to patients presenting with mental health concerns. Prioritization of a patient's need for care might require a different approach for those with mental health concerns versus individuals experiencing chest pain. Instead of asking multiple questions about health history and dietary patterns, it is also essential to determine whether a patient is at risk for violence, suicide, homicide, or under the influence of drugs or alcohol.

Research demonstrates that triage guidelines correlate with wait times and patient satisfaction. When a single point for triage services is identified, the ability to provide a rapid and consistent response is enhanced (Doncliff, 2015). Innes, Morphet, O'Brien, & Munro (2013) examined admission processes and workflow patterns in an ED and determined that certain barriers contribute to delayed response times. Hitchcock et al (2013) concurs with this finding and suggests that defined clinical criteria following principals of triage ensure accuracy and

consistency of the assessment process (Sands, Elsom, Berk, Hosking, Prematunga & Gerdtz, 2014). Assessment and communication are key skills necessary to provide the best possible care for mental health patients who present to the ED with complex mental health issues (Kerrison & Chapman, 2007).

Methods

The methodology selected for this project is based on the PDSA design (plan, do, study, and act), a four-step approach to quality improvement and practice change. Each aspect of this problem-solving model guides practice implementation and helps to facilitate achievement of project outcomes (AHRQ, 2017). The following discussion outlines each stage of the PDSA cycle for this quality improvement project and how it relates to the overall project.

The Plan Stage was initially designed to better understand the practice problem and identify root causes for this organization's inefficiency. A Process Flow Diagram was created to map out the existing care process, which essentially retraced the patient's steps from walking through the ED doors to first meeting with a physician. Key measures during this stage included the number of staff interfacing with a patient throughout the triage process, vital information needed to both triage and admit the mental health patients and door to doc time in minutes. After mapping workflow, the Plan Stage was followed by a review of two electronic medical records to verify differences between written and actual processes. This chart review specifically intended to evaluate the ED timeline, including a date and time stamp of an ED event, details of the event (e.g., acuity assigned, arrival complaint, exposure screening, risk assessment, and vitals), and the time when the patient was first seen by a physician. This process intended to identify the current workflow, a timeline of events (e.g., door to doc time), and any duplication of any documented data.

The second stage, referred to as the Do Cycle, focused on implementation. During this stage, the ED implemented a triage process specifically designed for patients presenting with mental health concerns based on empirical evidence, best practices and available guidelines (Wright et al, 2012). This algorithm was presented to staff in three separate committees prior to the implementation phase to clarify roles and responsibilities, delineate the “who, what and when” of essential information collection, address staff questions and concerns, and delineate a streamlined workflow policy and process for all staff to follow. As part of the Do Stage, a launch date was identified and communicated to all ED staff via email.

During the 3rd stage, referred to as Study, an evaluation of the newly instituted triage algorithm was completed. Once again, a Process Flow Diagram was re-mapped and steps described in the Plan Stage were repeated. In addition, a provider survey was distributed to approximately fifty staff working with the mental health patients who were involved in pilot testing the triage algorithm outlined earlier.

Finally, the last stage of this project, described as the Act Cycle, was designed to study and evaluate findings and make final revisions to the newly updated processes. The PDSA cycle allows adjustments to practice change throughout each stage, with revisions dynamically occurring in real time. Specific process changes will be discussed in the results section of this article.

Results/Discussion

The following discussion presents project findings based on the PDSA design, with each stage discussed separately. As a review, all cycles in this process allow understanding and testing of proposed practice changes. From start to finish, this quality improvement process fosters greater awareness of the systematic barriers contributing to both delayed doc to door

time, staff ambiguity about roles and responsibilities, and staff perceptions about factors influencing patient dissatisfaction and outcomes. In this quality improvement project, patients were not queried about their satisfaction or experience with the triage process.

Plan Stage

As described earlier, the Plan Stage was designed to better understand the practice problem through the completion of a Process Flow Diagram and mapping of existing workflow patterns (see Table 1). Several system barriers were revealed, including the fact that a triage patient might interface with five different staff prior to meeting with a physician. In addition, when a licensed practical nurse (LPN) participated in the admission process, a registered nurse (RN) was required to complete aspects of the assessment falling outside the LPN's scope of practice, a factor contributing to repeated and duplicative questions. Removing the LPN from the triage process allowed for one less interaction during the triage process.

This systematic barrier to care was not evident prior to this mapping exercise and diagramming workflow patterns revealed unintended process barriers. Developing a streamlined process that considers the patient's presenting factors and assignment of acuity level consistent with the presenting symptoms is an important feature of effective triage (Hitchcock, Gillespie, Crilly and Chaboyer, 2013).

Besides identifying the number of staff interfacing with mental health patients, the workflow diagram also illustrated inefficiencies and duplication of collected data. When diagramming the admission algorithm on paper, staff shared that no one was entirely sure which aspects of the assessment was theirs, hence contributing to the duplication of questions and perhaps leading to patient dissatisfaction. A study completed by Doncliff (2015) reinforces this finding - when a single point for triage services is identified, the ability of staff to provide a rapid

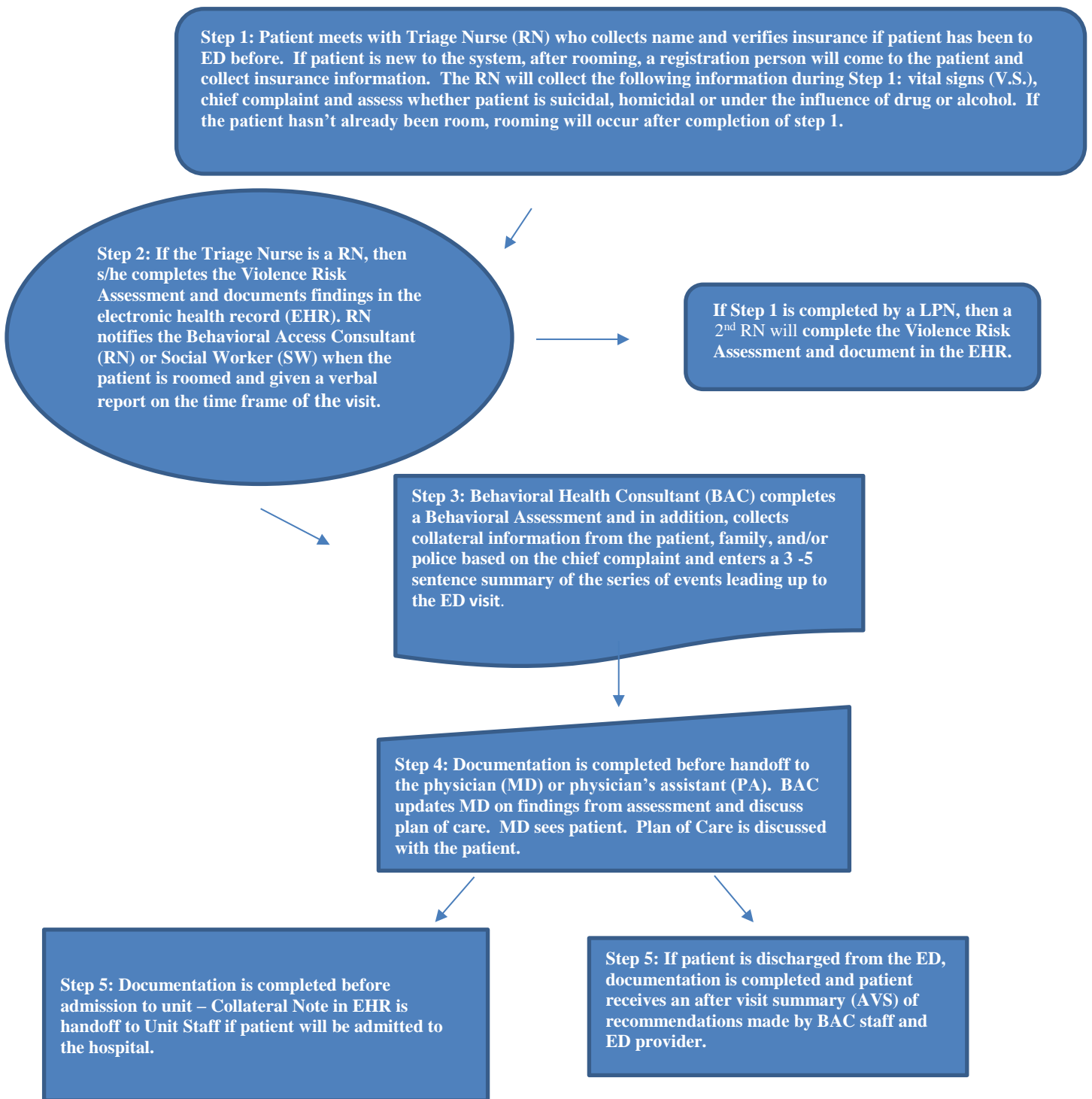
and consistent response is enhanced. Sands, Elsom, Berk, Hosking, Prematunga & Gerdtz, (2014) suggest that clinical criteria following principals of triage systems must be adhered to in the ED in order to ensure accuracy and consistency of the assessment process.

Finally, the lack of a streamlined process for triaging mental health patients, many gaps in workflow contributed to delays in door to doc time. For example, a patient might be asked to sit in the general ED waiting room, then move to a specific triage area, followed by transfer to an exam room, and finally if applicable, admitted to the hospital or transported elsewhere. Between each relocation time delays might occur due the several factors, such as the availability of an open room, a backlog of other patients requiring staff attention, or priority demands based on acuity. Due to the nature of the ED, overcrowding is a reality of practice however this negatively impacts workflow and leads to longer wait times and decreased patient satisfaction (Hitchcock et al, 2013). Overcrowding, wait times, and patient dissatisfaction influence whether mentally ill patients stay in the ED long enough to receive needed services or leave without care (Gerdtz, 2009).

Do Stage

The second stage of the PDSA cycle focused on implementation of a newly designed admitting algorithm. As mentioned earlier, the previous algorithm was based on a medically-focused model of care and was therefore redesigned to better align with the needs of this patient population. However, prior to initiation of this stage, the triage algorithm was introduced during a daily huddle to ensure clarity of roles and expectations, enhance stakeholder engagement, and prepare staff for the launch and piloting of this workflow process.

Table 1: Triage Process for Rooming Patients Presenting to the ED with a Mental Health Concern – Pre-Measure

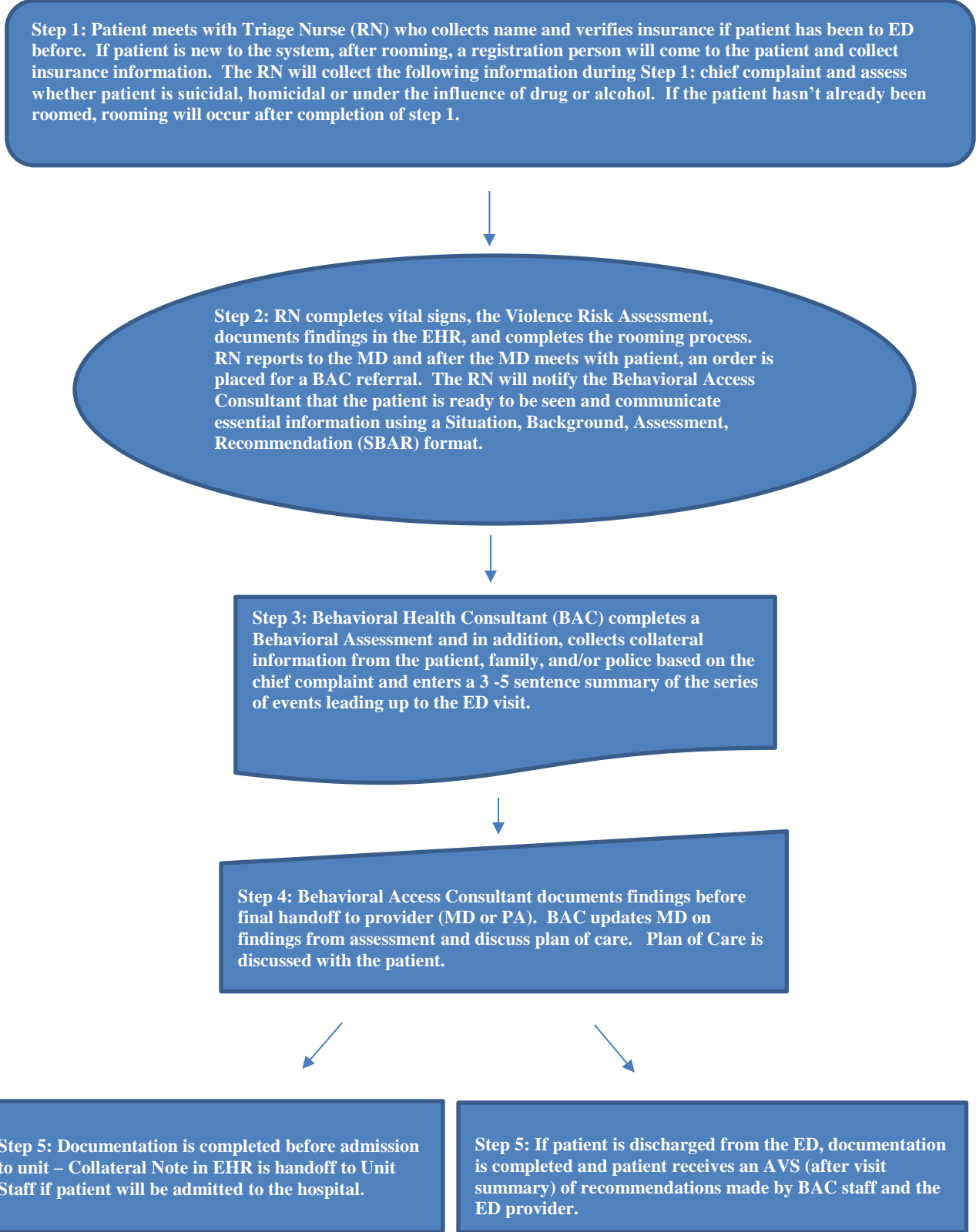


Study Stage

The third stage was designed to evaluate the newly instituted triage algorithm. As mentioned earlier, during this stage an evaluation of the newly instituted triage algorithm was completed (see Table 2). Once again, a Process Flow Diagram was re-mapped and steps described in the Plan Stage repeated. Findings from this cycle demonstrate that the number of RNs involved in the admitting process was reduced from up to five to three. In addition, because the assessment process was clearly defined, chart reviews indicated that vital information is collected in a manner and timeframe that facilitates access services efficiently and effectively. In other words, staff are no longer asking patients multiple, repeated questions – a previous source of frustration.

As a result of project findings, a specified triage area has been identified for all mental health patients who begin the admitting process in this defined space. After meeting with the triage nurse, patients are directly roomed, a significant change that reduces movement throughout the ED. In the past, the physician was the final step in the admitting process and this is no longer the case. The workflow algorithm now requires staff to alert the physician after the patient meets with the second RN, allowing an order to be placed for the patient to meet with a Behavioral Access Nurse if appropriate. It is not necessary for all patients to follow the steps outlined in the initial workflow diagram (Table 1) and by having the physician place an order earlier in the process, inappropriate referrals have been reduced, lessening the number of individuals a patient meets with, and ultimately these changes have enhanced access to care (Table 2).

Table 2: Triage Guidelines for Patients Presenting to the ED with a Mental Health Concern - Post Measure



As addressed previously, one of the major problems contributing to patient frustration and barriers to care involved staff who were not clear about their role in the admitting process. As a part of the study phase, a survey was sent to fifty staff after piloting the triage algorithm to determine satisfaction, solicit feedback on their experience, and determine whether role ambiguity persisted.

When staff didn't return their surveys by the designated time, reminders were sent out and again, staff did not respond. Reasons for this poor response rate might be due to the fact that at about the same time as this project started, the ED department initiated daily huddles to discuss workflow, general challenges of the ED, system issues, and how all members of the team could work together toward a common goal. At these daily huddles, staff actively participated in discussions about changing the triage and admission process for patients presenting to the ED with mental health concerns.

Staff seemed very interested and engaged in helping to shape this project and by the time a survey was distributed, many felt their feedback was shared and clearly communicated during daily huddles. In fact, staff believed their survey feedback was unnecessary because it essentially repeated what had already been said. None of these discussions were formally captured, however in hindsight, it would have been prudent to obtain an amendment from the IRB requesting a revision to the original application. With this said, ED and BAC staff openly expressed satisfaction about the newly created admitting process structure, stating they clearly understood practice expectations and found the workflow process easy to follow.

One of the primary goals of this project was to improve the organizational 'Door to Doc' time goal of twenty four minutes. After instituting the newly designed triage process for a two-week pilot period, the Process Flow Diagram workflow was re-mapped and findings compared

with chart reviews (Table 2). The Door to Doc time for the charts reviewed ranged from seven to nine minutes, compared with the pre-project chart review, which was thirty-one to fifty-two minutes.

Finally, the timeliness and communication of vital information needed to both admit and triage mental health patients was evaluated. In the chart reviews, the electronic record data supported that staff did not document duplicative data. From the Daily Huddles, concerns and staff report increased understanding and comfort with their assigned duties. The goal is that this will lead to workflow efficiency, access to services, safe and quality care, and enhanced communication.

A limitation of this project was the zero-response rate from the provider survey. Although information was obtained in the daily huddle, it was of value, but not documented. Also, because the algorithm was only piloted for two weeks, it is uncertain whether this practice change is sustainable.

Implications for Emergency Nursing

Door to Doc time is difficult to control, especially considering the dynamic and intense nature of the ED environment. Many variables in the ED are challenging, such as physical space, staffing, and demand for services. A patient who is in mental health crisis may be unpredictable as well and whether intoxicated, violent, or suicidal, require additional staff to manage. The reality is that although certain aspects of the ED are not easily predicted or controlled, a highly streamlined triage process decreases system barriers leading to inefficiencies in care, delayed access to services, and ultimately, patient dissatisfaction. By purposefully evaluating workflow, certain practice problems are easily identified, facilitating change. In other

words, by creating and implementing a triage process proactively, there is a perceived sense of controlled chaos in ED and the impact of system barriers are lessened.

Although patient satisfaction with services is the ultimate goal of all healthcare organizations, obtaining data from a mental health patient is often difficult. Many factors contribute to patient's dissatisfaction, however some sources of frustration are easily understood. When a patient waits for care for longer than deemed necessary and is asked for information countless times, it is easy to understand the decision to walk out the door without receiving care. It is important to remember that patient issues are often a result of system barriers.

Finally, inefficiencies in care delivery are expensive on a number of levels. It isn't difficult to calculate cost savings when services are streamlined. By reducing the number of RNs from up to five to three, this amounts to significant savings. When realigning workflow patterns and eliminating certain unnecessary steps, savings are significant in terms of preserving physical space, staff, and system resources. Many of the cost implications go beyond finances and must be thought of in human terms. What are the implications of delayed care? What happens when a patient in mental health crisis walks out of the ED without receiving services? What are the societal implications of treating mental health patients differently than those who present to the ED with physical concerns? How effective is care when the provider-patient relationship is compromised?

Conclusion

In summary, this quality improvement (QI) project provided information about the potential benefits of streamlining a triage process for patients presenting to the emergency department (ED) with mental health concerns. Admitting decisions and processes must follow principals of triage, yet be designed in a way that responds to the unique needs of this patient

population. When an efficient workflow design is in place, communication is enhanced between all staff. Ultimately the goal of triage is to assign acuity and urgency of care related to a patient's chief presenting complaint following specific clinical guidelines in order to offer an efficient workflow process, rapid and consistent responses, timely access to care, and patient satisfaction with the entire healthcare experience. As stated earlier, all patients deserve to be treated with respect and feel as though their needs are being addressed in a fair and equitable manner. This includes patients who present to the ED in mental health crisis.

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