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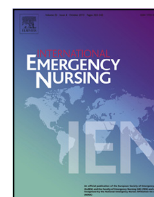

The impact of a flow strategy for patients who presented to an Australian emergency department with a mental health illness

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A R T I C L E I N F O

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Objectives: To describe and compare characteristics, care delivered, and outcomes of patients who presented to an emergency department (ED) with a mental health illness before and after the implementation of a patient flow strategy.
Methods: This was a retrospective, descriptive study. Health care data of patients who presented to a public teaching hospital ED in Queensland, Australia diagnosed with a mental health illness before (5th September 2011–4th March 2012) and after (5th March 2012–4th September 2012) the implementation of a patient flow strategy were analysed.
Results: A total of 3037 (before: n = 1511; after: n = 1526) mental health presentations (4.5% of all ED presentations) were made to the ED. Following the implementation of a patient flow strategy, improvements in ED length of stay, tests performed and nursing observations were seen. These varied by mental health diagnosis.
Conclusion: Our results indicate that a targeted approach to improving service delivery for a specific cohort of ED patients can make a difference without additional staffing. Further focused refinement of the strategy (such as time waiting for treatment) may be required.
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1. Introduction

Emergency departments (EDs) are the primary entry point to public hospitals in Australia, with patient presentations increasing by an average of 3% each year from 5.7 million in 2008 to 6.7 million in 2012 (Australian Institute of Health and Welfare [AIHW], 2013). Internationally, patient presentations and acuity are reported to be increasing and, coupled with a finite supply of hospital beds, has contributed to issues of access block (also known as boarding) and overcrowding within many EDs (Bond et al., 2007; Forero et al., 2011; Pines et al., 2011). In Australia, access block is defined as a situation where “patients are unable to gain access to appropriate hospital beds within a reasonable time, no greater than 8 hrs” (Forero and Hillman, 2008, p. 4) and leads to ED crowding. ED crowding has been linked to inadequate patient care due to prolonged wait times, delays to treatment, communication and medical errors, adverse events and increased risk of in-hospital mortality (Forero and Hillman, 2008; Pines and Hollander, 2008; Sun et al., 2013).

Similar to the general ED population in Australia, the numbers of patients presenting to public hospital EDs for mental health (MH) illness have increased by an average of 3% per year, from 236,654 in 2009/10 to 243,444 in 2010/11 (Australian Institute of Health and Welfare, 2012b). There has also been a reported increase in MH ED presentations over the last decade in other countries such as the USA and Canada (Chang et al., 2012; Hefflefinger, 2014; Leon et al., 2013). Previous studies have suggested that patients who present to the ED for MH illness may be susceptible to longer ED lengths of stays (Atzema et al., 2012; Bost et al., 2014).

In 2012, a targeted patient flow strategy was introduced at one hospital ED located in Queensland, Australia. The aim of the strategy was to assist with improving time to assessment and treatment for MH patients within the ED, improve flow for patients admitted to MH wards and streamline the discharge process. Expected benefits were a reduced ED LoS (Length of Stay) and a reduction of access block for patients who presented to the ED with a MH illness.

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1.1. *Mental health patient flow strategy*

The new patient flow strategy involved several elements that included: education regarding the use of a mental health triage tool by the ED triage nurse (Australian Government, Department of Health and Ageing, 2014; see Table 1); a streamlined assessment referral process from ED to MH clinicians and the use of the ED short stay ward for patients likely to be admitted. Other elements included the use of a "Mental Health Rapid Emergency Admission Destination Initiative" checklist (see Appendix 1) and the introduction of the "pull from the ED service delivery model."

The pull model is based on the concept of hospital wards actively pursuing the transfer of patients from ED (Queensland Government [Qld Gov.], 2014). Via the hospital bed manager, a MH hospital bed is located for the patient to be admitted from ED. A nurse from the MH ward attends the ED, takes a verbal handover from the ED nurse, completes the checklist with the ED nurse and escorts the patient to the ward (see Fig. 1).

Prior to the new patient flow strategy, the push model had been used where the ED nurse escorted the patient to the ward and transferred the patient and information (handover) to the nurse on the ward. The final element of the strategy was for the admitted patient to be given a brochure that provided names and contact information regarding the MH ward, nurse in charge and treating doctor, patients' expected date of discharge, allocated community case worker and information for themselves, family and/or carer to use after the patient was discharged (Qld Gov., 2014).

The project manager responsible for implementation of the patient flow strategy oversaw the education of the nurses. Education was delivered through informal information sessions at around 14:00 hrs during the change of shift times between the day shift (07:00 to 15:30) and the afternoon shift (14:30 to 23:00). ED staff resources were unchanged during the implementation of the strategy.

Additionally, prior to the implementation of the patient flow strategy, the National Emergency Access Target (NEAT) was introduced as a national performance benchmark. The goal of NEAT is that by 31 December 2015, 90% of patients are discharged from ED, admitted to a hospital ward or transferred to another hospital within 4 hrs (Australian Institute of Health and Welfare, 2012a).

The implementation of the patient flow strategy provided an opportunity to undertake research to answer the following question: What is the impact of a targeted patient flow strategy for patients presenting to the ED with a MH illness in terms of characteristics, care delivered and outcomes (e.g. ED LoS, access block, admission rate)?

2. Methods

2.1. *Design and setting*

This was a retrospective descriptive study, using a before and after design, of all patients who presented to a Queensland hospital ED with a MH illness between 5th September 2011 and 4th September 2012; six months before and six months after the implementation of the patient flow strategy. The study site was an urban public teaching hospital with over 350 beds that serviced a population of around 280,000 (Australian Bureau of Statistics, 2011).

Table 1
Australasian Triage Scale (ATS) using Mental Health Triage Tool (MHTT) guidelines (Australian Government, Department of Health and Ageing, 2014).

Triage code	Treatment acuity	Description	General management principles
1	**Immediate**	**Definite danger to self or others.** Severe behavioural disorder with immediate threat of or dangerous violence	**Supervision:** Continuous visual surveillance (person under direct visual observation at all times **Action:** – Alert ED medical staff immediately – Alert mental health triage or equivalent – Provide safe environment for patient and others – Ensure adequate personnel to provide restraint/detention based on industry standards – Calling security+/– police if staff or patient compromised – May require several staff to contain patient – Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management
2	**Emergency** – within 10 minutes	**Probable risk of danger to self or others and/or patient has required or does require restraint.** Severe agitation, aggression or behavioural disturbance	**Supervision:** Continuous visual supervision **Action:** – Alert ED medical staff immediately – Alert mental health triage or equivalent – Use defusing techniques (oral medication, time in quieter area) – Ensure adequate personnel to provide restraint/detention – Prompt assessment for patient recommended under Section 9 or apprehended under Section 10 of Mental Health Act
3	**Urgent** – within 30 minutes	**Possible danger to self or others.** Very distressed, risk of self harm, acutely psychotic or thought disordered, agitated/withdrawn	**Supervision:** – Close observation (regular observation at a maximum of 10 minute intervals) – Do not leave patient in waiting room without support person **Action:** – Alert mental health triage – Ensure safe environment for patient and others
4	**Semi-urgent** – within 60 minutes	**Moderate distress.** Under observation and/or no immediate risk to self or others	**Supervision:** – Intermittent observation (regular observation at a maximum of 30 minute intervals) **Action:** – Discuss with mental health triage
5	**Non-urgent** – within 120 minutes	**No acute distress or behavioural disturbance.** Known patient with chronic symptoms, social crisis, clinically well	**Supervision:** – General observation (routine waiting room check at a maximum of 1 hour intervals) **Action:** – Discuss with mental health triage – Refer to treating team if case-managed

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