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Clinician perspectives of a mental health consumer flow strategy in an emergency department

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ABSTRACT

Background: The increasing number of presentations to hospital emergency departments has seen the implementation of a variety of strategies in an effort to enhance care delivery and care continuity. One such strategy was designed and implemented to improve the transition of mental health consumers presenting to an Australian emergency department and admitted to a hospital mental health ward.
Aim: The aim of this paper is to present the findings of a study that explored clinician perceptions regarding the implementation of a mental health consumer flow strategy.
Methods: This was a qualitative study. Semi structured interviews were conducted with four emergency and four mental health clinicians employed at the hospital.
Findings: Three key themes emerged regarding the consumer flow strategy. 'Bridging the care provision gap' revealed a lack of shared understanding between departments, insufficient education and lack of process consistency that impacted on care provision. 'Ownership of and responsibility for consumers' revealed misunderstandings about ownership of the person with a mental illness in the emergency department. 'Dissonance in expectations of quality and timely care' revealed that the quality and timeliness of care was impacted by physical, organisational and communication barriers.
Discussion: Findings suggest that the implementation of the consumer flow strategy was supported in principal by clinicians. However, to improve the process and foster a shared understanding between departments, the provision of recurring education and adequate resources was required.
Conclusion: This paper identifies the complexities of introducing a new process to two hospital departments.

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Summary of relevance

Limited qualitative research exists that considers clinicians' views of strategies designed to improve the acute patient journey for people with mental health problems

What is already known

People presenting to emergency departments with mental health problems are a vulnerable population group who can have a different demographic and clinical profile to that of other emergency department presenters.

What this paper adds

The recognition that professional collaboration between emergency and mental health clinicians is required to support continuity of care for people with mental health problems who attend the emergency department.

1. Introduction

Hospital emergency departments (EDs) are often used by people seeking mental health (MH) services to address mental illness. Common mental illnesses include anxiety disorders, affective disorders (e.g. major depression), substance use disorders (e.g., alcohol dependence) and schizophrenia (AIHW, 2016). In addition to presenting with signs of mental illness, consumers may have other underlying medical problems which require treatment.

1.1. Background of the research

People who present to ED and are diagnosed with a mental illness can have higher hospital admission rates and a longer length of stay in the ED, when compared to those diagnosed with other

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illnesses (Bost, Crilly, & Wallen, 2014). Strategies to improve care delivery for people with mental illness include the employment of a MH nurse practitioner in the ED (Wand, D'Abrew, Acret, & White, 2016), employment of community psychiatric nurses in ED (Sinclair, Hunter, Hagen, Nelson, & Hunt, 2006) and further education (Clarke, Brown, Hughes, & Motluk, 2006). Perceived benefits of these strategies include: decreased time waiting for assessment (Wand et al., 2016), increased collaboration between departments (Clarke et al., 2006), and improved referral processes (Sinclair et al., 2006).

Whilst it is important to understand the outcomes of these strategies, limited within the literature are reports describing the processes by which new innovations are integrated into practice (Brewster et al., 2015). Implementing a new strategy or process into the workplace requires the employment of change management principles such as gaining support for the changes from those involved, ensuring adequate resources, training and support before, during and after implementation and an assessment of how the changes affect the workforce (Mierke & Williamson, 2017). The aim of this study was to explore ED and MH clinicians' perceptions of a mental health consumer flow strategy (MHCFS) that was implemented in one Australian ED.

1.2. A description of the mental health consumer flow strategy (MHCFS)

Commencing in March 2012, the purpose of the MHCFS (called '1 in 5′ at the study site) was to decrease the waiting times for assessment in ED, facilitate timely admission to MH wards, improve continuity of care between the departments and streamline the discharge process for admitted consumers returning home. The MHCFS operated 24 h/7 days a week.

Components of the MHCFS included staff education, a revised referral process from ED to MH services, a clinical handover checklist to be completed and signed off during the ED to MH nursing handover and a revised consumer transfer to ward process that required a ward MH nurse to attend the ED, receive handover and accompany the consumer from ED to the MH ward (Bost, Crilly, & Wallen, 2015). Additional components of the MHCFS included the use of a MH triage tool (Department of Health, 2016), the use of an ED short stay ward for those likely to be admitted and a discharge planning process from the ward to community services.

2. Methods

2.1. Design

Situated within a larger mixed-methods study, this qualitative study used a constructivist inquiry methodology to enable an open-ended interpretative approach (Lincoln & Guba, 1985) allowing researchers to capture detailed descriptions of the participants' experiences and perceptions (Petty, Thomson, & Stew, 2012), in this case, of the MHCFS. A quantitative outcomes analysis of the MHCFS is presented elsewhere (Bost et al., 2015).

2.2. Setting and participants

The study site was a public teaching hospital with 419 beds servicing a population of around 288,000 in South East Queensland, Australia (ABS, 2011). Approximately 65,000 patient presentations were made annually to the ED at the time of the study; 4.5% of consumers were diagnosed with a mental illness (Bost et al., 2015).

A list of ED and MH clinicians was provided by the MH nurse educator and ED nursing director. Purposively selected clinicians who worked in various nursing and medical roles (clinical nurses, clinical nurse consultant and doctors) in the ED and MH services were approached by one of the researchers who explained the study and invited them to participate in an interview at a place and time convenient to them. Inclusion criteria were: currently employed full or part-time within the ED or MH service, aged ≥18 years. Exclusion criteria were: consumers and carers as this study specifically aimed to understand the impact of the MHCFS on service delivery as experienced by clinicians.

2.3. Data collection

Semi-structured interviews were undertaken by two experienced researchers between October 2012 and April 2013. These were digitally recorded and conducted in a private room at a time and location convenient to the clinician. The interviews lasted, on average, 26 min (range 15–51 min).

An interview guide was used to facilitate participants' recount of their experiences in caring for consumers presenting to ED with a mental illness and their perceptions of the MHCFS. This method is recommended to obtain in-depth information from clinicians that is based on their own experience, situations and contexts (Bogdan & Biklin, 2007). The four overarching questions asked as part of the semi-structured interview were: "Can you tell me about your experience of caring for patients who are suffering from mental illness in the ED?", "What do you think are the barriers to providing effective care for people with mental illness in the ED?", "What do you think would improve the quality of care for patients who present with mental health concerns to the ED?", and "Have you noticed any changes with the patient flow strategy [1 in 5] implemented in March 2012?" Concurrent checking with participants included clarification of meaning via direct questions and paraphrasing during the interviews.

2.4. Data analysis

Interview recordings were transcribed verbatim, analysed using a thematic analysis approach by two investigators initially, then checked and discussed with two other investigators (Braun & Clarke, 2006). Sub themes were deductively identified from the transcripts (Vaismoradi, Turunen, & Bondas, 2013). An inductive approach was used to consolidate sub themes into the final themes (Braun & Clarke, 2006). This enabled researchers to establish when data saturation was reached.

Measures incorporated to ensure rigour included the construction of an audit trail and the purposeful sampling strategy (Tracy 2010). The quality of the findings was enhanced through independent interpretation amongst the investigators and consensus agreement was achieved on themes that emerged. Part of using a constructivist approach requires the researcher to comment on their own influences in the study. It is an approach that positions the researcher within the context of the research that is constructed from the realities of the participants. Furthermore, the research process involves an active effort on the part of the researchers who bring their personal values to the study (Dahl, Dahlen, Larsen, & Lohne, 2017). As applied in this study, one of the researchers undertaking the interviews had knowledge of ED processes (having worked in both clinical and research roles in a different ED). This assisted the understanding of the context and some of the processes and minimised the risk of bias and potential power influence.

2.5. Ethics

This study was approved from the hospital and health service (HREC/12/QPAH/354) and University (NRS/51/12/HREC) Human Research Ethics Committees. Participation was voluntary.

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