USE OF A STANDARDIZED PROCEDURE TO IMPROVE BEHAVIORAL HEALTH PATIENTS' CARE: A QUALITY IMPROVEMENT INITIATIVE

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Contribution to Emergency Nursing Practice

- A quality improvement, nurse-driven initiative can improve care for behavioral health patients while maintaining staff and patient safety.
- Demonstrates how a nurse-driven protocol reduced time to first medication for behavioral health patients from 43 minutes to 5 minutes.
- Standardized procedure instituted by nursing reduced use of restraints by more than 50%.

Abstract

Problem: Meeting the complex needs of behavioral health (BH) patients in the emergency department is an ongoing challenge. Delays in care can have adverse consequences for patient and staff safety and delay transfer to specialized care.

Methods: A quality improvement, nurse-driven initiative using a standardized procedure (STP) was developed and implemented in our busy Southern California Emergency Department, which focused on improving time to first medication and reduction of restraints. The project used a multidisciplinary team to develop the STP scoring tool and corresponding medications. Improvement was seen in all quality metrics. Time to first medication decreased from 43 minutes to less than 5 minutes. Adopting the STP resulted in a 50% decrease in use of restraints and time in restraints. Staff injuries remained low, with less than 3.6% of staff sustaining physical injuries.

Discussion: The STP is an effective method to initiate immediate treatment of patients with signs of anxiety and aggression and thus reduce risk of violence. Additional benefits are reduced time to disposition and earlier initiation of specialized BH care. This process can be replicated in other emergency departments with similar clinical environments through the use of STPs or protocols based on state regulations.

Key words: Emergency nursing; Restraints; Behavioral health (BH) patients; Psychiatric patients; Violence reduction; Standardized procedure (STP)

Introduction

With the reduction of many inpatient psychiatric beds and the increasing complexity of navigating access to community resources, emergency departments have become the primary source of care for many patients experiencing behavioral health (BH) crises.[1] Recent national statistics demonstrate that 1 of 8 visits to an emergency department is for a BH complaint.[2] Further, an even more complex subset of BH patients are those who are homeless, in which case the emergency department is often their only option for care and addressing the types of social concerns that have impact on their health.[3,4] Among this population, initial visits and readmissions to the emergency department for BH complaints far exceed that of the general population,[5,6] and diagnoses representing serious mental illness are more than 8 times higher than those among housed persons.[3]

Emergency departments are less than optimal settings for delivering psychiatric care. Assessment and treatment for BH patients may be delayed to provide care to medical patients who are perceived to be more acutely ill. Underlying conditions are often complex among BH patients. Medical histories may be incomplete because of their lack of cooperation or inability to participate in self-care.[4,7] Environmental noise and excessive activity

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associated with a normal emergency department is the converse of the quiet, calm setting that is most beneficial to a patient struggling with an acute BH crisis.

Emergency nurses are frequent recipients of aggression and violence from the BH population.[8,9] Identified among the top conditions associated with ED physical assaults are "under the influence of alcohol/drugs," "drug seeking," and "mental health issues or mental health patient."[8,10] Research findings demonstrate that many acts of aggression and violence occur within 1 hour of arrival in the emergency department.[11,12] Therefore, delays in care may exacerbate the risk of aggression or violence.

Our Southern California community hospital emergency department struggled with an increasing volume of BH patients, totaling more than 5,000 annually. Recent interpretation of county requirements dictated that community psychiatric crisis teams preferentially transport patients to emergency departments in hospitals with inpatient psychiatric units (eg, designated facilities). Law enforcement was strongly encouraged to do the same. Our county, with greater than 3 million inhabitants, has 4 such facilities. Southern California, like many other temperate regions of the country, has a disproportionate number of homeless patients, many of whom struggle with BH problems.[13] This population comprises a significant proportion of BH patients requiring emergency care. As a result, it became evident that the ED in this designated facility needed to find a solution to provide better expedient care to those afflicted with BH disorders.

Methods

A team composed of emergency staff nurses, ED leadership, and physicians met to define the scope of the problem and identify issues associated with providing care to BH patients. At project initiation, time to initial physician evaluation with medication ordered was often in excess of 40 minutes after patient arrival. Data demonstrated that many patients progressed to "Code Gray" (significant aggression or violence) or required restraints before medication was administered or took effect. Occasions when multiple BH patients arrived within a short time of each other magnified the problem. An agitated patient often incited others to agitation. All these issues led to risky clinical situations.

Input was sought from nursing and medical staff. Emergency nurses reported feeling hindered in caring for these patients while waiting for physician evaluation and medication. They expressed frustration as patients' behaviors escalated despite verbal interventions. Physicians identified that the highest-acuity emergency patients were their initial priority for assessment and treatment; these patients were most often those with traditional medical concerns.

Generated reports were evaluated, and project goals were developed. The primary goal was to improve timeliness of care for the BH population. Additional goals were to reduce acts of aggression and use of restraints. It was postulated that prompt assessment and administration of medication would reduce the need for restraints and Code Grays. After a review of the literature, possible solutions were evaluated by the team. Development and implementation of a standardized procedure (STP) was selected to meet the goals.

An Evidence-Based Solution

In California, STPs are legally sanctioned processes that allow registered nurses to "perform functions which would otherwise be considered the practice of medicine" (California Code of Regulations 1470).[14] Standardized procedures must be developed collaboratively within the organization with the input and approval of nursing, medicine, and administration.[15] Experience of the nurse, including training or education that must be completed before use of the STP, must be defined explicitly.[14] Rigorous monitoring is required to ensure compliance.[15] Although terminology may differ, other states have legal mechanisms to provide expanded scopes of practice for clinical nurses (eg, protocols in Georgia).[16–18]

Because STPs are prescriptive, nurses can perform clearly defined actions only in specific circumstances. A consistent method for assessing, treating, and evaluating patients needed to be developed. Historically, valid instruments assessing for agitation in the emergency setting have been limited. However, a recently developed scale, the Agitation Severity Scale,[19] was identified during a review of the literature. This observation-based instrument was designed to measure a range of behaviors—indicating movement along a continuum of behaviors—ranging from mild to severe agitation. Clinical staff members observe the patient for 17 behaviors and rate the frequency of each behavior from "not at all (0)" to "always present" (3). Scores are calculated by summing the value assigned to each observed behavior; higher scores indicate higher levels of agitation. Psychometric evaluation of the scale demonstrated internal consistencies of 0.88 and 0.91 on 2 separate measurement intervals; convergent validity was established

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