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REDUCTION OF PSYCHIATRIC PATIENT BOARDING IN THE ED

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Reduction of Psychiatric Patient boarding times in the ED

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Clinical Leadership Theme

The aim of this study is to identify measures to decrease emergency department length of stay (LOS) for psychiatric patients. The project aims at reducing LOS by 3 hours. At my current clinical site, below are the LOS stays for the past months: March 2015: 24 hours, April 2015: 26.6 hours and May 2015: 22.7 hours

Our current ED case for change;

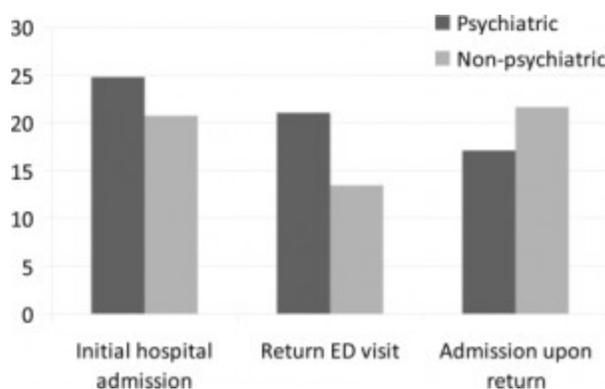
- 5% increase in patient volume since 2008
- Current annual census 75,00
- 72% increase in patient LOS > 6 hours
- 59% increase in total hospitalist admissions
- No increase in ED capacity

According to the Agency for Healthcare Research and Quality (2010), mental disorders and/ or substance abuse are related to one of every eight emergency department cases in the U.S. This translates into nearly 12 million visits to hospital emergency departments in a year. This is not any different at my clinical placement. Psychiatric patient boarding in the ED has played a huge role in the 72% increase in - patient LOS > 6 hrs.

To accomplish this project, these clinical leadership roles will be applied: effects change through advocacy; achieve quality client outcomes, actively pursues new knowledge and skills, identifies clinical and cost outcomes that improve safety, assimilates and applies research based information to design, implement and evaluate client plans of care.

Statement of the Problem

ED crowding is a public health concern and a threat to patient safety. Psychiatric patients experience longer LOS in the ED when compared to non-psychiatric patients. The prevalence of psychiatric emergencies in the United States continues to increase due to the strain on mental health services. 53M mental health related emergency department contacts were reported in the united states in 1992 to 2011 (Pelletier, Camargo et al). With the increasing cuts to mental health resources, the number is said to continue to rise which consequently, jeopardizes the safety of both staff and other patients in emergency departments. Marco & Vaughan estimate that 20% to 50% of all psychiatric emergency visits in the United States involve patients at risk for agitation with 1.7M medical emergency department contacts per year involving agitated patients. Psychiatric patients awaiting inpatient placement remain in the ED longer than non-psychiatric ED patients. The psychiatric patients also tend to have more admission rates than non psychiatric patients as shown below



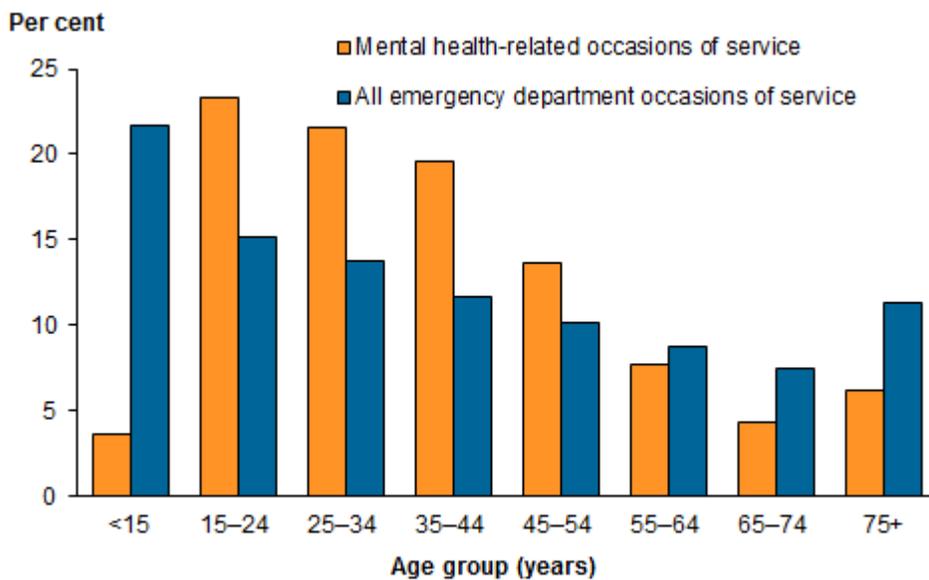
Project overview

At my current placement, I reviewed the EMTALA transfer log and below were the average LOS for the past few months for psych patients: March 2015:

24 hrs., April 2015: 26.6 hrs., May 2015: 22.7 hrs. When psychiatric patients are held longer in the ED, it affects bed turnovers hence loss of payments. In addition, prolonged stays increase the risk of elopement and increased risks of self-harm or suicide; as EDs are not equipped to handle psychiatric patients. Poor clinical outcomes have been reported from delays in care as well as more patients leaving without being seen (LWBS). Studies have shown that ED boarding is evidence of health care system failure—HIPPA failures, medication errors and ambulance diversion.

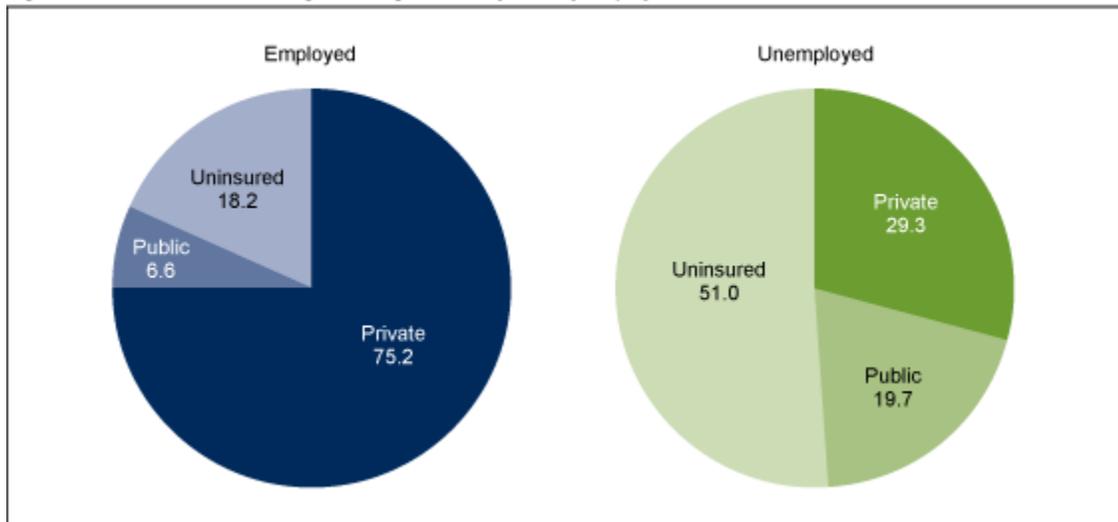
Rationale

Studies have demonstrated the adverse effects of emergency department (ED) boarding. The financial impact of having patients board in the ED is enormous. Research shows that the longer non-psychiatric patients wait for treatment, the more likely the hospital is to suffer declines in quality of care, patient satisfaction and public reputation.



In addition, from a business perspective angle, the cost of a ED bed is almost thrice the cost of a psychiatric bed. At a local psychiatry facility, the daily cost is approximately \$1500 as compared to ED stay \$3900. The financial impact of psychiatric boarding accounted for a direct loss of \$1,198 compared to non-psychiatric admissions. Factoring the loss of bed turnover for waiting patients and opportunity cost due to loss of those patients, psychiatric patient boarding cost the department \$2,264 per patient. Mental illness affects the person's ability to become gainfully employed. Approximately 90% of adults with severe mental illness are unemployed, this translates to 2.5 Million individuals. There's a correlation between mental illness and unemployment and lack of medical coverage

Figure 1. Insurance status among adults aged 18–64 years, by employment status: United States, 2009–2010



In addition, mental health patients in the emergency department contribute to other system issues such as increased ancillary resource utilization by safety attendants or security officers as a safety measure to protect staff and patients.

This leads to increased labor costs. We have 1 guard per 4 psychiatric patients. Applying the average financials for each ED patient that would otherwise be cared for, the impact from each psychiatric boarded patient represents a loss to the system.

Methodology

This project partially began last semester when I focused on the use of restraints in the ED on psychiatric patients. I witnessed patients wrongfully restrained by security and the number one cause of agitation and aggressive behavior was frustration. Frustration due to elongated unnecessary length of stays in the ED. Restraint data I analyzed was specific only to psychiatric patients. The overall documentation accuracy was 53.3%; Psych specifically was 37.5. The ED restrained 8 psych patients and saw 68 in February 2015

Psych patients waited in the ED anywhere from 4 to 24 hours for mental health evaluations. To implement this project, we collected restraint data and causes. After Identifying LOS as the number cause, we analyzed data from EMTALA log and security documentation on psychiatric patient stays in the ED. March 2015: 24 hrs, April 2015: 26.6 hrs, May 2015: 22.7 hrs.

I then shadowed crisis workers to figure out how they assessed psychiatric patients. I was able to identify that there was no order/form in which these patients were evaluated. I have set a standard using the mental health evaluation log. Patients are to be assessed based on LOS as long as they are medically cleared. We have added a time slot on the mental health evaluation log, crisis

workers can now see patients based on who has been in the hospital longest as compared to before when patients were not seen in a timely fashion.

To check if my project is effective, I will go back to the EMTALA log and security documentation of LOS. I will compare the numbers from this month to the previous months. The goal of the project is to reduce LOS by an average 3 hours this month.

Data Source/Literature Review:

The site of focus for this project is audits. It is more appropriate for this project because it is important we focus specifically on psychiatric patients. Psychiatric patients awaiting inpatient placement remain in the ED 3.2 times longer than non-psychiatric ED patients according to The Department of Emergency Medicine. In addition, the longer waits prevent 2.2 bed turnovers per psychiatric patient waiting for inpatient care. The same study reported that approximately \$2,250 is lost in revenue per patient waiting.

Although data will be collected on a monthly basis, I will personally collect data of psychiatric patient ED stays for the month of July and August. I will then compare the data collected to previous months. I have gathered data from December to July. So far, the data from July does not look very promising. We had patients wait in the ED for very long due to uncontrollable circumstances. A lot of factors impact psychiatric patients LOS in the ED with placement being the number one cause. It so happened that last month, the psychiatric facility that takes most of our patients has been undergoing a lot of changes. The facility is getting ready to go live with EHR next month and they also had a shortage of

psychiatrist hence cut down on admission. I witnessed a patient stay in the ED for 5 days. As I continue to analyze data from last month, I can only predict that the goal of the project was not met.

Extended LOS for psychiatric patients in the ED is undeniably due to placement issues. There are not enough facilities in which patients can be placed due to budget cuts. Being a full time employee at Sutter Center for Psychiatry has been an asset to my clinical placement site. After successfully completing last semester in the ED, I have been able to identify some of the causes of the delays in psychiatric patient discharge and placement.

1. Crisis workers have not had any order in which they complete mental health evaluations. Some patients were seen within 2 hours while other patients had to wait for more than 24 hrs.
2. Patients were not evaluated thoroughly, crucial information was missing on which delayed placement. For instance, legal paperwork for minors was never provided. Some of the crisis workers did not know about ward of court kids, JV220 and guardianship paper work that is required at the psychiatric hospitals before placement. I was able to make up a list of required documents for placement that is visible to all crisis workers in the office
3. Restraint use: Psychiatric facilities require that a patient is free from restraints for 24 hours before referring for placement. Educating security and mental health workers about this requirement and the need to keep patient restraint free has been accomplished
4. Medical clearance: To complete a mental health evaluation, a patient must

be medically cleared and this is a requirement for all psychiatric facilities. A lot of patients would receive medical clearance but nurses were too busy to communicate this to unit secretaries. The ED uses a lot of travelers, most were not aware and sometimes forgot to pass on this information

I was able to identify the above issues last semester and I have set my project around them this semester. To decrease patient boarding time in the ED, assessments must be completed thoroughly in a timely fashion. All placements depend on these assessments, the more time patient board in the ED results into an increase in LOS. Through collaboration with crisis workers, psychiatric response team and nursing staff in the ED, an action plan was improvised.

The mental health evaluation log did not include the time patients had been in the ED. Patient names were written in the log based on when the RN alerted that unit secretary about medical clearance. We have now included a slot where LOS in hours is written to make certain that crisis workers complete mental health evaluations based on who has been hospitalized longer.

I have gone over the legal paperwork that is needed for minors before placement with crisis workers. I have also printed out a list for all required documents for them to refer to. Last semester, I was able to successfully educate staff on de-escalation techniques. During my clinical hours, I am available to de-escalate patients to prevent restraint use which affects LOS. Staff and security currently use restraints as a last resort. The hospital continues to work on providing crisis prevention training to all staff.

Results: In July 2015, we saw 180 psychiatric patients in the ED with average LOS =22.4 (refer to table below)

STAYS IN EXCESS OF 10 HOURS	32
STAYS IN EXCESS OF 20 HOURS	27
STAYS IN EXCESS OF 30 HOURS	43 @37, 35, 92
	33, 52, 57, 69, 53, 47, 66, 71, 72, 71, 29,
	65, 65, 42, 43, 56, 99, 54, 53, 49, 70, 43, 70,
	69, 50, 65, 56, 72, 40, 64, 64, 77, 47, 55, 39,
	54, 67, 46, 49, 90,
TOTAL PATIENTS	180
PATIENT WATCH HOURS	4039
AVERAGE LOS=	22.4

Conclusion: The project aim was to reduce LOS by 3 hours; this goal was not achieved. Numerous factors negatively affected this project such as, time constraints, travelers (inconsistency in staffing) and EHR. There was not enough time to train the staff on the proper use of the mental health log and mental health assessment. In addition, due to the implementation of the EHR in this same time frame, travel nurses were brought in to cover regular nurses who were being trained on EHR use. With the inconsistency in staffing, the log and assessment tools were not fully utilized hence affecting results

This project is very relevant to the nursing field because psychiatric patient boarding is a problem that affects all hospitals. More still the fact that patient boarding affects outcomes and most importantly jeopardizes safety of both staff and patients. As clinical nurse leaders, it is our duty to identify issues and solutions to help improve safety and outcomes. Reduction of patient boarding

times in ED impact nursing in that it helps in improving hospital quality, efficiency, and nursing care. A staff driven performance improvement project like this one supported by leadership improves both the quality and efficiency of hospital care thus better outcomes.

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FAAN

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