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Reducing the Time It Takes to Execute a Legal Hold on Patients Currently on a Voluntary Status and to Transport Them to a Locked Inpatient Psychiatric Facility

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Clinical Leadership Theme

This project focuses on the Clinical Nurse Leader curriculum element essential 3 of the CNL competency, which is "quality improvement and safety" (AACN, 2013). The clinical nurse leader's role is to serve as a team manager and educator to coordinate with other department heads to facilitate the implementation of a new policy and procedure. I will be leading the assessment of the legal hold process of transferring the patient from an offsite hospital location into a locked psychiatric inpatient unit.

Statement of the Problem

When a patient is deemed psychologically unstable and placed on a legal hold, his or her behavior is at the point of being unpredictable. The following step is to inform the patient that he or she is being placed on a legal hold. The risk of a patient's running away from potential captivity is a realistic one that leads to incident reports, the involvement of law enforcement, and poor patient outcome. Approximately 1,800 successful suicides occur each year, with half of those suicides occurring within a hospital (Reiling, 2008). This high level of risk is categorized as an acute crisis situation.

The most difficult obstacle in the process of stepping a patient up to inpatient is the time required and the multiple departments involved in the process. The logistics of transporting a suicidal patient from one building to another through a parking lot between a freeway and a busy street with average car speeds of 40 to 50 mph increases the risk of patients' becoming AWOL or injuring themselves and/or others. The use of one staff member to escort a patient to a particular unit requires going through anywhere from three to seven locked doors. This project's purpose is to reduce the amount of time and steps it takes to facilitate a patient transfer and to

notify multiple departments involved in the process of placing a patient on a legal hold to 30 minutes or less.

Project Overview

The proposed project in coordination with multiple department heads is focused on reducing the "step-up" process of a patient by 50% with a goal of 30 minutes. The plan is to assess and recommend redistribution of the amount of work and resources spent by each department in the process. The author of this paper's first hand experience has shown that this process is subjective to each staff member and which unit the patient is going to when it should be a uniform process that requires less uncertainty from each staff member.

The AIM statement of this project is to reduce the incidents of patient harm during transfer from voluntary outpatient status to 5150-inpatient status to less than 10% per month by September 30th 2016. We also aim to improve communication within departments resulting in less time spent on transporting a patient from outpatient site into a locked psychiatric facility. The process begins with a patient's presenting as a danger to self, danger to others, or gravely disabled. The process ends with a patient being transported to the appropriate psychiatric unit within a locked facility and a report given to unit staff. By working on the process, we expect improved communication within departments required for legal hold placement, faster facilitation of legal hold and transport of patient, improved staff satisfaction and productivity, and increased level of safety for staff and the patient.

It is vital to work on this now because patient turnover is rapid, and the average number of legal hold placements occurs once every 2 weeks. This is draining resources and time for staff already spread thin. It also presents safety risks in transporting unsearched

patients, from the outpatient into the inpatient hospital, deemed a danger to themselves and/or others with unpredictable behavior.

Rationale

A root cause analysis was undertaken to assess the factors contributing to the delay of transitioning a patient from outpatient to legally held inpatient (step-up). Surveys were conducted with the charge nurses of multiple units from chemical dependency, psychiatric ICU, adolescent, and "high-functioning" units. These surveys demonstrated that only 50% of the unit staff was familiar with the step-up process (see Appendix B). The field scenarios and interviews with administrative staff concluded that on average, a step-up process for one patient takes about 1 hour.

The cost analysis of this project would take 30 minutes of time from department heads of four departments. At $40 an hour, which is roughly $80 for one meeting to educate departments on the process and address any issues regarding a new policy. Another 30 minutes with eight inpatient psychiatric charge nurse units at roughly $30 an hour would equal $120 for 1 day of in-service on the unit. (See appendix A).

Methodology

The objective of facilitating a new policy and procedure for the step-up process is to reduce the time it takes to transition a patient from outpatient into the inpatient setting within 30 minutes. The change theory used in this project is Kotter's Eight Stages of Change to Guide the CNL (King & Gerard 2013). Creating a sense of urgency occurred via discussion within the outpatient clinic. The risks of safety to patients and staff were the primary concerns. This now has to be relayed to the other departments to provide an understanding of this project's urgency, which in turn creates a "guiding coalition" with the

power to lead and support a collaborative change effort (King & Gerard, 2013, p. 140). The

vision and strategy will be established in the policy and procedure, which will

communicate the change vision that is to reduce the amount of time it takes to step a

patient up into a locked psychiatric facility. By providing surveys to the staff and in-service

meetings with different units, the inpatient staff will be empowered and more efficient in

facilitating an inpatient admission from the outpatient clinic. Any reduction in time and

resources for the step-up process can be categorized in Kotter's change theory step 6,

which for the future can encompass steps 7 and 8 and that consolidates gains, produces

further change, and anchors new approaches in the culture (King & Gerard, 2013, p. 140).

When the project is implemented, continual assessment of the time it takes to

facilitate a step up of a patient from outpatient along with serving as the point of contact

from the other departments involved for any recommended changes for the process will be

my task. Post intervention surveys and time recorded from patient notes and reports will

serves as the data required to see whether any changes were successful for the project. My

predictions are that once the project details specific tasks within the new procedures that

all departments can agree upon, the project's time goal will be attainable.

Data Source/Literature Review

The study's focus regarding this project will be on every situation involved in a

patient being placed on a legal hold. Being the only registered nurse in the outpatient

program, I would be in the field within the microsystem and a part of virtually every

patient transfer from outpatient setting to inpatient hospital. This gives me the advantage

of being able to audit the process for the outpatient setting and to make adjustments as

necessary.

The next area of study will be upon my personal interaction with the admissions and records department and notification of the doctors. This process raised concern for the program initially because there was little uniformity in the process to help facilitate a patient being placed on a legal hold. Oftentimes, the patient is on standby in the lobby and is only visually observed by staff as we wait for admissions and records or the doctor to give permission and the location the patient is being transported to. This time lapse can increase a patient's paranoia exponentially as he or she waits for what is in store.

One factor that has never been assessed is an environmental one that comes into play regarding patient transfers. The facility design plays a significant role in lack of safety when only one staff member is available to transport a patient into the hospital setting. Loss of productivity can be attributed to poor communication with staff and with multiple opportunities for patients to escape and harm themselves. This risk is present in the architectural design of the hospital itself (Reiling, 2008)

Many of our patients have bipolar disorder and schizophrenia with history of self-harm and assaultive behavior. Assigning these types of patients to one person to escort them to the hospital poses a huge risk. Research has shown how patients who suffer from schizophrenia and paranoia and voicing statements of self-harm have twice the risk of carrying out successful suicides (Weiser, 2015).

The risks of self-harm by patients within an emergency room are documented to be extremely high when patients are placed on legal holds (Petrik, 2015). Factors include time, privacy, collaboration and consultation with other professionals, integration of a standard screening protocol, and a call for a more uniform standard procedure. These are the same challenges placed in the outpatient setting and pose even more danger because it

is in an environment with fewer resources, no security staff, and little control on patient

contraband.

The majority of staff currently lacks the field experience and training needed to

handle patients who are deemed a danger to themselves and/or a danger to others. People

placed on a legal hold for 72 hours have unpredictable behavior. In the field, experience has

shown only two licensed clinicians knowledgeable and comfortable in writing legal holds to

place patients within the inpatient setting. Having relatively new staff in the outpatient

setting can result in stress and frustration from the health team if they feel unprepared or

improperly trained. A 97% increase in work satisfaction was found with improved

productivity in hospital settings for staff dealing with suicidal patients (Wolfersdorm,

2015).

The risk of staff being hurt by patients when transporting them to the inpatient

setting is high because the staff members are alone for a distance of about 200 yards—

having to walk from the outpatient building, through a parking lot to the next building.

Some incidents that have already occurred include staff members needing to take stress

leave and requiring multiple sessions of debriefing and training due to traumatic stress if

from personal injury or witnessing patient self harm; other risks fall into the loss of

productivity by staff who have to deal with patient suicide and self harm (Matandela,

2016).

The two most popular categories of risk factors within a psychiatric hospital are

suicide risk and self-harm. These categories are further increased on days where there is

the lack of adequate number of staff to monitor patients and the time lapse in monitoring

patients properly (Erlangen 2016). Having only one member to transport an unpredictable

patient over a long distance puts the staff and general public at risk as well. Reducing the time it takes to transfer a patient will proportionally reduce the risk of patient harm to themselves and/or others.

Timeline

July 5, 2016: The first week will be used to present outpatient survey information to outpatient management to establish a sense of urgency so that by August 2016 a meeting with the department heads will occur in which to present the proposed new policy and procedure. This will include Social Services, Admissions and Records, Outpatient, the medical director, nursing management, and a hospital executive to approve the new policy.

Expected Results

The expected results will be an understanding of the importance of having a uniform policy and procedure that incorporates all involved departments in placing a patient on a legal hold. Although the process is similar to a patient's coming in from the emergency room, the situation is unique because lack of trained staff and extended time and opportunity for patients to harm themselves from the outpatient setting and into the inpatient setting. The expectation is that the new policy addressing each department's role will be agreed upon, signed, and implemented as new hospital policy and procedure for a patient step-up.

Nursing Relevance

The fact of the matter remains: President Obama's $150 million dollar proposal for mental health first aid has been on hold for the past few years, National Institute of Mental Health had to cut $12 million in government funding, 5% cutbacks on mental health have been ongoing every sequester, the Mental Health Parity Act of 2008 which was passed to

eliminate differences among insurers on copays and length of stay has not been enforced and Medicaid amendments for expansion of mental health funding has been rejected due to its affiliation with "Obama care" (Johnson A., Candisky C., 2013)

I believe that the current understanding of mental health and mental health facilities are being understood and less stigmatized. The world of mental health however appears to be the least value area of medical care in the United States based on the ongoing trends of government funding. With multiple mentally unstable individuals being presented in the media over the past decade, congress has attempted to pass more funding for mental health awareness but is going at a snails pace.

It is because of this lack of resources that many people are unaware of the risk to patients placed on legal holds. Thousands of attacks occur in hospitals every year and articles and research show that psychiatrists have up to a 48% chance of being attacked by a patient within their career and that odds are 50% health care workers will be assaulted within 4 years of their training (Rueve M. & Welton R. 2008). Although behavior can be unpredictable, we can implement countermeasures and defensive strategies to prepare for a worst-case scenario.

Summary Report

In summary, the objective of the CNL Internship Project is to improve the communication within departments involved in placing a patient on a legal hold when they are currently on a voluntary status. This process takes up to and often times over an hour when the process should not take more than 30 minutes if every department had a clear understanding of their roles with an administrative policy and procedure to back it up. The less time this process takes, the less chance for a patient to AWOL, less opportunity for

patient to act on self harm behavior and less chance for patient to assault staff members

and distract other patients who may be triggered by the presence of another unstable

patient that is requiring more attention from the outpatient team.

      This project applies to our population of patients enrolled in the outpatient program

who are stable enough to not be placed on a legal hold, but mentally acute enough that lack

of follow-up care from the outpatient program may result in their returning to the

psychiatric facility. The outpatient clinic is comprised of 5 different programs that include

partial hospitalization (patients who are at high risk of being placed on a legal hold),

intensive outpatient (patients are higher functioning but go to behavioral therapy 3 days a

week), dual diagnosis (this includes patients who need partial hospitalization coupled with

some kind of substance abuse program), adolescent program (13 years to 18 years old),

and chemical dependency program (patients are looking for coping skills regarding alcohol

and/or substance abuse).

      Methods used to implement this project include surveys of random departments

and staff involved in the step up process, GANTT chart for a measurable timeline, and

meeting with administrative personnel to draw attention and give suggestions on how to

address this particular area of concern. No methods were changed from the prospectus

other than having to reschedule meetings in the month of September due to the hospital

having a massive hiring orientation. An amendment I would add to the prospectus is

attempting to incorporate an in-service meeting during new hired nursing orientation to

teach about the outpatient program.

      Baseline data revealed that about 50% of unit staff were familiar with the existence

of the outpatient program (see Appendix B). A recent code blue situation which required

nurses from the hospital to run to the outpatient clinic due to a patient being unresponsive had multiple staff going to the wrong building because they did not even know where the clinic was located at in the parking lot. Lost time is lost resources which put staff and our patients at risk of having a poor patient outcome and when staff doesn't even know where to go during a code situation, that is telling of lack of proper training. This information proved useful in raising concern and need for this project.

The data that was collected showed to be as expected in regards to the little understanding from multiple departments about the outpatient program. The surveys and informal discussions with other staff usually will lead to questions of uncertainty in the roles they play when a patient is stepped up to the inpatient psychiatric hospital. In having these discussions, it was discovered that there did not even exist a formal policy and procedure with the admission and records office on how to step a patient up from the outpatient program. It was treated as a general patient admission but given the severity and high level of possible assault and AWOL, the concerns were raised that this process needs to have its own formal policy and procedure which is the main focus of the sustainability plan in keeping the changes put in place.

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Appendix A

Root Cause Analysis
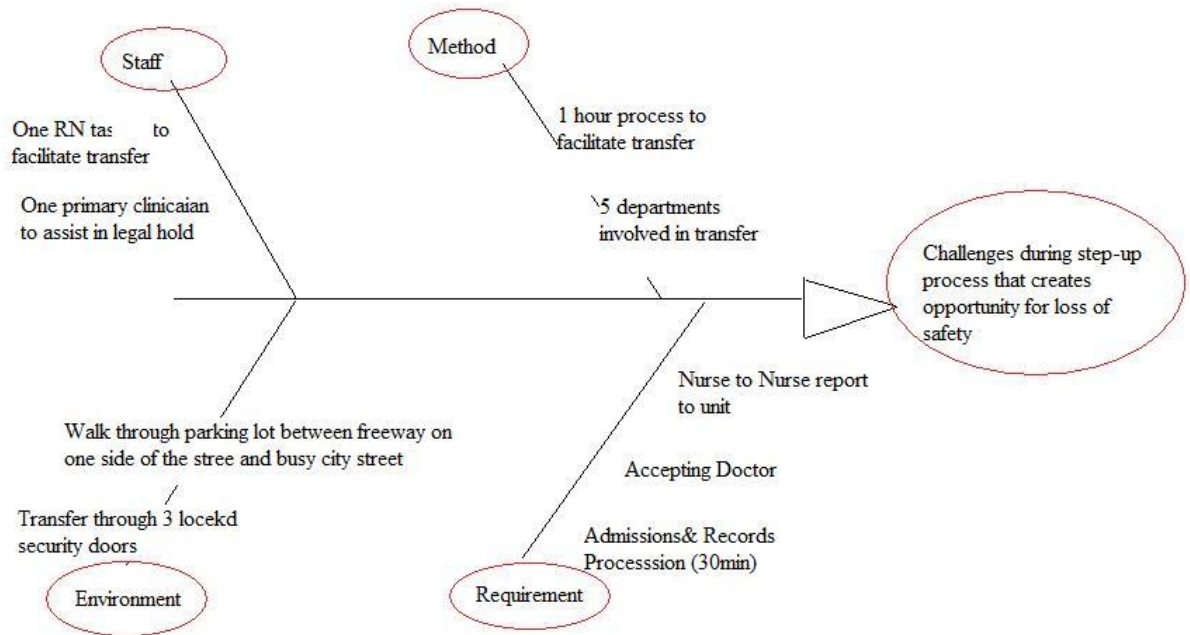
Appendix B

<u>GANTT CHART 2016</u>

	Jan-Feb	Mar-June	July-September
Microsystem Assessment	X		
Observation and Survey		X	
Development of Interventions		X	
In-service/Staff Meeting			X
Policy and Procedure Presentation			X
Post-Intervention Collection			

Appendix C

Outpatient Nursing Survey

Name:_____

Unit:_____

Answer the questions using the following scale:
4=Strongly Agree, 3=Agree, 2=Disagree, 1=Strongly Disagree

1. I know what the outpatient building is. (Where it is, what they do, how it affects you?)

2. If I received notification of an outpatient step up, I am familiar with the transfer process

3. If there was a code in the outpatient building, I would know where to go

4. If I have questions about my patient on the unit who was just transferred from outpatient, I know who I would contact in the outpatient building?

Appendix D

<u>SWOT ANALYSIS</u>