MyED Touchpoints - patients with mental health conditions

Summary:

MH patients perceive the ED as a safe place to come for care when they need help, and/or when they are feeling unsafe. They also may be referred to ED from community providers. Patients confirm that prolonged waiting times in the ED environment heighten their anxiety. On seeing other sick patients in the ED, some feel that their need is less important and that they should just leave. MH patients generally want to be understood, receive reassurance, be informed, have access to their usual medications, and be able to rest.

An estimated 10-12 presentations per day (~5%) to Blacktown and Westmead EDs are MH-related. Managing patients presenting with MH concerns should be viewed as core business for EDs, similarly to patients presenting with physical health issues, however access to specialist staff and inpatient beds/units have not kept pace with demand. ED staff are concerned about long wait times, escalating patient behaviour, and harm to staff and patients and identify a need for streaming patients to different care models. Rigid criteria currently used to separate services are unhelpful, and a collaborative, all-of-service approach is required to codesign:

A. Earlier clinical review and inhouse process improvements to support patients presenting to ED. For example, reassurance, communication, finding out their communication needs, checking in, ways of finding quiet or distraction, design of spaces, early appropriate referral to community services such as PACER, Safehaven, etc. This may be in conjunction with:
B. Integrated models of care, treatment and support for patients who are acutely intoxicated, presenting with/at risk of acute, severe behavioural disturbance associated with substance use, psychiatric conditions, or other co-occurring health conditions.

*** Step 1.1 – Non-participant observations**

At Mount Druitt, patients needing admission transferred to Blacktown (mostly); there were long delays for both initial assessment (via iPad) and transport. At Blacktown and Westmead EDs, MH patients, scheduled and unscheduled, occupied acute beds or chairs among the general patient population or waited in the waiting room or corridors. Duress alarms were available to staff; Blacktown staff had heightened awareness following recent episodes with aggressive patients.

Two different MH service models operated at Blacktown and Westmead to better manage patients presenting to ED for MH care. A Psychiatric Emergency Care Centre (PECC), under the governance of MH services, operated adjacent to the Blacktown ED. Strict inclusion and exclusion admission criteria meant patients who were scheduled, in police custody, had concurrent medical issues (e.g. intoxicated or sedated) or had acute severe behavioural disturbances remained in the main ED. Escalating patient behaviour, several Code Black calls, and use of physical and mechanical restraint were observed in ED during the observed shifts. At Westmead, a Consultation Liaison (CL), or EDMH model, operated under the governance of the ED where 6 ED beds had been quarantined as an MH pod, staffed with MH nurses. Intoxicated or aggressive patients and the elderly were excluded. The MH pod was often full, so patients waited in the ED waiting room or corridors.

*** Step 1.2 – Interviews with providers**

43 interviews with 44 ED staff were conducted. Staff commented that MH presentations were generally not seen in a timely manner. The prolonged physical and MH assessments were sometimes viewed as unnecessary, while only a subset of patients were considered to have more complex comorbid physical and mental health concerns. ED staff also referred to intoxicated patients as they perceived a lot of comorbid substance use in their MH patient presentations. Clinically unwell patients were often prioritised for ED beds ahead of MH patients as MH patients were often younger and ambulant. Staff perceived MH patients were wronged and sometimes harmed by the lack of timely care afforded them. Sometimes patients harmed themselves in the ED or left the ED. Harm, to patients or staff, caused considerable staff distress.

Three main themes:

1. *Threats to safety:* ED staff perceived long wait times in a high stimulus environment compounded patient agitation leading to aggressive behaviour that threatened the safety of the patient, staff and others in the environment. Some patients demonstrated challenging behaviour requiring restraint (physical, chemical and/or mechanical) to keep themselves, other patients, and staff safe. The Code Black response that was instituted in 2021 had helped manage aggressive behaviour, but this was also resource-intensive in a busy ED environment. Many staff believed an earlier clinical review (therapeutic response) for MH patients would alleviate a lot of patient's escalating behaviour and provide patients with required care, preferencing this ahead of a later security response only.
2. *Need for an earlier clinical review (therapeutic response):* The importance of interpersonal skills – active listening, reassurance, accommodating smoking, as well as access to usual medications (eg anxiolytics), or calming medications (eg benzodiazepines), to assist MH patients in ED and mitigate agitation.
3. *Problems with the organisation of services*: Staff thought the process of physical and MH assessment to be overly long and believed there was need for better organisation, stratification and earlier streaming of MH patients to appropriate care.

'But for some reason, the model of care that pertains to this ED … is that every patient presenting with a mental health problem automatically has to wait for a mental health assessment by a psychiatrist or a mental health clinical nurse consultant. That means there's not a lot of ownership of the mental health issues that we have, like not all patients who present need a detailed mental health assessment. They're probably connected to services, they're known to community health, they're having a crisis and I've seen this type of patient managed earlier in their journey without having to wait. The consequence of having to wait is overcrowding, bed block and poor flow and that's incredibly poor. It involves patients waiting inordinate amounts of time, like 12 hours, 24 hours, two days, three days, for this type of processing to happen.'

ED1 – Mount Druitt – For MH patients presenting at Mount Druitt, MH assessment was difficult (sometimes completed from a distance over an iPad) and there was a long wait for transport to ED2. There was some misunderstanding about lifting the MH Act order for sectioned patients.

ED2 – Blacktown - *ED staff perspectives of the PECC*

When staff moved to the new unit they believed the PECC, with specialist MH staff, may be part of ED, accepting their high-risk patients. Instead, the PECC received 'lower risk' patients who require a short stay (up to a week) and then are discharged to the community. Staff perceived

this to be the minority of their MH patients, leaving those requiring specialised psychiatric care in ED for non-specialist staff to manage. This did not make logical sense to ED staff, whose frustration was compounded by a perceived staff to patient ratio in PECC that exceeded that in the ED and low risk patients lying in the corridor in ED waiting for an available bed in the PECC because PECC would not accept them without an available bed space. And when PECC required medical assistance (MET or Code call), ED staff were obligated to respond immediately.

'We'd be able to manage them here. Probably get them discharged from here but they're going there. They've got three nurses over there. They've got the CNC sitting there. There's lots of resources in there that we could really use out here.'

ED3 – Westmead - *ED staff perspectives of the EDMH pod*

At the time of interviews, ED staff believed the MH pod had impacted the ED positively with many high-risk patients under the care of specialist mental health staff. However, the MH pod was still seen as a high-stimulus environment. Inability to admit or transfer patients meant the pod was often full, so MH patients continued to wait in corridors and chairs. Staff identified a PECC model might assist with providing a low-stimulus environment for some.

All EDs – Main ideas for improvement

- ~ Early clinical review (therapeutic intervention) including low stimulus environment
- ~ Early risk stratification of MH patients to different MoC
- ~ Equitable bed space allocation for Cat 2 MH and Cat 2 medical patients

<u>*Step 1.3a – Interviews with Users</u>

Interviews were conducted with 29 patients when they were ready for discharge from the ED.16 were at WM EDMH pod and 13 at Blacktown PECC; 16 arrived by ambulance, 2 were escorted by police, 9 self-presented with/without family, and it was unclear how 2 patients arrived. Patients viewed ED as a safe place to come for care. Patients confirmed that (if they are conscious when they arrive), they are highly anxious and/or have limited capacity to think and/or self-regulate emotions/behaviours, and the high stimulus environment increased their agitation.

Main themes across both EDs

1. *Physical Environment:* The noise, inability to get sleep or find quiet is annoying, irritating, and aggravating. Patients feel unsafe and vulnerable mixed in with prisoners and high-acuity MH patients. Bathroom facilities are inadequate for the number of patients. A significant portion are smokers/need access to outside. There is little privacy.

2. *Patient needs while waiting:* Sleep is important to this cohort; they want to sleep while awaiting care planning, however this is often difficult due to the lack of beds and private spaces – eg some patients left and went home to bed before being seen. Medications given to alleviate anxiety cause drowsiness, increasing the need for sleep, but waiting areas and chairs are not conducive to sleep and patients reported feeling unsafe dozing off in busy areas with people coming and going.

'Because Olanzapine, it did help me – it helps me soothe in the sense that I just kind of went drowsy and it was like, you know. But I was still hurting. I knew that I was a risk to myself, but I was left in the waiting room. If you're alone and you're sleeping in a waiting room and people are unwell and you're unwell mentally and not in a good head space, it doesn't feel very safe. It

doesn't feel very confidential. It doesn't feel like people are there for you because the only questions that I was asked by the staff beforehand was just, 'How old are you? What medications have you had?'

- While they are waiting for long periods, patients sometimes missed their usual medications (eg anxiolytics).
- Patients expressed a need for reassurance from staff – that they are in the right place and their need is important (as they see lots of physically unwell people and so think that they should not be there/not important and should leave). They want to know what to expect, and how they can get help if something changes eg they start to feel overwhelmed

'I think they just need to come and say 'hi' to you every two hours or something, or an hour and say 'hey'. I was sort of getting – I thought it was like I shouldn't be here, I should go [laughs]. That sort of vibe. Then getting told that I have to stay, I think if they just came passed and reassured me, especially with this psych,, because where I was at, at that point, which was not good. If you just come back and, 'hey, it's all right, you are doing the right thing being here'.

- Some patients want complete silence, while others need activities to distract them from negative, unhelpful thoughts.
- Patients often have family responsibilities so want to be able to communicate with family and friends about their children or others or talk with their family.
- Some patients have had poor ED/healthcare experiences in the past, so have heightened sensitivity to staff attitudes/behaviours, and can misinterpret these as negative.

3. *Communication:* examples of both good and poor communication were reported.

- Good communication and supportive behaviour from staff is compassionate, reassuring, kind, non-judgemental, validating, tells them who will be looking after them, are approachable, ask them about their needs, check in on them regularly to make sure they are okay and to reassure them and keep them calm, protect their sleep, make sure they get access to food and drink, recognise their vulnerability, and 'see the person behind the mental illness', communicate the plan for their care, and are reliable.
- Many patients reported a need for more information about involuntary care under the MH Act, what it is, what it means for them, why the order has been made, what their rights are, why they must be escorted everywhere, when it will be withdrawn.

'I'm not really happy with anything, to be honest. But, I guess, happy? No, I'm scared. I don't know, I want to be treated like a - I don't know. I know I'm a patient, but I feel like a criminal, like I'm going to be trapped.'

- As patients are in ED for days and with different staff, they are sometimes told conflicting things about when they will get care, a bed etc. Truth is imperative but uncertainty is not always helpful eg instead of saying that it is not known when they will get a bed/see a doctor, communicate that the person is being cared for now and what can be done for them while they are waiting for the next intervention/plan

'Knowing there's five people in front of me is not - that's actually quite scary because - and it makes it seem like there's no triage process. I think it would be better if they just stuck with something reassuring and they were like, 'we're able to care for you in some other ways until you can get to the other kind of care. Let us know how we can care for you', or something.'

- There may be a need to speak more slowly than usual, and repeat messaging as medication and/or MH condition sometimes makes patients memory of communication vague.

4. *Support:* Family/friend support is highly valued. Family can advocate for the person when they are feeling too vulnerable/fragile to make inquiries or requests on their own, provide reassuring company, and to look out for them while they sleep.

Patient perspectives of the different ED MH models

PECC: Patients found the PECC a safe space to be – it is quiet, friendly, reassuring, care is MH-specific, secure (they don't have to worry about absconding and hurting themselves or others, but can move around without close escort from security), they can engage with patients like them, they don't feel rushed to get out of the bedspace and value being able to take 1-2 extra days to feel comfortable before discharge as they recognise from previous experience that their anxiety will be heightened on discharge particularly if not prepared/linked with services and that this increases their risk of relapse.

'It's a lot calmer here, and it was a lot easier to bring myself down and settle myself down here, once I'd gotten myself into a bed. Because it's just very loud out in the ED. There's not much you can do about that, that's just a crowd of people. Even if they are trying to be quiet, there's always going to be some level of noise.'

EDMH: Patients do not escape the noisy, bright ED environment. There remains a lack of privacy, and they do not like being mixed with high acuity patients and those in custody which makes them feel vulnerable, scared, and like they don't belong.

'I am pretty vulnerable right now...Obviously you can't get separate rooms and stuff, but I think it's listening to everyone else and it's like, I don't know, the curtains don't provide much of anything. Then obviously you overhear some conversations and stuff and then the conversations are a bit overwhelming. I don't know, that makes me put things into perspective, like I don't belong here.'

'I do feel safe. I feel sorry for them. Some of them are suffering a lot. Physically, or whatever. Mentally. Some of them are really old. Like, there's a really old lady by the toilet on the other side who keeps screaming for her mum, which is pretty sad. She's very old. Yeah. But it does get annoying, as well. Like, kind of, it's not like fear, it's more just, they get annoying. At the moment, I'm very sensitive to really loud noises and it does get annoying.'

Main areas identified for improvement:

- *Patient care while waiting* – if not a shorter wait time, then getting access to what they need during the waiting time – reassurance that they are in the right place and are being cared for now, medication to alleviate anxiety, attendance to basic care needs including sleep, quiet or distraction, personal hygiene and if necessary, wound management. Good communication, including regular support/checking in from ED staff, especially when in waiting room.
- Some separation of lower and higher acuity patients.

Step 1.3b – Interviews with Epistemic experts

Epistemic experts were included as a source of knowledge of MH patient experience for the MH cohort as we were initially concerned about low sample numbers. 16 epistemic experts were interviewed, 7 were MH specialist doctors and 9 were MH advanced practice nurses;12 worked at WSLHD, and 4 worked in other Sydney hospitals. Focussing on ED, the following themes were found:

1. *Increasing demand for ED care outpacing adapted resources:* All acknowledged the demand for ED care is overwhelming and resources, including specialist staff and beds/units, has not kept pace with demand. Patients often have poor experience/outcomes in ED through prolonged waits in the high stimulus environment with heightened anxiety and increasing overwhelm.
2. *Need for different models of care:* Different MH models of care are required to better manage demand and stream patients earlier into most appropriate care.

Touchpoints:

The areas concern as indicated in the WDA were 'patient management', 'care decisions and pathways', and 'communication'. Triangulating all data, the issues identified as common concerns for potential ED improvement are:

- Earlier clinical review and inhouse process improvements to support patients presenting to ED. For example, reassurance, communication, finding out their communication needs, checking in, ways of finding quiet or distraction, design of spaces, early appropriate referral to community services such as PACER, Safehaven, etc. This may be in conjunction with:

- Integrated models of care, treatment and support for patients who are acutely intoxicated, presenting with/at risk of, acute, severe behavioural disturbance associated with substance use, psychiatric conditions, other co-occurring health conditions.