Responding to the problem of conflict and containment in emergency departments

Towards an integrated Model of Care

Royal College of Nursing Conference 2019

05.09.2019 Sheffield Hallam University City Campus

Abstract 0353

Symposium 16

Setting the scene

Acknowledgements

Staff of the Royal Melbourne Hospital Emergency Department

Professor George Braitberg and A/Prof Jonathan Knott **Centre for Integrated Critical Care The University of Melbourne**

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- North Western Mental Health
- Melbourne Health
- Victorian Department of Health and Human Services
- VMIA
- Pathtech Pty Ltd

Overview

Restrictive Interventions in Emergency Departments: ***An Australian Perspective***

Knott J, Gerdtz M, Dobson S, **DANIEL C**, Graudins A, Mitra B Bartley B Chapman P.

Behavioural Assessment Unit: ***A New Model of Care for Patients with Complex Psychosocial Needs***

Braitberg G, Gerdtz M, **HARDING S**, Knott J, Pincus S, Thompson M, Yap, Kong D, Taylor D, Stewart K.

Screening and Brief Intervention for Drug Use in the Emergency Department: ***Perspectives of Nurses and Consumers***

GERDTZ M, Yap C, Daniel C, Knott J.

Adapting and implementing Safewards for Emergency Departments

Gerdtz. M, **DANIEL** C, Corrales, M, Ryan, A, Rosenbauer, M, Bendall, K.

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Restrictive Interventions in Emergency Departments:

An Australian Perspective

Knott J, Gerdtz M, Dobson S, DANIEL C, Graudins A, Mitra B Bartley B Chapman P.

Background

Restrictive interventions (RI)

-mechanical restraint

-physical restraint

-sedation

Risk identified = restrictive interventions may be used

RI= Victoria, MHA has clear guidance

Acute care settings, including EDs, RI are guided by hospital procedures Duty of Care (DOC)

Care/authorisation/governance are not consistent

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Management of Behavioural Emergencies

Source: News Corp Australia, 22 Aug 2015

Methods

Five EDs within Victoria were chosen to provide a cross-section of acute hospital settings

All sites provide occupational violence and aggression management training to staff

All presentation to the ED within the period of January 1st 2016 to December 31st 2016

Data

All data was obtained from the clinical information systems

Linked to Code Grey events

Sample was 100 ED patients who had a Code Grey who had a least one restrictive intervention

Manual extraction of data from the clinical records was then undertaken

Results

Overall the five sites had 327 454 patients in 2016

Age: median 40 (24-63)

Male: 52%

Presentation

Self	69%
Ambulance	30%
Police	1%

Code Grey results

One site excluded; for the remaining four

3871 consumers had a Code Grey (1.5%)

1-14 Codes per person

Consumers who had a Code Grey were more likely to be:

male (59% versus 41%)

younger (median age 36, IQR: 27-44)

Most consumers who had a Code Grey were given a final discharge diagnosis related to a mental health issue (59%).

Those with a toxicological issue made up a significant minority (20%).

A higher proportion of patients with a Code Grey were admitted:

- to an observation unit 32%
- to a mental health ward 17%

For those consumers who had a Code Grey:

942 (22.7%) had at least one restrictive intervention

Mental Health Act

	N=494	(%)
MHA status on arrival	n	(%)
No status	147	(30)
Section 351	254	(51)
Assessment order	11	(2)
Involuntary treatment order	20	(4)
Unknown	62	(13)
MHA status at 1st intervention - n (%)		
Duty of Care	311	(63)
Assessment order	108	(22)
Involuntary treatment order	10	(2)
Unknown	65	(13)

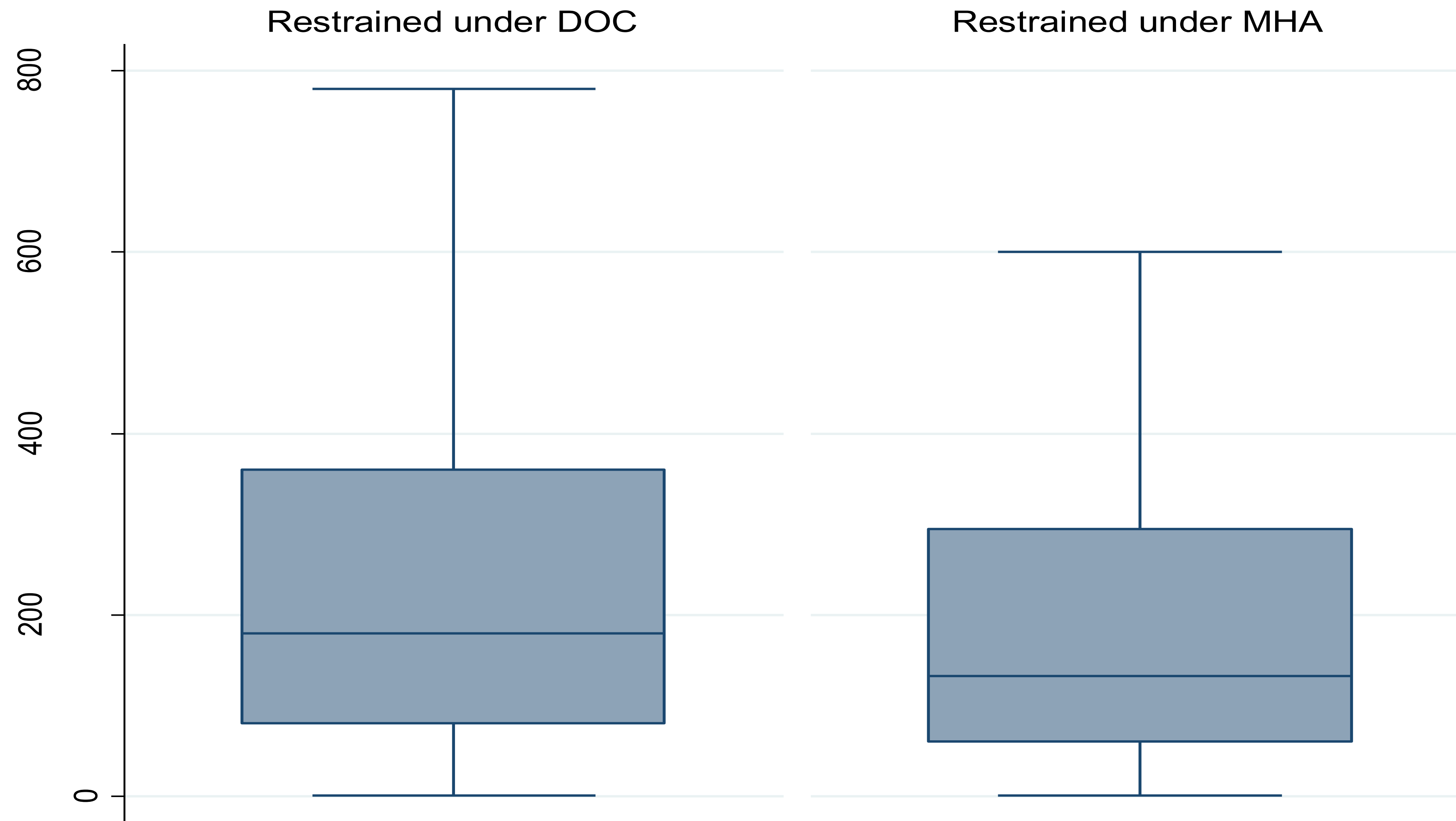
Reason for Restraint

	n=494	(%)
Reason for restraint - n (%)		
Aggression / Agitation	371	(75)
Risk of harm to self or others	218	(44)
Risk of absconding	140	(28)
Attempting to self-harm	110	(22)
Refusal of medication	101	(20)
Damaging property	36	(7)
Trauma care	8	(2)
Unknown	19	(4)

Disposition

	n=494	%
Discharge Diagnosis Category - n (%)		
Mental Health	265	(53)
Toxicology	125	(25)
Trauma	42	(9)
Other	60	(12)
Unknown	4	(1)
Disposition - n (%)		
Home	139	(28)
Observation medicine	112	(23)
General ward	103	(21)
Mental Health ward	81	(16)
Critical Care	13	(3)
Correctional facility	10	(2)
Inter-hospital transfer	5	(1)
Left at own risk	31	(6)

Length of stay



Discussion

Majority of RI required in the ED is via DOC

Unlike MHA, there is no standardised state-wide process or documentation of restraint use- high risk intervention that is occurring but we don't know how often

More than half the patients who received a restrictive intervention were subsequently admitted to an observation ward or sent home from the ED

Less than one in six were admitted to a mental health ward.

Limitations

Accurate reporting of Code Grey rates depends on adequate, standardised data collection.

All five sites had differing systems for recording Code Grey data and the use of restrictive interventions.

No organisation had a dedicated system for recording restrictive interventions or the MHA status at the time of the intervention.

Documentation at the sites varied with four of five using paper–based forms for recording restrictive interventions that occurred under a DOC.

The more detailed data required manual extraction and the records are not standardised.

Recommendations

A framework for the governance of restrictive interventions in acute settings needs to be developed (Residential Care/Aged Care Act, MHA, acute health policies)

The use of restrictive interventions in the ED should be clearly documented using a standardised tool

The rate of Code Greys and restrictive interventions should be reported to organisational occupational violence and aggression committees “dashboards”

Recommendations

Interventions should be a component of a program of recovery-orientated, **trauma-informed care**.

Behaviours of Concern should be managed in way that shows decency, humanity and respect for individual rights, while effectively managing risk/need for treatment.

Training for staff in ED should consider a cross-cultural approach involving ED clinical staff and mental health clinicians familiar with the ED working environment

Models of care should be developed that emphasise low stimulus, high resource environments that combine acute and mental health care.

Behavioural Assessment Unit:

A New Model of Care for Patients with Complex Psychosocial Needs

Braitberg G, Gerdtz M, HARDING S, Knott J, Pincus S, Thompson M, Yap, Kong D, Taylor D, Stewart K.

The Royal Melbourne Hospital Emergency Department

- Level 1 – State Trauma Service
- 80,000 ED presentations per year
- 60% presentations are Cat 1, 2 or 3
- Admission rate 50%
- 50% admissions to SSU/BAU
- ED team
  - *220+ Nurses*
  - *75 Medical staff*
  - *26 EDAs*
  - *30 Clerical staff*
  - *15 Allied health*
- Overall presentations are up 6.8% year on year

Melbourne Health

- Largest provider of mental health services in Victoria
- Services over 1.2 million people
- Six programs spanning 32 sites

BEDS ACROSS MELBOURNE HEALTH

714

Beds at RMH City and Royal Park Campuses

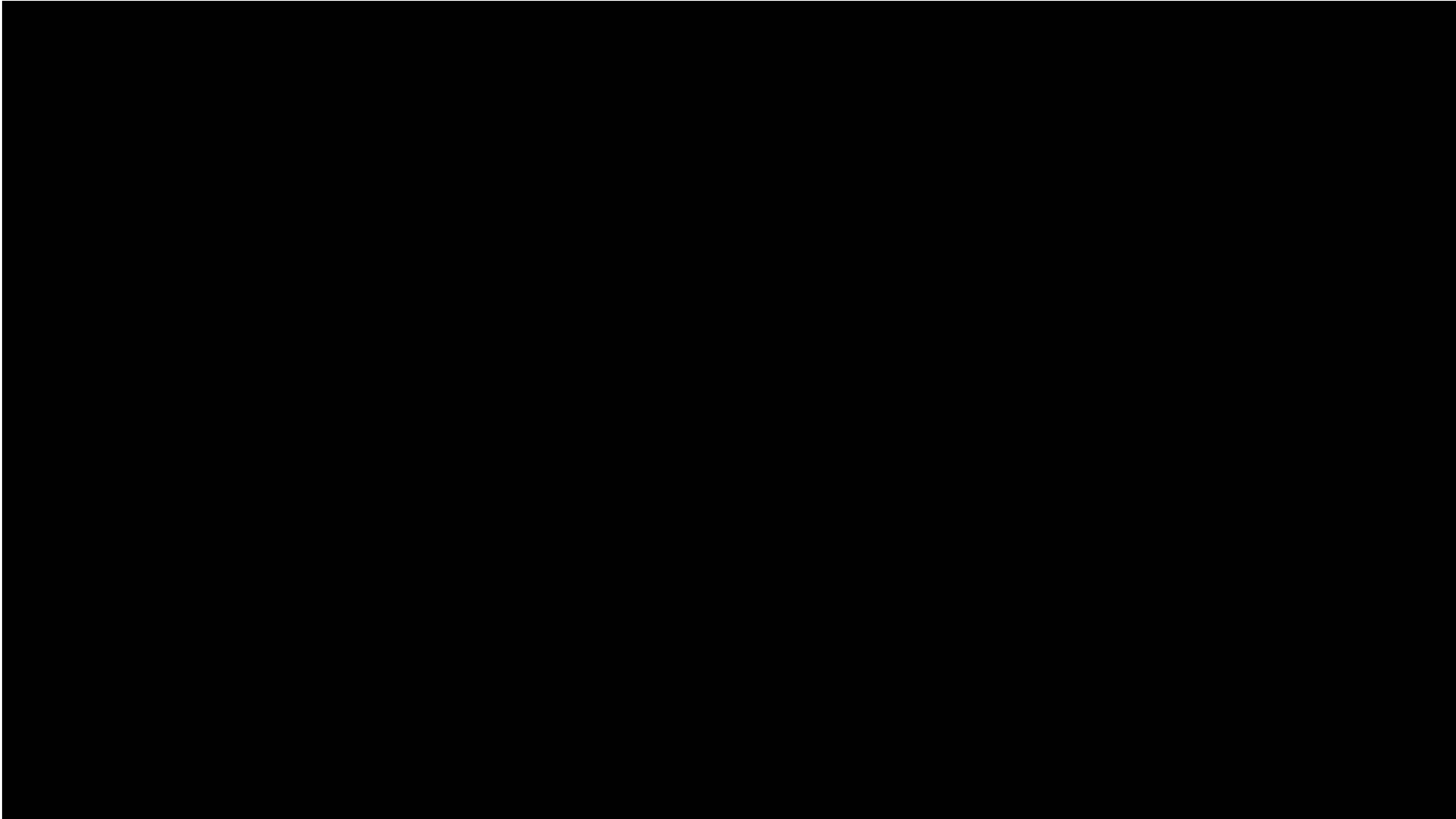
137

Residential Aged Care beds

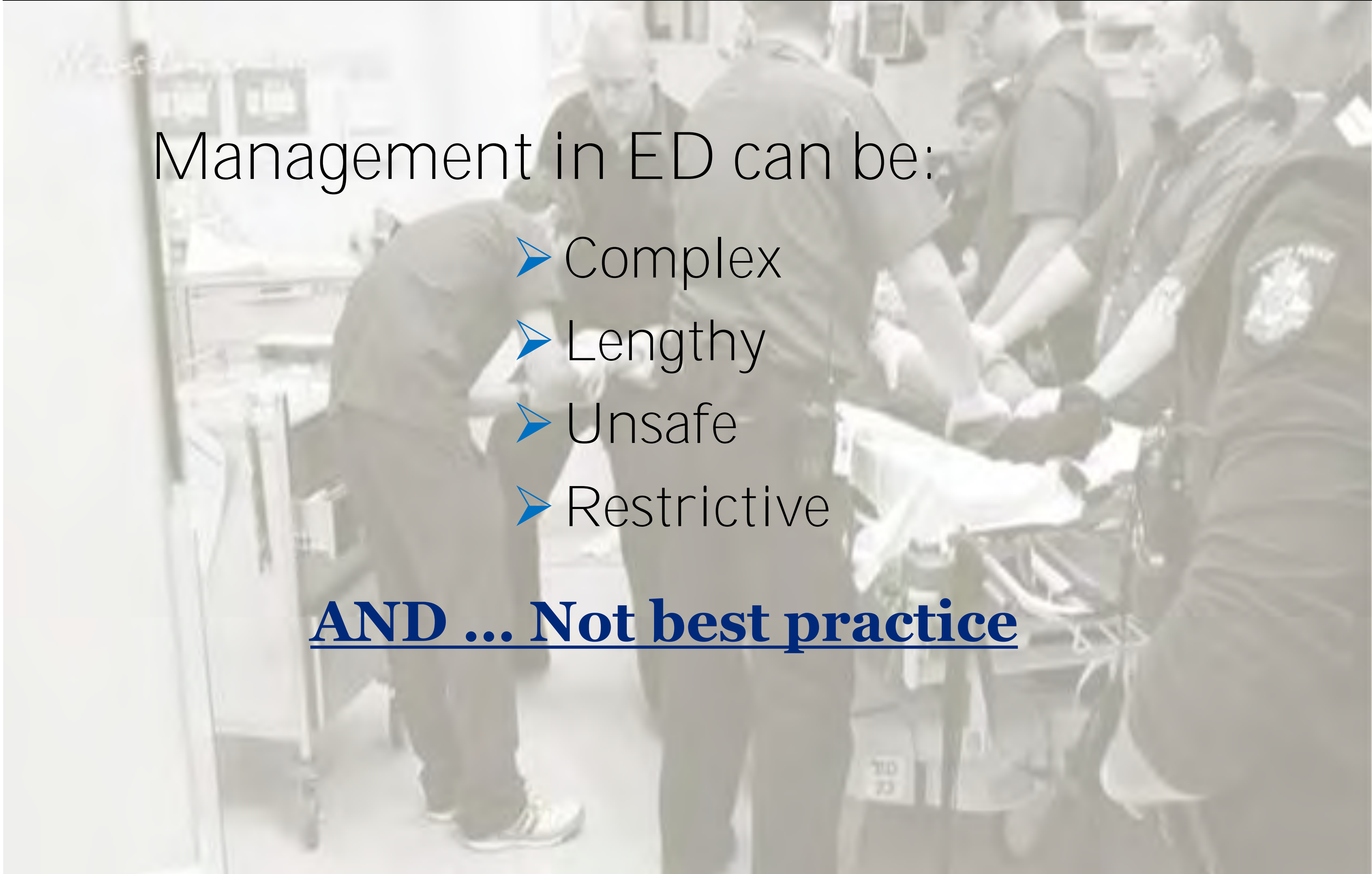
502

Mental Health beds

LINE
OF FIRE
9NEWS



Behavioural Emergencies

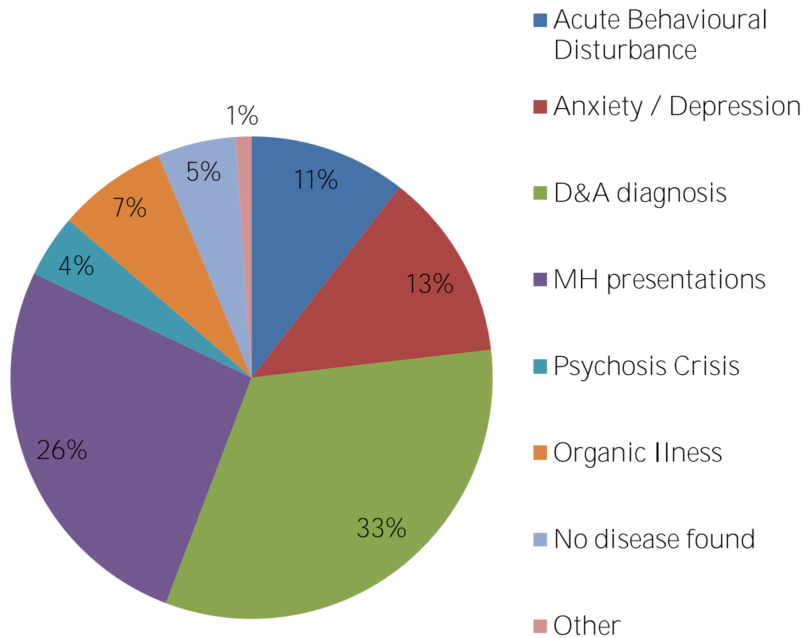


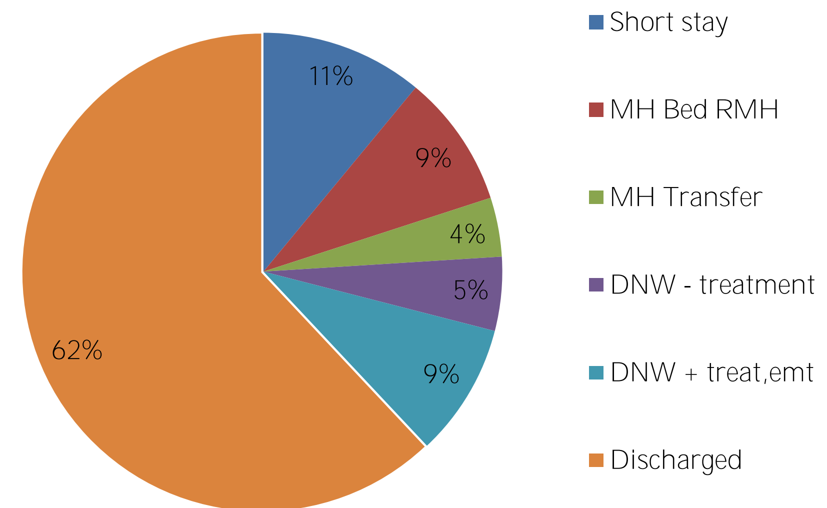
Management in ED can be:

- Complex
- Lengthy
- Unsafe
- Restrictive

AND … Not best practice

What we knew





RMH ED BAU

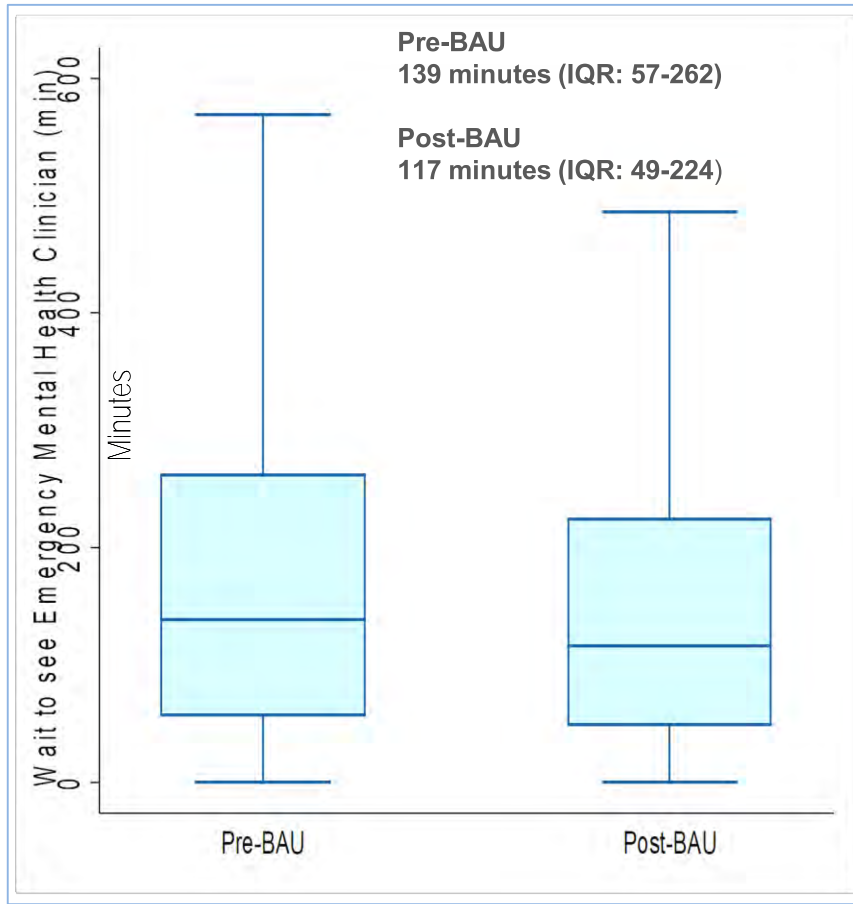
The BAU was established to provide a safe and therapeutic environment for our patients

1. A dedicated 6 bed area within our OM unit
2. 2:1 nurse patient ratio to service the toxicology cohort
3. Co-located Emergency Mental Health & Drug & Alcohol

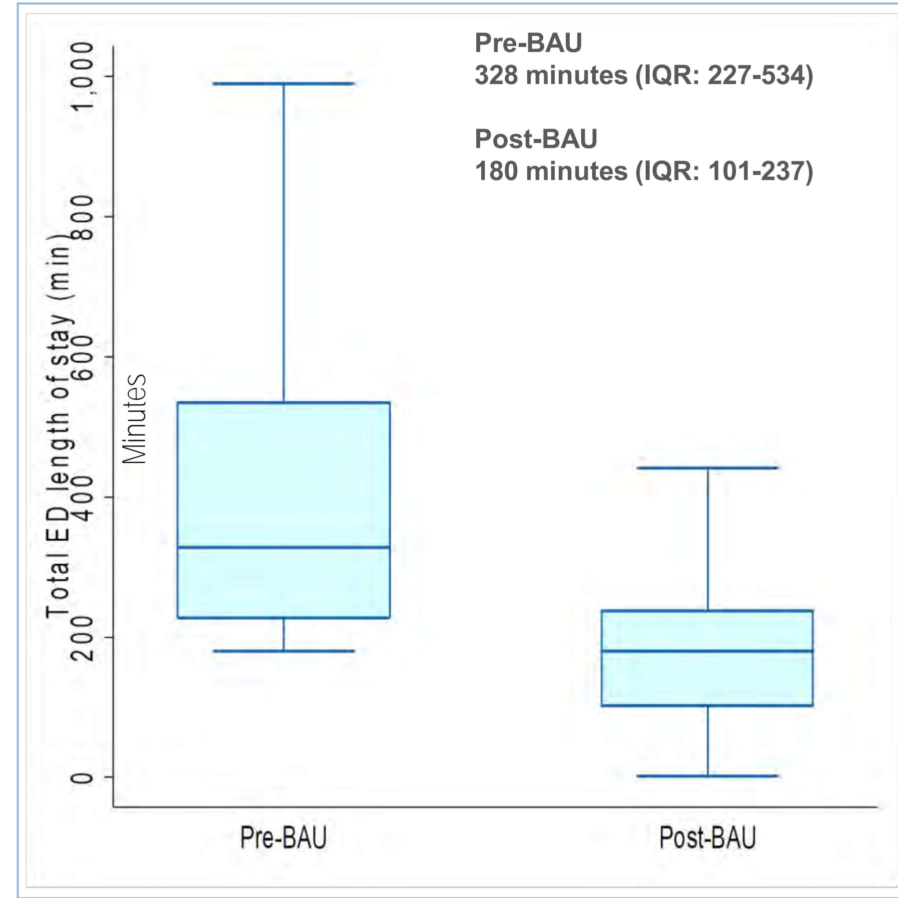
BAU = safe, timely, person centred care:
The right patient to the right bed in the right timeframe

Pre & Post BAU

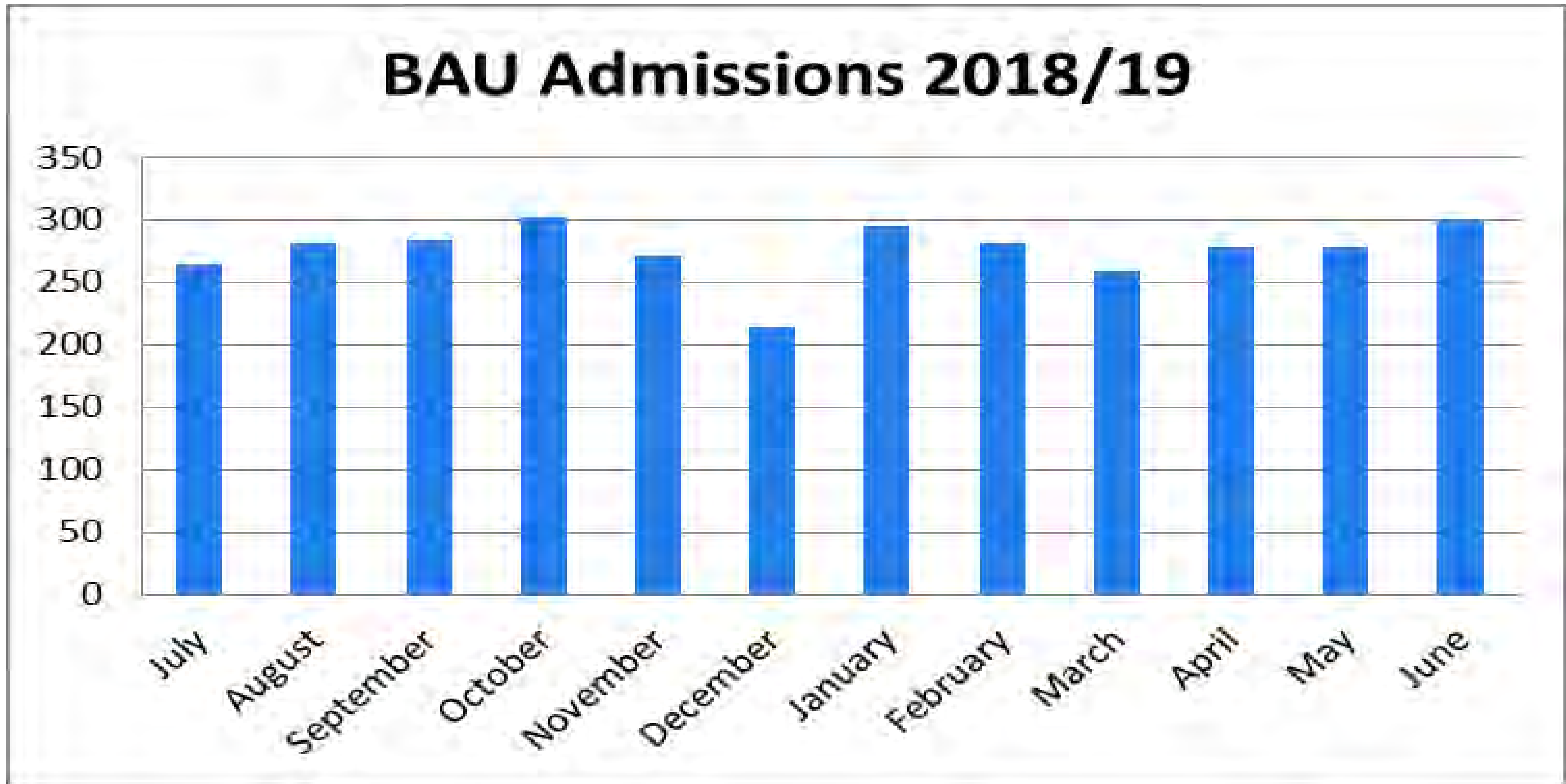
Waiting time to EMH



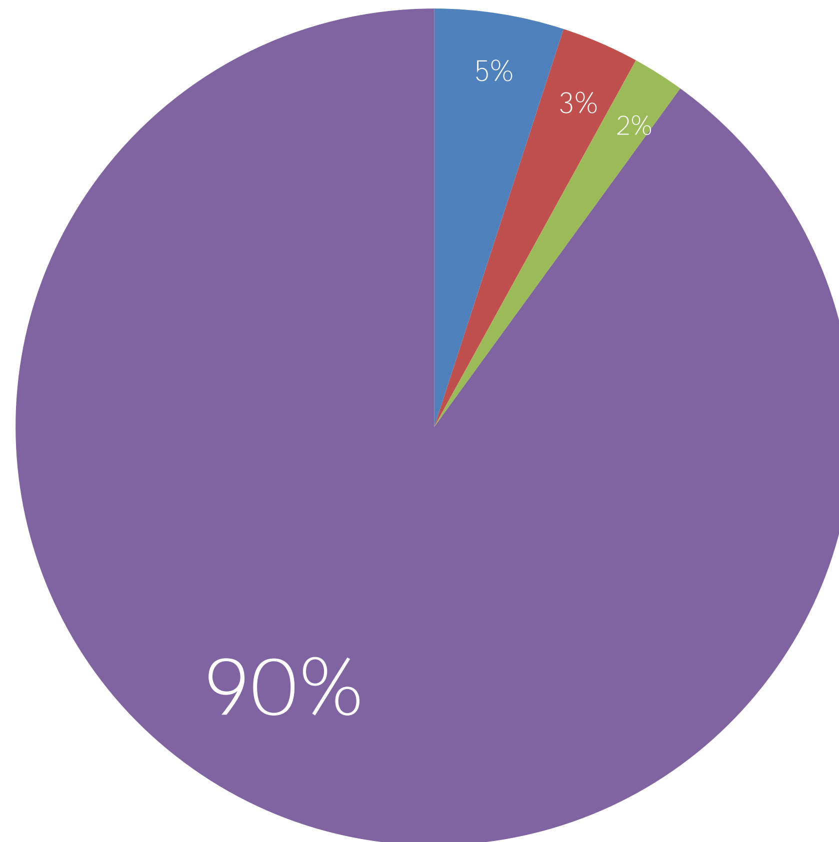
ED Length of stay



Admissions to BAU 3 years on

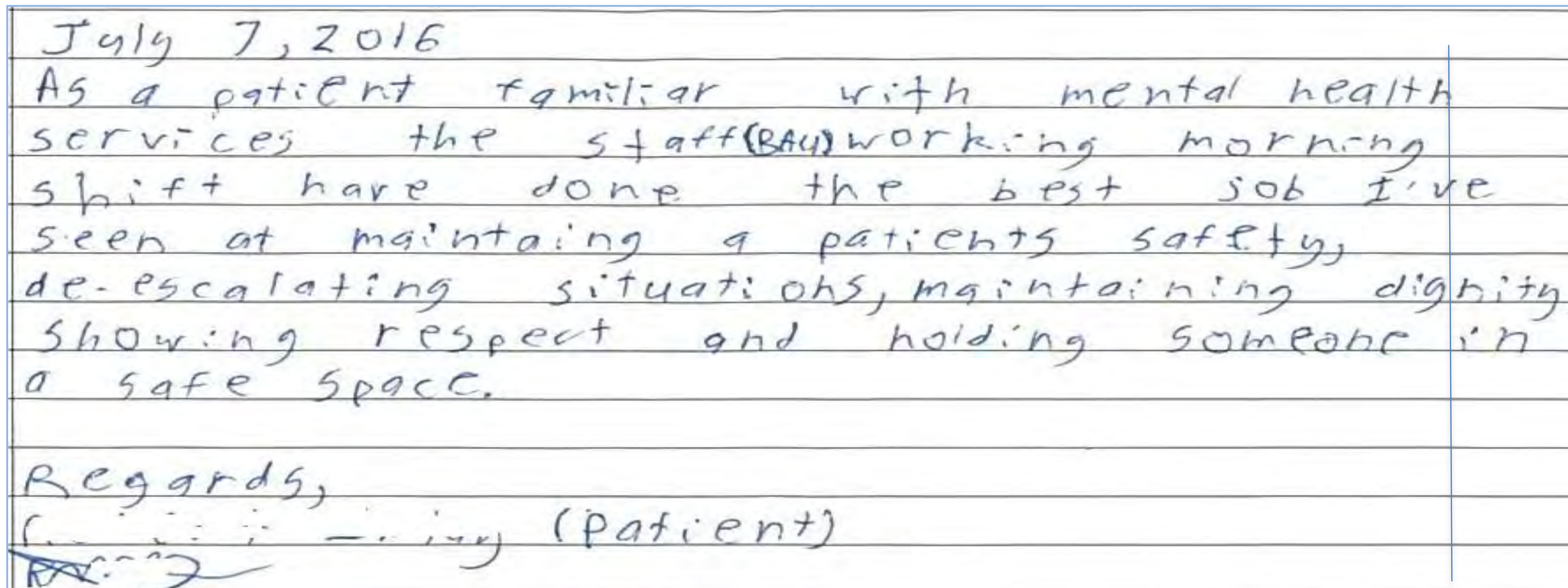


Disposition from BAU 18/19



Conclusion

- Best practice does exist – trust in S.T.E.P
- ED patients with complex psycho-social issues can be moved to an alternative space, rather than the ED
- The BAU model of care improves ED flow and reduces some restrictive interventions
- Patients appreciate the safer environment



July 7, 2016

As a patient familiar with mental health services the staff (BAU) working morning shift have done the best job I've seen at maintaining a patients safety, de-escalating situations, maintaining dignity, showing respect and holding someone in a safe space.

Regards,

[illegible] (patient)

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Screening and Brief Intervention for Drug Use in the Emergency Department:

Perspectives of Nurses and Consumers

GERDTZ M, Yap C, Daniel C, Knott J.

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Background

- The emergency department (ED) represents **a frontline point of access** for people with acute behavioral disturbances and concurrent illicit drug use [1]

- **Differentiating the cause of acute behavioural disturbance in the ED is both complex and challenging**, especially when behaviour threatens staff safety [2,]

1. Rikki, J., Cindy, W. & Kim, U. 2018. Rates and features of methamphetamine-related presentations to emergency departments: An integrative literature review. Journal of Clinical Nursing, 27, 2569-2582.
2. Sibanda, N. C., Kornhaber, R., Hunt, G. E., Morley, K. & Cleary, M. (2019). Prevalence and Risk Factors of Emergency Department Presentations with Methamphetamine Intoxication or Dependence: A Systematic Review and Meta-analysis. *Issues in Mental Health Nursing*, 1-12.

Evidence

Research

- The ED visit provides **a potential window of opportunity for screening, brief intervention and referral to treatment** (SBIRT) [3, 4]
- **Opportunity for a "*teachable moment*"** [4]

Policy

- *Emergency departments should take every opportunity and be resourced to promote public health and the prevention of illness and injury….(including).. screening for drug and alcohol misuse, and undertaking brief interventions where appropriate*." [5]

3. Butler, K., Reeve, R., Arora, S., et al. (2016). The hidden costs of drug and alcohol use in hospital emergency departments. *Drug and Alcohol Review,* 35**,** 359-366.
4. Woodruff, S. I., Eisenberg, K., McCabe, C. T., Clapp, J. D. & Hohman, M. (2013). Evaluation of California's Alcohol and Drug Screening and Brief Intervention Project for Emergency Department Patients. *Western Journal of Emergency Medicine,* 14**,** 263-270.
5. Australasian College for Emergency Medicine (2015). Policy on Public Health,. Document No P56
ed.: Australasian College for Emergency Medicine.

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The Gap

- **How can problematic drug use can routinely be identified and treated among patients who present to the ED?**

- What is the evidence regarding **uptake and patterns of referral** for those most at risk of harmful drug use?

Aims

1. To determine the prevalence of illicit substance use for all individuals admitted to the ED Behavioural Assessment Unit (BAU) [6].

2. To explore perspectives of staff and consumers regarding routine drug screening and brief interventions for drug use.

6. Gerdtz MF, Yap C., Daniel C., Knott J., Kelly P., Braitberg G (2019). Prevalence of Illicit Substance Use Among Patients Presenting to the Emergency Department with Acute Behavioural Disturbance: Rapid Point-of-Care Saliva Screening. (Unpublished - submitted manuscript under review).

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Approach and Setting

Design

- Observational study of prevalence
- Focus group interviews with nurses regarding barriers and enablers to drug screening
- Consumer survey regarding public acceptability

Setting

- Metropolitan tertiary referral hospital ED
- 6 bed Behavioral Assessment Unit (BAU) co-located within the ED [7]

EMA Emergency Medicine Australasia

Emergency Medicine Australasia (2018) 30, 353–358

doi: 10.1111/1742-6723.12905

ORIGINAL RESEARCH

Behavioural assessment unit improves outcomes for patients with complex psychosocial needs

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Abstract

Objective: We aimed to assess the impact of a new model of care for patients presenting to the ED with acute behavioural disturbance.

Methods: This pre-/post-intervention study involved creating a dedicated, highly resourced six bed unit, the behavioural assessment unit (BAU). Co-located with the ED at the Royal Melbourne Hospital, the unit was designed to fast-track the admission of patients affected by intoxication, mental illness or psychosocial crisis and provide front-loaded interventions.

Results: In 12 months from 1 April 2016, 2379 patients were admitted to the BAU. They were compared with a similar cohort of 3047 patients from the entire 2015 ED population. The BAU resulted in a decreased wait to be seen (40 min [interquartile range (IQR): 17–86] *vs* 68 min [IQR: 24–130], $P < 0.001$), a decreased wait for a mental health review (117 min [IQR: 49–224] *vs* 139 min [IQR: 57–262], $P = 0.001$) and a decreased ED length of stay (180 min [IQR: 101–237] *vs* 328 min [IQR: 227–534], $P < 0.001$). Patients admitted to the BAU were less likely to have a security code (349 (14.7%) *vs* 538 (17.7%), $P = 0.003$) and less likely to have mechanical restraint (156 episodes (6.6%) *vs* 275 (9.0%), $P < 0.001$) or therapeutic sedation (156 episodes (6.6%) *vs* 250 (8.2%), $P < 0.001$).

Conclusion: A unit specifically designed to improve the care of patients requiring prolonged ED care due to mental illness and/or intoxication reduces the time spent in the ED and the use of some restrictive interventions. We recommend this model of care to EDs that care for this complex and challenging group of patients.

Key words: *behavioural emergency, emergency psychiatry, patient flow, restrictive interventions.*

Key findings

A purpose built unit designed for the management of behavioural emergencies:

- improves patient flow though the emergency department;
- decreases restrictive interventions; and
- is financially sustainable.

Introduction

Acute behavioural disturbance is a medical emergency. It is an increasingly common clinical problem facing health services and EDs,[1] and poses a significant direct risk to patient safety as well as to the welfare of staff, the public and hospital property.[2] Patients with acute behavioural disturbance are not a homogenous cohort. Previous studies into the causes of acute behavioural disturbance have demonstrated a relationship to drug and alcohol misuse, drug-induced psychosis, exacerbation of a pre-existing mental health diagnosis or an underlying organic illness.[3,4] A primary mental health illness (including psychosis) accounts for only 15%.[5]

In the acute setting, the cause of an acute behavioural disturbance may be hard to differentiate and the initial management of this patient group requires the use of de-escalation strategies, an appropriate environment, highly trained staff and adequate clinical resources to protect the safety and dignity of all concerned.[6]

Care of acute behavioural disturbance in the ED is particularly challenging, often requiring more resources and specialised care than other patient groups.[7] A study of the mental health population within EDs, a substantive proportion of those patients with acute behavioural disturbance, shows that this patient group have been observed to have a disproportionately extended ED length of stay with significant variation in their management.[8]

In Australia, there have been calls to improve the management of this population, including within the ED.[9] Barriers to providing optimal care to this patient group include

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Accepted 24 October 2017

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7. Braitberg, G., Gerdtz, M., Harding, S., Pincus, S., Thompson, M. & Knott, J. (2018). Behavioral assessment unit improves outcomes for patients with complex psychosocial needs. *Emergency Medicine Australasia,* 30**,** 353-358.

Observational study (July-December 2017)

Aim

Determine the prevalence of meth/amphetamine and cannabis use among individuals admitted to BAU

Outcomes

1. the prevalence of amphetamine-type stimulants and cannabis use among patients using POC saliva testing and self-reported drug use.

2. Secondary outcomes were rate of acceptance and referral outcomes for patients who tested positive for, or who self-reported amphetamine-type and/or cannabis use.

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Observational study (July-December 2017)

Approach

Prospective observational study

8

Participants

- All patients admitted to BAU over a 6 month period

9.

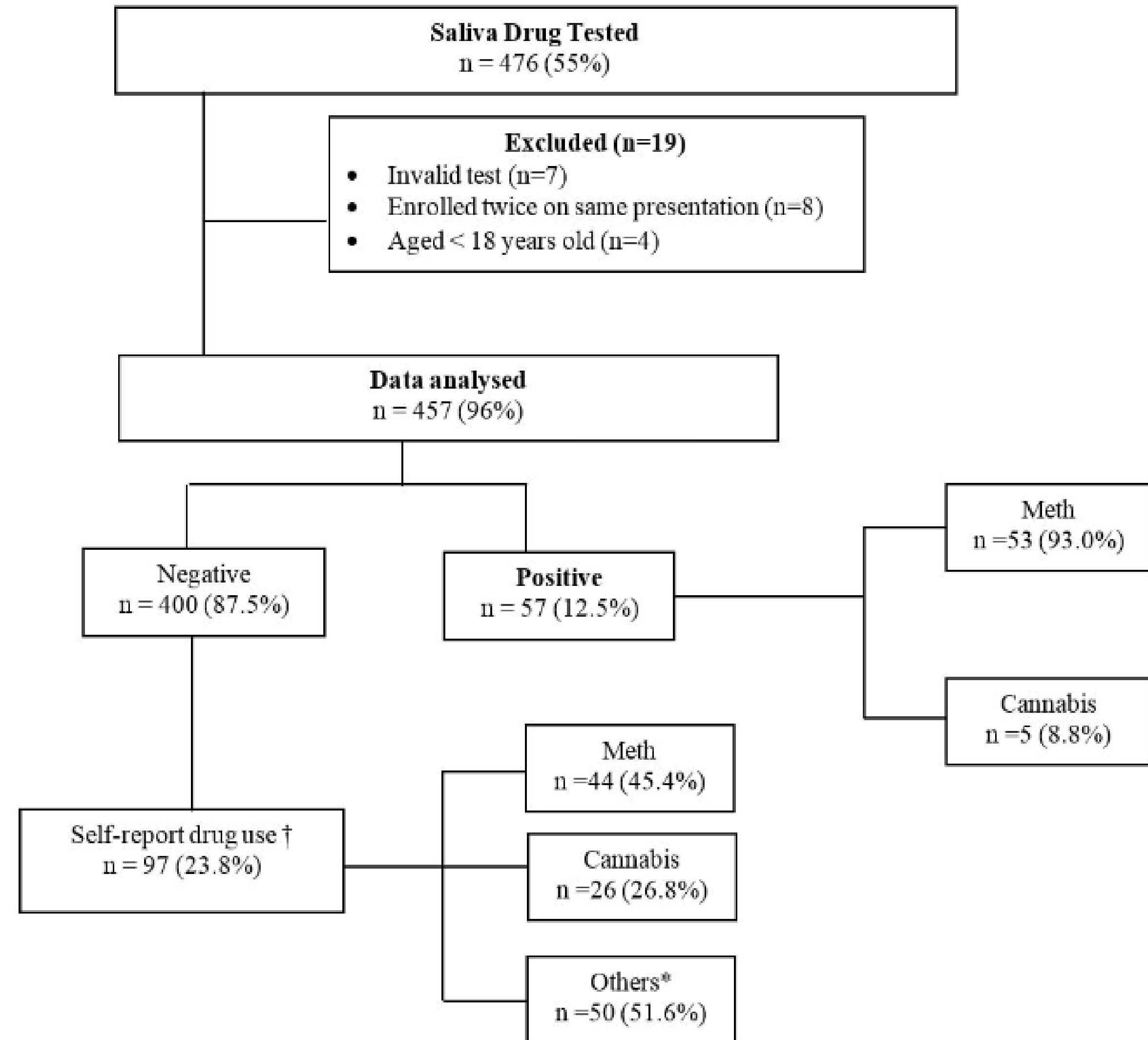
Screening Brief Intervention Referral to Treatment [8, 9, 10]

8. Securetec Drug Wipe® Twin
9. Melbourne Health & Substance Use and Mental Illness Treatment Team (SUMITT) (2015). Reducing Harm from Methamphetamines.
10. Gerdtz MF., Yap, C., Daniel C., Knott J., Kelly P., Innes., Braitberg G (2019). Amphetamine-type Stimulant Use among Patients Admitted to the Emergency Department Behavioural Assessment Unit: Screening and Referral Outcomes . (Unpublished - submitted manuscript under review).

Results

Combined prevalence of meth/amphetamine and other drug use was **21.2%**

85.6% accepted referral to the alcohol and other drug clinician



Focus Groups (August-October 2018)

Aim

- To explore perspectives of ED clinicians regarding drug SBIRT.

Approach

- Qualitative - thematic analysis

Setting

- Metropolitan tertiary referral hospital ED

Participants

  - Nurses (30)

How is the current model of care implemented?

What are the barriers and enablers of SBIRT?

Results – 5 focus groups n=30

Barriers and enablers to SBIRT in the BAU exist at three levels:

- **Patient** (receptiveness to screening)
- **Staff** (knowledge and perceptions of role)
- **Systems** (time pressures, lack of established pathways to referral, communication between ED-AOD services)

Results – barriers to SBIRT (Patient)

Patient receptiveness

- *"… sometimes I don't probe because you can see they're getting agitated with you by asking the questions, **you're increasing their behaviours and potentially become more dangerous and escalated** …"*

- *"…I think it's a bit touchy with some people because people get quite defensive about it, not because they've taken it, but because they can't believe that you're going to ask them that question, so **you kind of don't want to get off on the wrong foot with your patient**…"*

Results – barriers to SBIRT (Staff)

Knowledge

- *"… we **don't have a skill set** for that, and so you think that **it's not your role**, you think that is actually an important conversation and **I don't want to go in there and give the wrong information**, so I'm just going to step back from that…"*

Role delineation

- *"I don't know if that changes the patient care…which again makes me **wonder if ED is the right point at which to do** how much of the work…"*

Results – barriers to SBIRT (Systems)

Time pressure

- *"… so often **we don't ask, because you get so pushed just to do the work** and get them out, the 4 hour rule screws everything…"*

Pathways to referral

- *"when you come to behavioural drug affected patients, **there's no pathway, there's no guideline**, there's no nothing. So **no one really knows what to do**…"*

Collaborative approach to ED-AOD services

- *"…on the Friday, they're on a bender…and they will say , ok, just refer to drug and alcohol, but, there's no drug and alcohol so we'll put in an after hours referral and it's like **I don't know what's going to be and is that collected? Is that being followed up?"***

Results –Enablers to SBIRT (Staff and systems)

Knowledge

- *"…if you were to empower the nurse with sort of information on harm minimisation strategies and effects of illicit substances, nurses would go oh wow I'm allowed to say things like that. Because it's very formal, it's extremely factual, it would be amazing…"*

Collaboration

- *"…it'd be good for us to clarify if we make a referral will AOD clinician follow up these high risk out of hours, just I think communicating that to all the nurses will increase your compliance for referrals…"*

Resources

- *"If we just have a brochure we have some simple information we can give them…we can give them something that they can hold onto and take with them…"*

Consumer survey (March-April 2019)

Aim

- To explore perspectives of ED consumers regarding drug SBIRT.

Participants

- English speaking adults with no symptom distress or cognitive impairment and able to provide written consent

Setting Sample

- Metropolitan tertiary referral hospital ED
- Random stratified sample (by location) of 20 participants per day

Survey

Patient Beliefs and Attitudes Survey

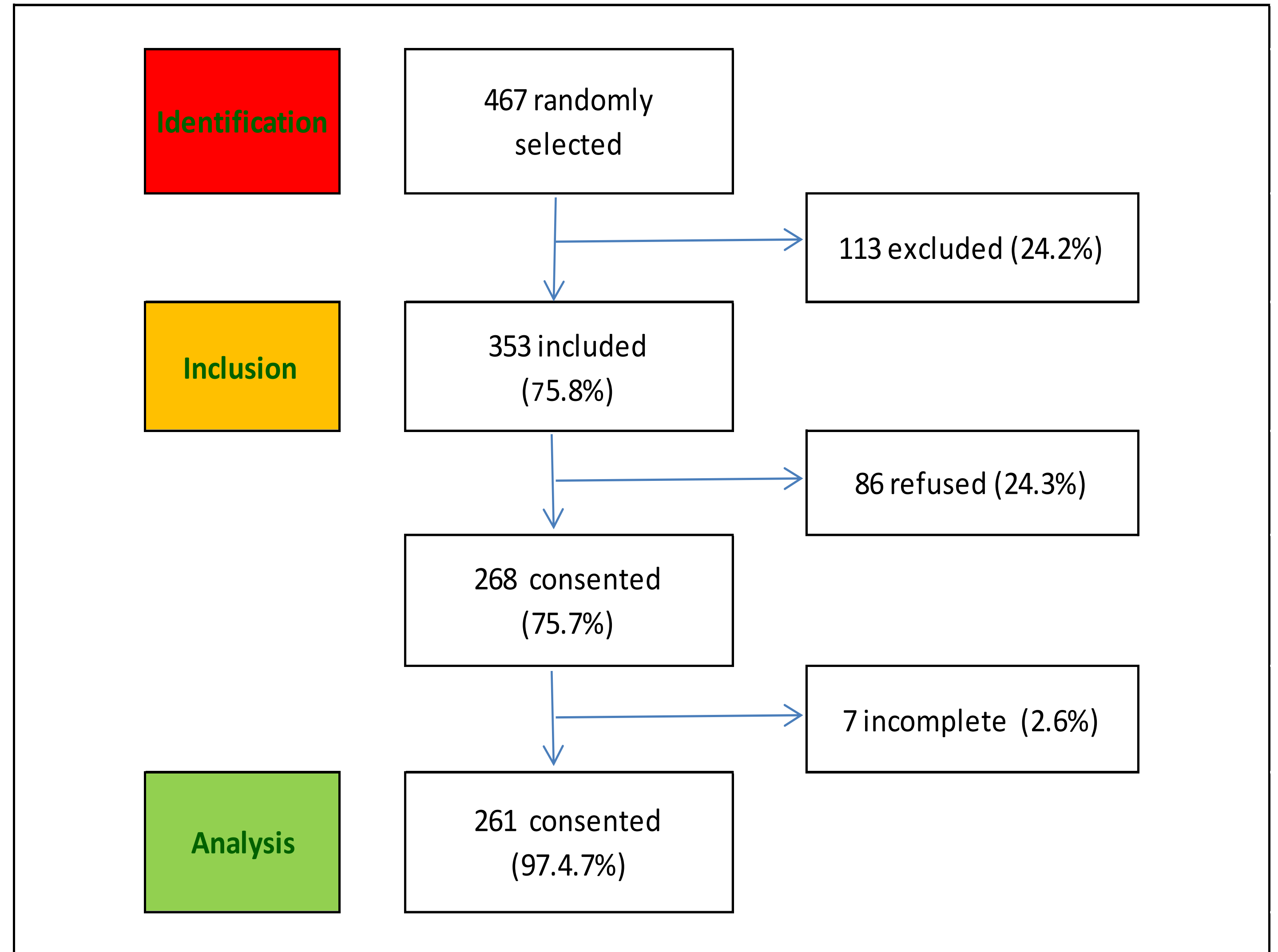
- 11 items measured on 5-point Likert Scale indicating level of agreement
  - Appropriateness
  - Thoughts
  - Level of comfort
  - Relevance/importance to visit
  - Preferences

These questions ask about attitudes towards Alcohol and Drugs screening in the Emergency Department.

Mark your level of agreement with the following statements.

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
It is appropriate to be questioned about my alcohol consumption during my emergency department visits.	○	○	○	○	○
It is appropriate to be questioned about my substance (e.g. cannabis, ICE) consuption during my emergency visits.	○	○	○	○	○
I feel I am being judged by the emergency department staff if they ask me about my alcohol consumption.	○	○	○	○	○
I feel I am being judged by emergency staff if they ask me about my substance use.	○	○	○	○	○
I feel comfortable answering questions related to my alcohol consumption during my emergency visits.	○	○	○	○	○
I feel comfortable answering questions related to my substance use during my emergency visits.	○	○	○	○	○
It is important for emergency staff to know about my alcohol consumption.	○	○	○	○	○
It is important for emergency staff to know about my use of substances.	○	○	○	○	○
It is a good idea to screen everyone for alcohol and substance use during their emergency department visits.	○	○	○	○	○
I'd prefer to self-complete the alcohol and substance use questionnaire instead of being asked by the emergency department staff.	○	○	○	○	○
I'd prefer to have these questions being asked by the attending nurses instead of the attending doctors.	○	○	○	○	○

Results



Results (N=261)

- 85% it is appropriate it is to be questioned about substances
- 88% comfortable answering questions about substance use
- 89% agree it is important for staff to know about substances use
- 80% believe it's a good idea to screen everyone

Key points

- The **prevalence of illicit substance** use among individuals admitted to BAU unit **is high**.
- **Most patients** who screened positive for illicit drug use were **willing to be referred to AOD clinician**.
- The ED visit represents a window of **opportunity in which nurses cans screen for drug use, implement education regarding harm minimisation, and make referral to AOD services**.
- Key challenges for clinicians in initiating SBIRT are related to **time pressures, role legitimacy and lack of training**.
- The vast majority of the consumers who were interviewed **felt it was appropriate to be questioned about drug use and were comfortable answering questions** related to this during their ED visit.

Adapting and implementing Safewards for Emergency Departments

Safewards Victoria

Adapting and Implementing Safewards for Emergency Departments

Dr Catherine Daniel

Professor Marie Gerdtz

Marisol Corrales, Office of the Chief Mental Health Nurse, DHHS
Ashleigh Ryan, Peninsula Health
Monique Rosenbauer, Bendigo Health
Kate Bendall, Peninsula Health

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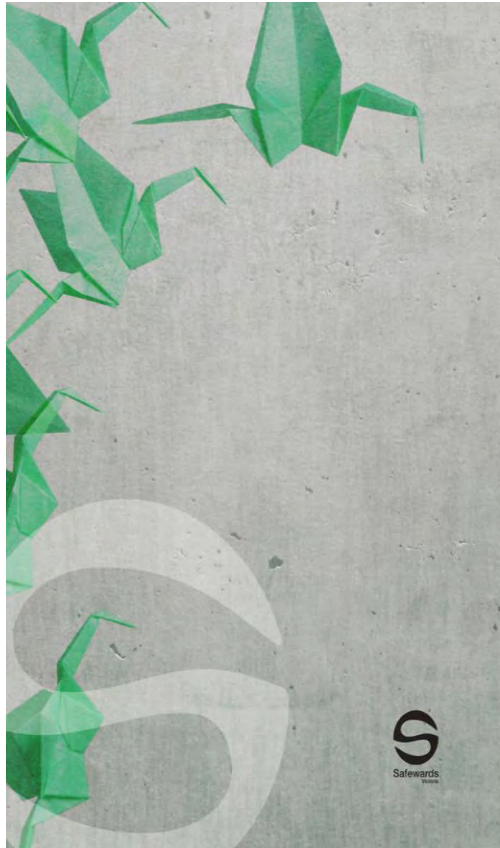
vmia Risk Management and Insurance

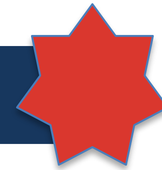
VICTORIA State Government | Health and Human Services

Safewards Implementation in Victoria



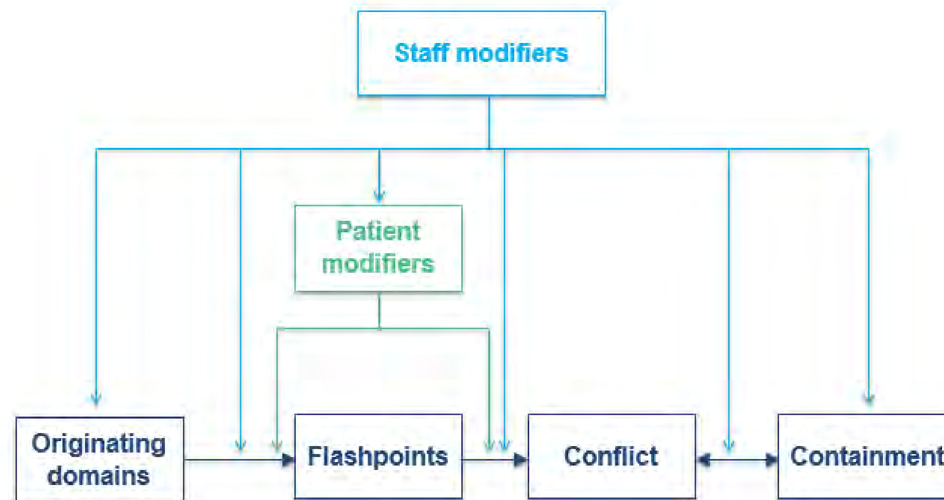
2016-2018 - Stage 1 - Mental Health

2019 - Stage 2 - ED



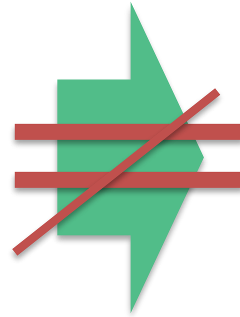
2020 - Stage 3 - General

The Simple Model



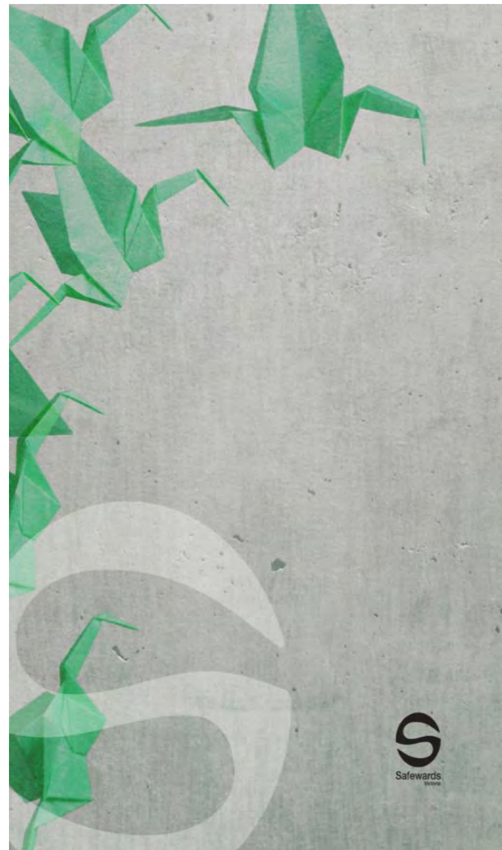
Conflict and Containment

Conflict
anything that could lead to harm for the patient, others or staff

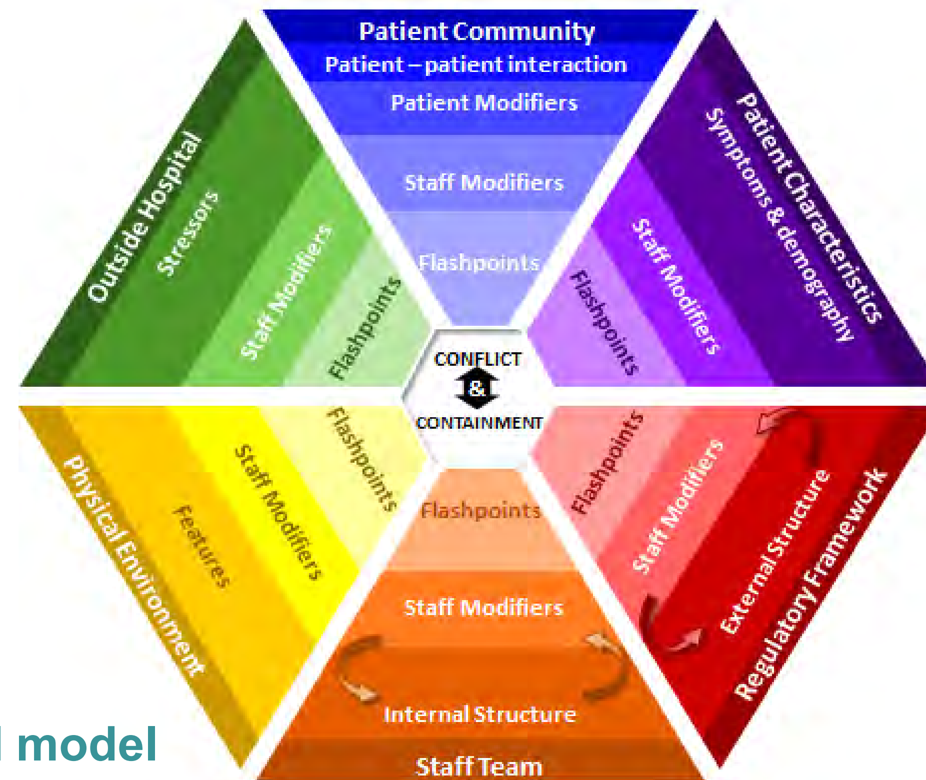


Containment
what staff do to prevent conflict events or minimise harmful outcomes

The Safewards Model

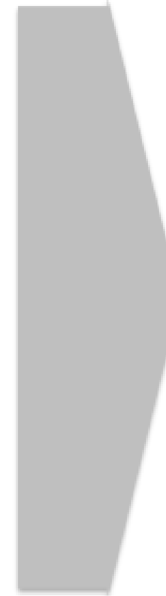


Technical model



The Originating Domains

1. The patient community
2. Patient characteristics
3. Regulatory framework
4. Staff team
5. Physical environment
6. Outside hospital



Why Safewards?

- Service interest
- VMIA interest
- 14.6% reduction in conflict
- 23.6% reduction in containment events
- 36% reduction in seclusion events (Vic)

Fletcher J, Spittal M., Brophy L., Tribble H., Kinner S., Elsom S., and Hamilton, B (2017). Outcomes of the Victorian Safewards trial in 13 wards: Impact on seclusion rates and fidelity measurement. *International Journal of Mental Health Nursing*, 26, pp 461-471.

Safewards in the ED Trial

- 2 year pilot project, June 2018-June 2020
- Dedicated project leads at each service
- 2 services, 3 trial EDs
- All service users, patients, carers, family members
- 2 different methods of training/implementing
- Adaptation of resources

Engagement at sites

Mixed response from medical staff –nurses reports that this should be for all staff and not just nurses.

“This is political correctness gone mad”

“If this prevents one situation from escalating to use of restraint its worth it”

Focus on well being of staff also- for example ED nurses noted that they don’t have access to clinical supervision like mental health nurses do.

Video, cake launch and BBQ to launch Safewards

Challenges

In comparison to Mental health settings

-applies to all people who use ED

-Length of stay shorter

-acutely unwell (both with acute mental health symptoms, medical complexity and intoxication with ETOH/substances

-use of mechanical and physical restraint regularly used

-unionised approach to occupational violence

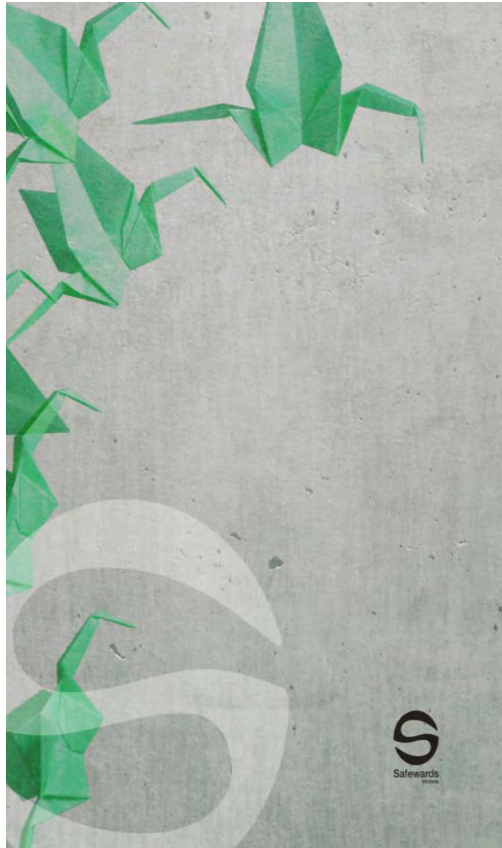
-dynamic environment

-bed pressures with NEAT pressure to move people though in 4 hours

-restraint used and presents risk to staff and patients

-focus has been on envrimental controls ie wire at triage

The 9 trial Interventions in ED



Know Each Other

Positive Words

Reassurance

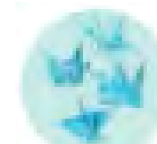
Respectful Limits

Senior Safety Round

Talk Through

Calming Methods

Perception and Awareness



Delivering Bad News

Know each other

Know each other - Patients and staff share some personal interests and ideas with each other, displayed in common areas.

- *Builds rapport, respect & common humanity*

Concerns raised about privacy however information shared is at the discretion of each staff member

Bendigo – reported on staff preferences ie favourite drink/pet/football team
This has generated conversation, mutual topics, and allowed for engagement

Frankston – posters on staff –first name, hobbies, interesting information, and staff photo

Positive words

Positive words - staff say something positive in handover and clinical discussions about each patient. Staff use psychological explanations to describe challenging actions.

- *Increases positive appreciation and helpful information about working with patients.*
- *Relevant for handover*

“Iphone positive”
“Suitcase positive”
“behavioural”
“aggressive”

Evaluation

Phase 1 Evaluate Safewards Training

Phase 2. Evaluation of the Safewards Implementation Process

Phase 3. Impact of Safewards on Coercion

Phase 4. High Risk Presentations

Phase 5. Organisational Impact/s

Phase 6. Patient and carer experience Questionnaire

Phase 7. 48 hour Observational Visits

Safewards in the ED trial results so far...

- Anecdotally generally well received by ED Nursing staff
- Positive and some challenging feedback in first of 4 external evaluation focus groups
- Concerns expressed re time, risk being ignored
- Interest by medical staff, administrative clerks and volunteers

“The whole is greater than the sum of its parts”

Aristotle

www.health.vic.gov.au/safewards

Thank you