Assessing Care Provided to Behavioral Health Patients in ED

BRONSON

Why?

Bronson LakeView Hospital

- Emergency Department: 14 beds
  CY 2023 ~ 25,000 ED patient visits
- Inpatient Acute Care Unit: 16 beds
- Inpatient Psychiatric Unit: 10 beds
- Surgery/Procedure: 2 operating rooms and 1 procedure room

Bronson South Haven Hospital

- Emergency Department: 14 beds
  CY 2023 ~ 17,000 ED patient visits
- Inpatient Acute Care Unit: 8 beds

Scope

- **Seen in Emergency Department**
- **Chief Complaint – Behavioral Health related**
- **Length of Stay ≥ 24 hours**
- **All Payors and Age**
- **All Dispositions (transfer, admit, discharged)**

Committee Workflow

Frequency - Quarterly meeting

Membership – 10 Multidisciplinary members

- Emergency Department Managers
- Medical Social Workers
- Patient Safety & Quality

Chart Review (sampling) – 1 chart per member

Information We Review

Timeliness

- Triage, Roomed, First Contact
- Screening completed with precautions identified and implemented
- Transfer/Discharge

Quality

- Comforts of Care
  - example: move from ED cart to hospital bed, meals provided, distraction i.e., TV)
- Documentation
  - Provider handoff and note with each shift change, RN handoff and reassessment, Hourly rounding, Vital signs
- Pharmacy Factors:
  - example: Med Recon complete and home meds administered

Safety

- Any safety events
  - example: violence, attempted elopement

Tool Use to Guide Our Work

	Reviewer Assigned	Location	ED Arrival Time	MRN	Hosp Acct	Provider First Contact	ED Departure	ED LO	ED_Disposition	**Patient Story:** (example: Chief Complaint, HPI, Final Diagnosis)	**Patient Comfort of Care:** (example: move from ED cart to hospital bed documented within first 24 hours, meals provided, distraction i.e. TV)	**Suicide Precautions:** moderate to high risk - - -place referral to MSW or Behavioral Health Clinician -1:1 monitoring -environmental check -Assist patient into hospital gown, completely undress the patient; may leave their underwear on. (ED: belongings will be placed in a locked cabinet/drawer within the room or inventoried and stored outside of the room (i.e., nurses desk). -accompany the patient to the bathroom -Patient safety assistant, patient sitter or designee documents safety and behavior observations Q30 minutes for 1:1 observations	**Documentati** -Provider handoff a -RN handoff note u Airway, Breathing, each shift change -Hourly rounding ch performed hourly -Vital signs: includin pressure, heart rate location once every tu
1	Betty	BLH TRAUMA & ED	7/15/2023 15:24			7/15/2023 15:45	7/17/2023 13:11	45:47	Transfer To Another Facility				
2	Cindy	BLH TRAUMA & ED	7/27/2023 10:52			7/27/2023 11:16	7/28/2023 13:07	26:15	Transfer To Another Facility				
3	Holly	BLH TRAUMA & ED	8/14/2023 0:51			8/14/2023 0:58	8/15/2023 9:44	32:53	Discharge				

Changes Implemented

Problems	Changes
Documentation of discharge planning was fragmented	Developed shared note for documenting discharge planning
Delay in patient receiving their home medications	Implemented standard work for Pharmacy to complete Medication History at 12-hour ED LOS
Inconsistency of Care (activities: amb in dept., TV, movies, hospital bed offered..)	• ED Behavioral Health order set being developed to direct activities allowed and precautions required • New ED cot mattresses ordered to improve comfort
Provider Notes and handoff documentation inconsistent	Provider Note template improved
RN handoff and assessment documentation	ED Behavioral Health order set being developed to initiate action for RN reassessment

Changes Implemented

Problems	Changes
VS not completed per policy	ED Behavioral Health order set being developed to indicate VS frequency needed
Safety, Security events	• Initiated "Flagging" pts with history of violence • Security Officer FTE's increased • Finger Food menu developed • Edits to policy to increase staff safety
Delay in transfer out (delay in EMS, delay in acceptance from facility)	• Developed a Regional Pediatric Psychiatric Patient Transfer Guidelines for transfer at 24 hours • Tracking/reporting EMS delays
Gaps in completing the Suicide Assessment	• Development and training of a Suicide Assessment note for MSW, and House Supervisors

Next steps

- Increase number of charts per review
- Celebrate and Recognize Exceptional Care

Questions, please reach out

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