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Improving the Assessment and Triage of Patients with Mental Illness attending the Emergency Department

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Improving the Assessment and Triage of Patients with Mental Illness attending the Emergency Department

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2011
Abstract

Since the amalgamation of mental institutions with acute hospitals there has been an increase in presentations of patients with mental illness to the Emergency Department. The first point of contact for the patient attending the Emergency Department is typically triage. It is the point where emergency care begins with the nurse assessing the patient and assigning a triage category that best suits the patient’s clinical need. Traditionally triage had its origins in assessing patients presenting with a physical injury or illness and did not consider those with a psychological illness. Present-day triage has improved but not to the extent that is required for best practice. Furthermore staff in the Emergency Department may have received no formal training in the speciality that is Mental Health. Specialised training is necessary to provide a consistent and high standard of nursing care and assessment. The purpose of this study was the implementation of a change management project. This was initiated in a large Emergency Department in Dublin. The project involved the introduction of a mental illness triage tool, a computerised pop-up screen in triage and nursing assessment documentation specifically designed to manage the care of the patient attending the emergency department with a mental illness.
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Chapter 1

Introduction

1.1 Introduction.

Change involves altering the way things are done with the intention of improving practices. This is particularly relevant to the Health Services which is in a constant of transformation and reform. The Emergency Department (ED) is a prime example of this. There is a continuous endeavour to improve the delivery of care and services to the public. This process involves assessment, planning, implementation and evaluation to achieve the quality of service required (Welford, 2006). All changes must have the patient as the central focus of any initiative, and accordingly, in the context of this project, patient welfare was a primary consideration in my decision to implement a change in the way ED staff triage those who present for treatment. This project was undertaken in a busy ED in Dublin. The change process was carried out in conjunction with the Health Service Executive (2008) Change Model.

In this chapter I discuss the rationale for choosing this particular change management project which addresses the triage and assessment of patients with Mental Illness in the ED. The presentation of this group of patients attracts extensive debate within the department and therefore I believed that I should devote my time to bringing about change to improve the assessment and treatment of these patients. Chapter 2 relates to the Literature Review where I consider mental illness and its prevalence in today’s society and the negative attitudes towards mental illness. In the final section of the Literature Review I discuss the concept of triage and its importance in the ED. I also examine the Mental Health Triage Tool devised in Australia for use in the assessment of patients with Mental Illness.

Chapter 3 deals with Methods which involves a discussion of organisational culture and considers its significance in the change process. A brief analysis of the chosen change model (the Health Service Executive (2008) Change Model) and the rationale for its selection
follow. The chapter concludes an overview of the change process carried out under the steps of the change model chosen which are: Initiation, Planning, Implementation and Mainstreaming.

Chapter 4 examines the change project in terms of evaluation and considers the tools used for the purpose of evaluation. The final Chapter 5 relates to discussions and conclusions and looks at the strengths and the weaknesses of the project, recommendations for future improvement and my reflections on the change management project.

This project was derived from an observed need to improve the triage and assessment of patients presenting with mental illness to the ED. To achieve these improvements I introduced three elements which were: a Mental Illness Triage Tool, a computerised pop-up screen in triage and finally nursing assessment documentation for the assessment of patients with mental illness.

### 1.2 Background and Rationale for carrying out the Change.

In my role as a Clinical Nurse Manager in a busy Emergency Department I am cognisant of the necessity for change throughout the organisation generally, and, more specifically within my own department. While I considered a number of areas for this change project, having had regard to time constraints and cost implications, I was keen to implement a program that would have immediate benefits for both patients and staff while remaining as cost effective as possible. In the current economic climate, I believe that support might not have been forthcoming had I selected a project that required an extensive outlay of capital.

The Emergency Department is a common site for the mainstreaming of patients with mental illness. Traditionally, individuals with a mental illness would have attended an acute assessment unit on the grounds of a mental institution. However, government-led changes have seen the amalgamation of mental institutions with acute hospitals. Many patients will attend their General Practitioner (G.P) with issues such as depression or anxiety. The G.P may decide to refer the patient to a psychiatrist, psychologist or counsellor in the community.
However there are a large number of patients who may require more intensive intervention and possible admission. These individuals will then present to the emergency department, often deciding not to attend the G.P, in order to access the mental health services within the hospital.

The triage nurse is generally the first point of contact for patients with mental illness. The Manchester Triage System is used to assess patients with the allocation of a triage category based on level of acuity. At present there is no streaming of patients in the department which means that those with a mental illness will be triaged in the same way as individuals presenting with medical or surgical complaints. All triaged patients are then returned to the waiting room unless they need immediate intervention. They then wait until they are called through to the cubicle area to be assessed by a clinician. Patients with mental illness in the vast majority of cases will be reviewed by an emergency department clinician first and then if deemed necessary referred to a psychiatrist. Few patients are seen directly by the psychiatrist if they attend the ED. This may cause the patient further psychological distress due to long waiting times in an overcrowded and noisy waiting room.

Another issue in the emergency department in relation to caring for patients with mental illness is the lack of formal training and education the emergency nurse receives in this specialist area. While the triage nurse plays a pivotal role in the assessment of all patients, a possible lack of knowledge and understanding in relation to those presenting with mental health issues, may place the patient at a disadvantage. Traditionally triage was concerned with physical illness or injury and accordingly, psychological factors were secondary considerations.

In an effort to address these issues, I firstly developed a triage system in the form of a computerised pop-up screen that can be accessed by the nurse if it appears that the patient is presenting with mental health issues. The triage nurse is then prompted to answer seven questions in relation to the patient. Six out of the seven questions require a “yes” or “no” answer, while the remaining question is to ascertain who is accompanying the patient. The reasoning behind this initiative was two-fold: firstly to ensure that the triage nurse would ask the more relevant questions and secondly, it was envisaged that it would potentially reduce triage time, as the nurse would spend less time on the handwritten report. The second element to my project was the implementation of a “triage tool” which was adapted from the
Australian Mental Health Triage Scale. This “tool” is in the form of a wall-chart modified to suit the needs of the department. It is a detailed triage assessment tool with descriptors specific to mental illness presentation. This is used as a guide in determining the most appropriate care for the patient.

The final element in this project is the introduction of a “nursing assessment” document which is designed specifically for the assessment of the patient with mental illness. This “nursing assessment” document (Appendix A) provides for the patient presenting to the ED with a mental illness. The current ED nursing documentation (Appendix B) is designed essentially for those with a physical injury or illness.

Ultimately, it is hoped that by implementing these elements as outlined above, an improved standard of triage and assessment should result for the patients attending with mental health issues.

1.3 Conclusion

As outlined above this project is concerned with the triage and assessment of patients attending the ED. In Chapter 2, I consider mental illness and the negative attitudes to patients alongside the concept of a triage tool for the assessment of patients with mental illness.
Chapter 2

The Literature Review

2.1 Introduction

A literature review is an expression of an individual’s interest in a particular subject which involves scrutiny of research, policy and other relevant documents. The sources of information can be material found in books, journals and internet sites. All of these sources support the relative understanding and views of others on the chosen topic (Randolph, 2009). The literature review should consider published information of the subject area by recognized researchers and academics.

The objective of this review is to examine and assess the available literature pertaining to the assessment and treatment of individuals presenting to the Emergency Department traditionally known as Accident and Emergency, with mental illness, under the following broad headings:

- Mental Illness
- Negative attitudes towards mental illness
- A Triage Tool for the Assessment of Mental Illness in the Emergency Department.

Whilst a great deal of literature exists in the field of mental illness and attitudes towards mental illness, there are relatively few published articles in respect of triage tools used in the assessment of those presenting with mental illness in this jurisdiction. Indeed, while conducting a search of the literature from an Irish perspective in relation to triage tools I failed to discover any relevant material. The bulk of published articles concerning the development of triage tools for mental illness appear to have been pioneered in the Southern Hemisphere particularly by Australian and New Zealand researchers.

The literature reviewed as part of this work was obtained primarily from nursing and medical journals. Articles and/or books were retrieved following a search of the following
databases Cochrane, Wiley, Medline, PsychINFO Cumulative Index to Nursing and Allied Health (CINAHL) via an Athens account. The search engine Google was also used in the literature search. Searches of these databases were performed using title combinations and keywords such as mental illness, suicide, self-harm, emergency department, triage, triage assessment, triage tools and nurses’ attitudes to mental illness.

2.2 Mental Illness.

“Mental health is a most important, maybe the most important, public health issue, which even the poorest society must afford to promote, to protect and invest in”.

(World Health Organisation (W.H.O), 2003:4)

The World Health Organisation (2003) reported that mental disorders represent approximately 12% of global disease and they estimate that this will probably increase to 15% by 2020 and advises that mental health expenditure in many countries only equates to 1% of the total health budget which the W.H.O state is inadequate to meet the required standards for this portion of society.

Many definitions exist for mental illness including that of The Law Society’s Law Reform Committee (1999: 7) where they suggest that mental illness is: ‘A state of mind which affects a person’s thinking, perceiving, emotion or judgement to the extent that he or she requires care or medical treatment in his or her own interests or the interests of other persons’. A more recent description by Mental Health Ireland (2011) contends that the individual is unable to carry out day to day functions as a result of encountering ‘severe and distressing psychological symptoms’. This altered mental status may cause the individual to feel isolated and afraid which may result in them not coming forward for necessary specialist care and treatment until such time as urgent attention is required. Due to this reluctance to seek help until such time as they have reached crisis point, they are often faced with the only option open to them in an emergency situation which is presenting to their local Emergency Department. This is often the first contact with Mental Health services and can prove to be very a very daunting and terrifying experience (Crowley, 2000). A large number of patients
with mental health issues, who present to the emergency department, are generally in this state of severe psychological distress and are therefore anxious to access the appropriate services as swiftly as possible. However, due to long waiting times, inappropriate facilities e.g. quiet rooms and the shortage of frontline specialist care such as mental health nurse practitioners, the individuals' crisis is greatly enhanced.

Mental illness is an umbrella term which encompasses an extensive range of mental and emotional conditions, including schizophrenia, bipolar disorder, depression, anxiety disorders. Suicidal behaviour in the form of self-harm or self-poisoning, (defined by the National Institute of Clinical Excellence (N.I.C.E., 2004:7) as “self-poisoning or injury, irrespective of the apparent purpose of the act”) is one of the most common, and most obvious manifestations of mental illness in patients presenting to the ED. According to the National Suicide Research Foundation (2009) almost 12,000 presentations of self-harm are treated annually in hospitals around Ireland.

It is recognized throughout much of the literature that those individuals with a history of self-harm are a high risk for suicide (McCann et al., 2006, Keogh et al. 2007). For example in a study carried out by Hickey et al. (2001) suggests that up to 4% of those that habitually self-harm will eventually go on to commit suicide. This may not necessarily be intentional but rather, occurred as a result of them “going too far”. The issue of self harm is often looked upon as a cry for help or a relief of the individual’s psychological pain (Howson et al, 2008). From an Irish point of view, the statistics for completed suicide make for very sombre reading. Information obtained from the Health Service Executive’s (H.S.E) National Office for Suicide Prevention states that 527 people took their lives in Ireland in 2009 an increase from 2008 when 424 people took their lives.

Much has been done to counteract and attempt to reduce the number that die by suicide. In 2006 a comprehensive framework for mental illness was introduced by the Irish Government titled “A Vision for Change”, examines mental illness in a holistic fashion based on biological, psychosocial and social aspects. There was a National Office of Suicide Prevention set up by the Health Services Executive (H.S.E) with responsibility for the implementation of ‘Reach Out’ which is a National Strategy for Action on Suicide Prevention 2005-2014. While there is no denying the work that is being done to improve services for those with mental illness, far more investment of time, resources and finances must occur.
before an acceptable standard is achieved. The World health report (2001) made several recommendations of ways to tackle this worldwide mental health crisis (Appendix C)

2.3 Negative attitudes to mental illness.

The frequent presentation of individuals with mental illness places an immense burden on an already overstretched resource that is the Emergency Department and therefore places further challenges on the ED staff of all disciplines (Rowe et al, 2011). They must contend with busy overcrowded departments, cope with abusive and aggressive individuals frustrated by long waiting times and still maintain a level of professionalism and competence in line with care for critically ill patients. This environment may be stressful for the staff but more importantly it can have adverse effects on the individual presenting with a mental illness (Thompson, 2005). In addition to this the patient may come in contact with a nurse or other healthcare professional with negative attitudes which can further distress the individual. Many emergency department staff will have had no formal training in the area of mental illness, in their formative years and hence there is a lack of confidence when caring for this particular group of patients (Wand, 2004, Thompson, 2005). Alongside this, many find this particular cohort of patient more difficult to deal with as it is considered that in some instances that they are attention seeking (Wheatley & Austin-Payne, 2009).

This lack of knowledge and expertise leads to inconsistencies in the provision of appropriate and timely care of the mentally ill patient (McCann et al. 2007). N.I.C.E (2004) recommends that staff should be provided with training to enhance level of understanding, knowledge and competence. This should be addressed through carefully planned instruction, training and community awareness not just within the hospital setting but nationally. Given the prevalence of mental illness, it is of paramount importance that nurses and other health care professionals are trained adequately to meet the needs of this often marginalized group.

The majority of research into the concept of negative “attitudes” towards self-harm. These studies cite self-harm as a major source of negative attitudes on the part of health care staff. One such study by McAllister et al (2002) surveyed thirty seven different hospitals in
Australia. The data was collected by way of questionnaires with a 35% response rate. The large sample size lends the study credibility. The researchers obtained their results by focusing on four aspects of nurses’ attributes, namely, confidence, empathy, dealing effectively with patients and the management of legal and hospital regulations. It found that nurses who obtained the higher scores in respect of all four were confident in their ability to care for these patients however there was still a high level of negativity towards the patients that self-harm. The research proposed that nurses should be up-skilled and educated in the assessment of patients that self-harm. It was indicated that continuous education is of great importance in the effort of reducing negative attitudes. The research of Wheatley and Austin-Payne (2009) also concluded that lack of education was a major contributing factor for negative attitudes to mental illness.

As has been outlined, there are a number of reasons for negative attitudes towards those with mental illness. Nevertheless, the common theme cropping up in the review of the literature pertaining to the subject appears to be the lack of education on the issue of mental illness. It has been suggested that employing Mental Health Nurse Practitioners would enhance the delivery of a quality service to these patients (Wand, 2004). In that context, it is useful to turn attention once more to Australia, which appears, on the surface at least, to be investing huge resources into this particular area of healthcare provision. An example of this is The Royal Prince Alfred Hospital in Sydney has developed a role descriptor for its Mental Health Nurse Practitioners (Appendix D). The Australians have also taken the time to develop and introduce a triage tool which is used for the assessment and guidance of mental illness within Emergency Departments. This shall be discussed in the next section of this literature review.

2.4 A Triage Tool for Assessing Mental Illness in the Emergency Department.

Triage originated from the French word, ‘trier’ which means to sort out, classify or choose to select (Smeltzer et al, 2010). Triage is generally used in the Emergency Department to assess those patients requiring emergency care. It involves immediate evaluation of the patients’ condition and the prioritizing of their care following a brief clinical assessment
In Ireland the Manchester Triage system is used. This is a five level acuity scale as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Immediate treatment required.</td>
</tr>
<tr>
<td>2</td>
<td>Very urgent, requires treatment within 10 minutes</td>
</tr>
<tr>
<td>3</td>
<td>Urgent, requires treatment within 60 minutes</td>
</tr>
<tr>
<td>4</td>
<td>Standard, requires treatment within 120 minutes</td>
</tr>
<tr>
<td>5</td>
<td>Non-urgent, requires treatment within 240 minutes</td>
</tr>
</tbody>
</table>

This scale directs the nurse to assign levels of acuity by basing the symptoms presented by the patient against fifty different algorithms or descriptors (McMahon, 2003). (The algorithm used for the patient with mental illness can be viewed in Appendix E.) A patient’s triage score however, may be inaccurate due to factors such as overcrowding and levels of expertise and experience of the triage nurse. Very often depending on the operator the patient may be under or over triaged which can potentially affect patient care, safety and outcomes (Dong, et al, 2006).

Triage is of fundamental importance in the emergency department not only in relation to prioritizing patient care and treatment but is crucial in the management of resources. Customarily triage is associated with assessment of physical illness and injury but it has not been tailored effectively to assess those with mental illness (Smart et al, 1999; Summers et al, 2003). The most common mental health presentations to emergency departments include patients with psychosis, depression, anxiety disorders, those who have attempted self-harm/poisoning and complications of substance misuse. Also it is worth noting that patients may often present with physical symptoms that may camouflage their psychiatric illness. N.I.C.E (2004) recommends that triage nurses should be competent in the assessment of the emotional, mental and physical needs of these patients and recommends the introduction of The Australian Mental Health Triage Scale. Triage scales should be “both reliable and valid” (Creaton et al, 2008:468).

The Australian Mental Health Triage Scale was developed with the collaboration of emergency department nurses, doctors, and liaison psychiatry and nurse management.
Following implementation of the National Triage Scale in the Royal Hobart Hospital in Tasmania, a need to develop a scale designed specifically to deal with the patient with a mental illness was recognised (Smart et al, 1999). The scale agreed upon was initially known as the Mental Health Triage Scale but has been renamed in more recent times as the Australian Mental Health Triage Scale.

Subsequent to the development and introduction of the scale, Smart et al (1999) collected data over a nine month period. They found that as a result of its introduction, waiting times were reduced from an average of 34 minutes to 26 minutes; patients with mental illness presentations were allocated more urgent categories than in the pre-trial period and frequent re-attendances were reduced. However the percentage of admissions remained moderately stable implying that the scale had no influence on this factor. Smart et al (1999) asserted validation of their study in a number of ways, including the acceptance of the scale by emergency nurses, the reduction in waiting times for this cohort of patients and finally the continued use of the scale when they followed up two years later.

The Australian Mental Health Triage Scale has been extensively endorsed as a most comprehensive and effective tool for the assessment of mental illness presentations (Broadbent et al, 2007). Nevertheless Happell et al (2003) embarked on a study to consider the level of agreement between psychiatric nurse consultants and triage nurses without the impact of an education program. The mental health triage scale was the principle method of data collection over a period of three months. Questionnaires were given to both the psychiatric nurse consultant and the triage nurse. The results showed that the triage nurse assessed a much higher proportion of patients as emergencies than the psychiatric nurse consultant; furthermore the two participant groups only agreed the same category ranking in 34% of all cases. Happell et al (2003) have suggested that further research ought to be carried out into the reasoning behind why the triage nurses categorised the patients in such a way that differed from the psychiatric nurse consultants. The limitations of the study are acknowledged as data was collected from only one emergency department therefore making it difficult to conclude whether or not this would be a widespread finding in other emergency departments.
2.5 Conclusion

In this paper a review of the literature on the subjects of mental illness, attitudes towards mental illness and a triage tool used in the assessment of patients was undertaken. The results of this paper have shown that mainstreaming of patients with mental illness through the emergency department has led to considerable difficulties for patients and staff, particularly for the triage nurses. It has also considered the negative attitudes towards patients with mental illness and the need for further education in order to address these reactions. There is a huge emphasis in the literature on the requirement of formal education in mental health.

The benefits of education in overcoming the negative attitudes and stigma towards those individuals with a mental illness have been addressed across a large section of the literature. This literature review has highlighted the fundamental need for a systematic approach to the triage of patients presenting with a mental illness along with a commitment reducing waiting times, accelerating transition to the appropriate services and effectively integrating the care of those with mental illness into the emergency department practices.

Finally the merits of implementing a Mental Health Triage Scale are widely recognised as it appears to reduce the knowledge deficit and the fear of the unknown for staff when it comes to this particular cohort of patient. It provides guidelines for the triage nurse to refer to in line with determining an assumption as to the urgency of the patient presenting to the emergency department.

The patient that attends the emergency department does so because they need advice at a time of crisis. It is essential for nurses to assess patients holistically and to consider their psychological and social state as well as their physical state. Irrespective of the reason for their attendance, Patients should be provided with a service that is appropriate to them. It was found that there is a paucity of literature on the perceptions and opinions of patients with mental illness who attend the emergency department; symptomatic perhaps of the lack of recognition currently given to this category of patient as a distinct group with particular needs within emergency departments. In this respect, it is submitted that much more needs to be done from an Irish context to improve the experiences of those patients with mental illness.
Consequently the subsequent chapters will explain in detail the change that was implemented and the processes undertaken in an effort to ensure its success.

Chapter 3

Methods and the Change Process

3.1 Introduction

The management of change is a complex and continuous process. It must be carefully planned to achieve success (Coghlan and McAuliffe, 2003). In the following chapter the influence of organisational culture and quality management are reviewed. These two elements are considered to be significant factors in organisational reform and change. Information on an organisation can provide a platform for improving processes and enhancing service delivery. Organisational culture comprises of employee behaviours, attitudes and expectations which all contribute to success or failure of any change (Muldrow et al, 2002). Therefore while communication to all stakeholders, it is of particular importance to those who will be most affected by the change. The implementation of a change in any organisation requires teamwork and should include feedback mechanisms (Shirey, 2011). Changing group behaviour within the healthcare environment takes time, negotiation and supervision (Huber, 2000).

A successful approach to change requires the use of a structured plan to be put in place before implementation begins. This plan can be achieved by use of a change model. Many models of change exist which will be reviewed briefly however for the purpose of this project the Health Service Executive (HSE) Change Model was chosen as the most applicable. The main body of this chapter is concerned with the implementation of the change project by utilising the HSE (2008) change model which consists of four phases namely: initiation, planning, implementation and mainstreaming. In advance of discussing the change model and the change process, one crucial element in bringing about successful change
requires consideration. The following section will briefly discuss organisational culture and its relevance to organisational change.

3.2 Organisational Culture.

In trying to comprehend the organisations culture one must first determine how the actual culture should be described (Willcoxson and Millett, 2000). The Health Service Executive (2006:21) suggests a simplified explanation on it suggesting that the way individuals speak of culture as ‘the way we do things around here’. Organisational culture is neither standardized nor motionless (Kavanagh and Ashkanasy, 2006) but may often occur as slight alterations between elements that typify the particular culture. Willcoxson and Millett (2000) highlight that although cultures are energetic in their adaptation to change and the initiation of new behaviours they still endeavour to preserve some of their old culture and values. For this reason it is necessary that managers are sensitive to the culture of the organisation and direct activities in a productive way thereby avoiding unhelpful behaviour of employees who are not dedicated to the organisations goals and objectives (Coghlan and McAuliffe, 2003).

The attempt to change the organisation’s culture or even departmental culture can prove a challenging prospect (Brazil et al, 2010). Culture change in the organisation is substantially shaped by the leader, therefore they must be confident in their ability to effect change and motivate others to follow. They are also expected to be effective communicators (Kavanagh and Ashkanasy, 2006). Kotter (1996) sound a note of caution however, and states that leaders should realise that management is concerned with planning, organising and controlling while leadership is related to motivation and inspiration of people.

Denison (2000) identified four qualities of culture and leadership namely; Mission, Adaptability, Involvement and Consistency (Appendix F). It is clear from the literature reviewed that while there are a number of definitions of organisational culture, the common theme is that it is imperative that everyone should be aware of what the culture of their organisation represents. It is suggested that if an organisation wishes to be successful they
must analyse their surroundings and adapt to engage in new challenges. If managers don’t have a handle on their organisation’s culture, it is very difficult to communicate goals and objectives to the employees thereby resulting in apathy and indifference (Davidson, 2010). Muldrow et al (2002) support this in suggesting that employees’ behaviours and attitudes towards the organisational values will contribute to the success or failure of any change process no matter how well it is planned. Change should be understood and managed in a structured way with realistic goals and objectives.

Analysing the culture of the ED was considered an important aspect prior to commencing the change process. Roger Harrison’s (1972) “Organisational Culture Questionnaire” (as cited in Brown (1998)). The questionnaire describes four types of organisational culture: power, role, person and task. It was determined using Harrison’s questionnaire that the ED represents a power and role culture mix however during the process of the change a task culture became evident which Knowles et al (2002) describes as a team approach where the focus is on the mission of the organisation and the end is the predetermined goal. This knowledge of the culture was important when proceeding with this change management project.

3.3 The Change Model

This project will focus on the Health Service Executive (HSE) Change Model (Appendix G). The objective of this study was the implementation of a change management project. The steps involved in the change model that was chosen will be outlined in conjunction with the processes involved in carrying out the change project. The model used had been commissioned by the HSE management team in 2008 with its primary focus on change implemented across the Health Services. The model was developed for a variety of reasons including:

- To improve the experience of patients and service users
- To help staff and teams play a meaningful role in working together to improve services
3.4 Rationale for choosing the Change Model

There are many change theories in existence and all have their merits for use within the change process. A number of models were considered for this project and included Kurt Lewin’s (1951) model cited in Guiding Change in the Irish Health System (HSE) (2006). Lewin’s model consisted of 3-stages. The first called the ‘unfreezing’ stage of the change process where attitudes and habits are assessed. Lewin expresses that it is this stage that will predetermine failure or success of the change process. The next stage is the ‘moving’ stage when change occurs and the final stage is named ‘refreezing’ which involves adapting the new way of doing things. Although Lewin’s concept is straightforward it was believed to be too restrictive for this project. It follows a certain pathway and there appears to be no option for variation or deviation in its approach to change, accordingly, it was considered too rigid for use in ED where one size would not necessarily fit all circumstances. The model is designed more specifically for “stable” organisations (Burnes, 2004) as opposed to the ever changing environment that is the ED.

Another change model considered for this change project was Kotter’s eight step model as outlined in Appendix (H). Not unlike Lewin’s model, Kotter’s model is structured in such a way that one feels compelled to follow his steps in sequence despite Kotter (1996) himself suggesting that this was not entirely necessary. Although Kotter’s model is observed as a very rational approach to change there appears to be little scope to go back to a previous step if the need required. This raises the questions that if momentum was lost at any stage of the process through human error or organisational issues would it result in failure? Fernandez and Rainey (2006) pointed out that Kotter’s model needs to be followed one step at a time and describe it as a ‘linear’ approach to change. In this respect it was decided that Kotter’s model did not meet the requirements of this particular project due in the main that the ED is unpredictable and therefore requires a model that portrays a degree of flexibility.
After consideration of the aforementioned models of change, the HSE Change Model was chosen as the most appropriate model of choice. The principal reason for selecting this model was its continuous cyclical nature. The model was developed by adapting various elements of other models to suit its purpose (HSE, 2008). It has been developed specifically to cater for the needs and requirements for both health service providers and service users. The model was deemed particularly suitable for this project as it seeks to involve individuals and teams which is a fundamental pre-requisite for success in any change initiative. Huber (2000) suggests that staff involvement and buy-in are important to the success of any program of change. Another advantage of this change model is that it was formulated by the Health Service Executive. It seems not unreasonable to posit that a model that was first created for the broader Health Service Executive can be readily adapted to suit specific areas that come within the remit of the HSE. Consequently if a change initiative is successful in one area of the executive it could be disseminated to other areas of the organisation with relative ease.

### 3.5 The Change Process.

As outlined in the previous section the structure of the HSE (2008) Change Model was used to undertake a change management project in a busy Emergency Department. The impetus to change both behaviour and performance in the healthcare system in the current climate requires an investment of time, effort and direction to enhance the quality of service delivery. The use of a model in providing a structure to the change initiative is essential in maintaining focus and momentum for any project big or small (Muldrow et al, 2002). The change project was executed under the four key headings of the HSE Change Model (2008) as outlined in Figure 1
Preparing to Lead the Change

The initiation stage deals with several aspects in preparing to lead the change. Included are questions related to what is driving the change? Who should lead the change? Is the organisation ready for the change? What are the opportunities to enable change to take place and the impact of the change? Also built into the initiation stage are objectives and the outcomes enabling change to take place (HSE, 2008). This is the first stage of the process and considers the driving force behind the change.

As Clinical Nurse Manager I have observed that patients with medical and surgical illnesses presenting to the ED have received a higher priority of treatment and care than those with mental illness. For the benefit of this project I held informal discussions with a variety of staff at all levels to investigate why such a discrepancy exists. Several reasons for this disparity of care were offered, including statements such as the ‘patient wasn’t displaying any physical symptoms’, ‘they did not require analgesia’, the ‘patient was reluctant to wait for treatment’ or the ‘patient was reluctant to engage in conversation’. A large number of staff explained that they had no formal training in mental illness and often felt overwhelmed by the individual presenting with a mental health crisis. They were concerned that by

Figure 1
questioning the patient about their presentation could result in unpredictable responses and violent outbursts.

Following on from these discussions I reviewed the nursing documentation which outlines nursing care and interventions undertaken by the nursing staff. I found a considerable deficit in recording of information for the patient presenting with mental illness. The nursing documentation only appeared to be commenced if a decision was made to admit the patient. This documentation contained very little information on the patient including their psychological state, who they were accompanied by or if they required supervision whilst in the ED. When staff were questioned about the poor standard of documentation it was explained as being due to the pressures associated with a busy ED. In addition to this some staff suggested that as the patient displayed no physical illness they didn’t require regular observation. However the importance of proper nursing documentation cannot be overemphasised. The purpose of such record keeping is to provide precise and timely accounts of patient care and to demonstrate the nurses’ knowledge and skills according to nursing’s professional code of practice (DeWolf-Bosek and Ring, 2010). From a legal perspective the ED nursing documentation is often requested for submission in relation to law suits or coroner’s inquests. This further displays a need for accurate and relevant record keeping in line with the nurses’ code of conduct (An Bord Altranais, 2000).

In light of the information gathered from these informal discussions with staff I commissioned a questionnaire (Appendix I) to gather information on a number of issues including: (a) the number of staff with a formal education in mental health, (b) their personal level of confidence in the ability to treat and assess patients presenting with mental illness? The format of the questionnaire was tailored to suit the respondents work schedule as I was cognisant of time constraints. I was aware that many other studies were taking place within the ED and I did not wish to over burden staff with a lengthy survey. I sent the questionnaire to 65 staff, including frontline clinical nurse managers, clinical facilitators and staff nurses. A poster was circulated around the department a week prior to the distribution of the questionnaire. The poster gave a synopsis of the reasons for the questionnaire and requested staff participation.

As a result of the questionnaire and discussions held with staff it was evident that there was a sense of urgency to change the way things were done. Kotter (1996) describes
establishing a sense of urgency as a crucial element to garnering attention and cooperation of staff. He suggests that the retention of external consultants to highlight the urgency to the key stakeholders would be beneficial. However as muted previously, due to internal hospital financial constraints any cost implications would possibly have immobilised this particular project and accordingly, Kotter’s suggestion was not adhered to. In any event, the overwhelming consensus from the feedback gathered, was that staff were already aware of the necessity of change and anxious that it be introduced with haste.

October 2010

The first step before the change project was put in motion was to obtain support and permission from the relevant authorities. The Director of Nursing, Assistant Director of Nursing, three ED consultants, one Psychiatric consultant, Information Technology (IT) management and Practice Development were all contacted prior to commencement of the project. Meetings were requested and letters were written to all the above which contained details on the proposed change and a Project Impact Statement (Appendix J). Involvement of top level management was seen as essential as they are responsible for both internal and external processes and are generally make the final decisions. Fayol as cited in Evans (2001) suggested that power to issue instructions as wielded by those in authority should be used in a responsible and appropriate manner. All but one level of senior management agreed to meetings in relation to the proposal however due to demanding schedules it was December before a general consensus was reached for the project to proceed. The initiation of the project was arranged for January 2011.

Once their permission and support was granted the frontline clinical nurse managers and staff within the ED was consulted regarding the proposed change which was outlined using a power point presentation to explain the aims and objectives of the proposed change management project which were:

- Development of Nursing Assessment Documentation (Appendix A).
- Introduction of a Mental Illness Triage Tool Wall Chart (MITT)(Appendix K)
- Development of a computerised pop-up screen for triage(Appendix L)
The benefits of successful implementation of the project were outlined to staff. The changes were patient focused. All staff were furnished with hard copies of the documents along with the project impact statement. They were requested to consider and disseminate the information which contained the rationale and the desired outcomes of the change. It was established that as I was proposing the change initiative that I would be the change agent. As the change agent it was my duty to develop a climate for change and to delegate responsibility to others in an effort to achieve desirable outcomes (Bennett, 2003, McAuliffe and Vaerenbergh, 2006).

A follow-up meeting for the second week in January was arranged to discuss their thoughts and considerations of the proposal. These meetings were organised as focus group discussions. Each focus group would consist of between six to eight staff. Discussions would be related solely to the change project and meetings would last no longer than thirty minutes. Times and dates for the meetings were posted on the staff notice board. These first meetings would a generalised discussion on the proposed change to get feedback. Kitzinger (1995) suggests that focus group discussions help to articulate individual views, generate questions and pursue priorities.

Prior to the next meeting staff were requested that while deliberating on the proposal that they would take into account aspects such as, patient safety, the impact of the change on the department, the change process being utilised to implement the change, the affects positive and negative the change would have on service users, resources available for the change, was it manageable/achievable in their opinion and finally were there aspects that were deemed acceptable or otherwise. Obtaining buy in from clinical nurse managers was a crucial aspect as they would be required to encourage and keep staff motivated whilst supporting them with the change initiative. Welford (2006) suggests that willingness and commitment from management is paramount in creating the momentum for change among subordinates.

In preparation for the planning phase of the model, I had to establish how prepared the ED, was for change. Madsen et al (2005) highlight that if employees are to be encouraged to alter the way things are done than the onus is on managers to recognise the factors that influence readiness for change. A Power Interest Grid was one tool used to assist in gathering and analysing information to determine whose interests should be taken into account.
Analysis of strengths, weaknesses, opportunities and threats (SWOT), force field analysis (Appendix M) were among the tools used to determine external and internal factors which might hinder or support the project. These tools helped to facilitate the change process by determining levels of expertise and enthusiasm related to the change project (MacPhee, 2007). Knowing the culture is one of the most valuable components to reforming service delivery as it creates the potential to maximise service quality for both health care providers and service users (Kalisch and Curley, 2008).

January 2011

Focus group discussions took place the last week in January. The issue of resources was the first item raised by a number of group members as they were concerned about fund allocation in specifically relating to the computerised component of the change project. It was explained that as triage was already computerised and well established in the ED there would be no requirement for external resources. I requested the input from the IT support staff to confirm this to all staff. I felt it was necessary to act in this way so that staff would realise that I was committed to the project and I had done all the necessary ground work.
Establishing trust was significant to obtaining commitment and motivation to engage in change (MacPhee, 2007). The focus groups suggested that there should be three separate change teams established for the implementation of each element of the project. These teams would be made up of individuals who were enthusiastic and committed to the change effort (champions). A clear vision was to be adapted and a mission statement generated. This process would connect with both internal and external stakeholders (MacPhee, 2007). Staff would put forward their suggestions at the next group meeting in February 2011.

Not all the staff embraced the need for change and some were at a loss as to why the present situation had to change. There was an element of resistance from certain members of senior management. It is imperative that the change agent recognises that resistance to change results for a variety of reasons including previous experiences of change (Patton and McCalman, 2008). I provided those resistant to the change with further information. Highlighted were certain incidents in relation to patients with mental illness which I had experienced. Many incidents were due to factors linked to inadequate assessment, inappropriate documentation and a lack of understanding to patient’s specific requirements. I was aware that individual reactions to change may vary greatly and relished this input from my colleagues as the more positive feedback, as it afforded me the opportunity to present real life examples of the difficulties in the area my project sought to address.

Generally reasons for resistance should be considered positive as it demonstrates an awareness that change is happening (Marquis and Huston, 2006). To mobilise all stakeholders it was proposed that the project would be piloted for a period of three months. The focus groups decided that it would be prudent to meet every two weeks until the implementation of the project. Marquis and Huston (2006) point out that empowering others is a pathway to avoiding or overcoming resistance. Identifying champions of change was essential to creating momentum for change. These were recognised as individuals that realised there needed to be a change from the status quo (Kotter, 1996)

Although the initiation phase was a lengthy process it laid the foundations for the remaining phase of the change process. With the successful gathering of support from the majority of the frontline clinical nurse managers and staff it was possible to advance to the planning stage.
Planning

Building Commitment

The purpose of the planning stage is to engage with staff and key stakeholders in creating a vision for the future (HSE, 2008). Creating a shared vision is instrumental in clarifying the direction of the change and thereby motivates individuals to take action however Kotter (1996) argues that the vision must be realistic and therefore achievable. I was cognisant that not everyone would share similar views to me. I engaged all staff in conversation to establish what their desired future state for the department was and therefore making it their vision and not just one individual’s aspirations for the future.

February 2011.

The change teams spent these meetings designing the process of implementation. Firstly a vision had to be agreed upon. Focus group discussions centred on devising the vision statement that would be used to create a picture of what all stakeholders imagined for the future. This vision needed to incorporate the goals set out by the Department of Health and Children (2001) in the document ‘Quality and Fairness-A System for You’ which included: better health for everyone, responsive and appropriate care delivery and high performance.

Rashford and Coughlan (2006) recommend a system where groups of three or four individuals would put forward their ideas on their vision for the organisation. After much debate but with a shared agreement a vision statement was established. This vision statement would be communicated at regular intervals by the change teams. Cartwright and Baldwin (2007) indicate that continuous repetition of the vision will have the greatest impact over time. The vision we would impart to all key stakeholders was that of ‘the provision of a better service by the improvement in knowledge, assessment and care of patients with mental illness attending the ED’. These teams consisted of varying levels of expertise which Michie and West (2004) consider as important in developing a team approach and diversity of interest and influence.
Group One: Nursing documentation-

Clinical Nurse Manager

3 staff nurses

(All above liaising with Nurse Practice Development)

Group Two Mental Illness Triage Tool (Wall chart)

Clinical Nurse Manager
Clinical Facilitator
2 staff nurses

Group Three Computerised Triage Pop-up Screen

Clinical Nurse Manager
Clinical Facilitator
2 staff nurses

Determining the detail of the change

Prior to the implementation of the Mental Illness Triage Tool wall chart and the computerised pop up screen, benefits might be gained in carrying out a small scale observational audit of current practice. Patients are ordinarily triaged using the Manchester Triage System; this is a five level acuity scale basing patients symptoms against fifty different descriptors (McMahon, 2003) outlined in chapter 2. Decisions of emergency care need are dependent upon the level of experience and knowledge of the triage nurse. The Australian College for Emergency Medicine (ACEM) advocates that all patients should be triaged by a ‘specifically trained and experienced nurse’. However when it comes to the triage of patients with mental illness even the more seasoned and accomplished staff nurses and clinical nurse managers can find the triage of this cohort of patient a challenging prospect. A member from each of group two and three sat in on the triage of patients presenting with mental illness with another triage nurse. The patients were triaged using both the Manchester Triage System (Appendix E) and the Mental Illness Triage Tool (Appendix K). The nurses also recorded the length of time it took to triage the patients using the
Manchester Triage System. This data was used to collect information on the difference in triage allocation using two separate “tools” of assessment and did not include any patient details in the analysis. When collecting data for audit, ethical considerations need to be assessed to protect both patients and staff (National Institute of Clinical Excellence (N.I.C.E), 2002). The triage nurses were willing participants in this small scale study and were informed prior to the data collection the purpose of this data collection. It was arranged that following implementation of the pop-up screen there would be an analysis of triage times again to determine if the new processes reduced triage times. This was one of the objectives for the introduction of the “tools”. Finally a date for implementation of the project was agreed and this was arranged for the first week in March.

Methods of the communication of the change management project were arranged. A brief informal session of approximately ten minutes duration took place each morning following handover to highlight the change project. These brief sessions would capture the majority of staff on day and night shifts. This took place over a two week period prior to implementation. Focus groups arranged dates for further meetings, the information on these were posted on the staff notice board. Staff were also furnished with e-mail contacts of the members of the change team. All members of staff were invited to attend and requested to e-mail items for attention prior to the meetings in relation to questions regarding the change project. Cooper and Benjamin (2004) counsel that continuous consultation and reassure of staff is significant and suggests highlighting how the change will impact on the organisation is of great significance and needs to be reinforced at every opportunity.

The clinical facilitators in the ED received information packs containing the documents and a power point presentation regarding the change project. They were requested by the change agent to outline and discuss the change initiative in their induction of new staff and also to highlight its importance to postgraduate students. The change teams would participate in educational sessions, communicating the progress of the change project and the vision.
Developing the implementation plan.

The development of the implementation plan was crucial at this stage of the process. The meetings arranged for the last two weeks in February informed all key stakeholders about the progress of the change project and how near to readiness it was in terms of implementation which included the confirmation of a start date for the change project. The majority of stakeholders were enthused at the prospect of the impending change however there were a select group that remained unconvinced and resistant to the change initiative. As change agent I felt the onus was on me to get buy-in from those resistant and I attempted to establish their trust by further communication of the vision, the benefits to patients and staff and the importance of their involvement in the change initiative. They were encouraged to voice their fears and concerns. Success of change depends on the change agent’s ability to communicate and their skills of negotiation alongside the expert power they possess (Cartwright and Baldwin, 2007). The decision was made to phase the three elements of the project in over a period of three weeks so that staff had time to adjust as other changes happening within the ED. Achieving change or otherwise depends on individuals’ perceptions on the way it was handled along with the pace of the change which can hinder success (Furst and Cable, 2008)

Elements of the Implementation/ Project Plan

Scope of the change

Assessing the scope of the change was done in collaboration with the three project change teams and the change agent. It was believed to be attainable within the designated time frame. In establishing a consensus on the timeframe several elements were considered including the amount of staff on annual leave, sick leave, the readiness and availability of the IT support team, and the fact that there were no other projects under way at this time. The change teams would all be available in order to offer support to all staff during this transition from the old to the new. The ED consultants were informed of the commencement date and the sequence of events and were very supportive.
Sequence of actions

Each element of the change project would be introduced on the Monday and evaluated on the following Friday through the medium of feedback from staff. This would allow for corrective action to be taken where the feedback recommended it as necessary. It was hoped that the constant and regular feedback would maintain the momentum and guarantee a sense of purpose and importance to staff feedback. Although the project was specifically designed for use in the ED there was a requirement to have regular communications with the psychiatry team. The liaison psychiatry clinical nurse manager’s feedback was of huge significance because of her specialist knowledge and this input was channelled through to the frontline staff and change teams.

Resource Requirements

It was noted that IT would be the main resource required after the frontline staff to facilitate the implementation plan. However due to circumstances they were unavailable to provide support on the first week of the implementation phase. It had been arranged that the computerised pop-up screen was to be the first element set in motion but owing to the situation we found ourselves in, the decision was made to introduce the Mental Illness Triage Tool. A commitment was given by IT that the computerised pop-up screen would be in place for week three of the implementation phase.

Risks

The main risk identified was that due to the delay in the installation of the computer element this would possibly give rise to delays with the triage of patients while staff became familiar with the new triage tool. The change teams proposed a solution in that if the triage nurse found that if there were time delays in triage, the clinical nurse manager would be contacted and an extra nurse would be deployed to assist with other triage presentations. This was put to the clinical nurse managers and they were supportive of this proposal. It was pointed out that these delays would not be long-term and it was only a matter of staff becoming familiar with the new triage system.
Communication

As discussed in relation to sequence of actions the elements of the project would be implemented over a period of three weeks with communication on Fridays. Staff had already received the change teams e-mail addresses and there would be brief discussions following morning and evening shift changes. Additionally there was a comments box left in the staff tea room which would provide staff to put forward their comments anonymously if they so wished. It was thought that this system might give a more true reflection of issues that staff had as some may have felt under pressure not to speak freely for fear of causing offense to the members of the change teams or change agent. The contents of the box would be reviewed every two to three days.

Presenting the change as a means to delivering a better service for patients was seen as a way to sustaining the interest and momentum in the initiative. Staff were ready to accept changes as it gave them a sense that they are doing something worthwhile. Kalisch and Curley (2008) suggest that letting staff know that the change is a team effort as opposed to coming directly from management could have practical benefits.

Implementation

March 2011

Implementing the change.

This stage of the change involves implementing the project plan and assessing if the objectives are in line with the plan (HSE, 2008). Communication forms an integral part of the implementation phase. Verbal communication needs to be clear and concise and easy to comprehend. There should be clarification sought at every juncture to ensure that all involved comprehend the process. McAuliffe and Van Vaerenbergh, (2006) articulate that regular and effective communication provides immense benefits to the change process. However some barriers continued to place pressure on the implementation of the project as certain groups at
senior management level were slow to let go of the ‘old’ ways of doing things. Armstrong (2001) expresses the belief that the shock of the ‘new’ way may cause insecurities in people who are afraid to lose their sense of familiarity and belonging.

In contrast frontline staff embraced the new changes enthusiastically and with vigour. They were aware of the need to change from a patient safety and efficiencies point of view. The staff took ownership of the project and in essence became leaders themselves in the process. Staff articulated that much of their enthusiasm for the project was due to their involvement from the initiation phase of the project. They considered the regular communication and educational sessions alongside the focus group discussions as key components in their acceptance of the project. Michie and West (2004) articulate that if individuals are managed effectively it will impact on their performance and behaviour. Furthermore, Shirey (2011) places emphasis on teamwork, regular reviews and feedback mechanisms as elements for successful implementation.

The introduction of the elements of the change project over a three week period was done in an effort to reduce the pressures on staff. They were consulted on each element at regular intervals and were requested to put forward their ideas and thoughts. Oreg (2003) advises that staff should not be overloaded with too much information about the change. It is suggested that this could lead to resistance of the change effort. The change teams were also supported throughout the change process and it was made certain that they understood what was required to make the change a success. Senior nursing management and the ED consultants received regular updates on the progress of the implementation phase.

Although frontline staff including clinical nurse managers had ‘bought in’ to the change effort there were some individuals at more senior level displaying consistent resistance to the change effort. These individuals gave the impression that the change management project wasn’t worth the investment of time and energy. Murphy (2005) expresses the fact that managers may become so entrenched in ‘day to day crises’ that they don’t involve themselves with the empowerment of staff. McAuliffe and Van Vaerenbergh (2006) suggest that without the implicit support of senior management, it is likely the project will end in failure.
Nevertheless as a change agent and leader of the project I was determined to overcome these obstacles. Conger (1998:93) states that ‘you must show your commitment to a goal is not just in your mind but in your heart and gut as well. Without this demonstration of feeling people may wonder if you actually believe in the position you’re championing’. Communication and negotiating efforts were improved to counteract resistance including representations made by frontline clinical nurse managers regarding the benefits of the change project they had experienced to date and the positive effect it was having on nursing staff.

**Sustaining momentum.**

Anchoring new practice in a culture can be a difficult undertaking one which Kotter (1996) considers as one of the greatest barriers to sustaining momentum. The importance of involving key stakeholders from the outset of the change process cannot be underestimated and for this reason the ongoing influence of leaders and their ability to engage and empower stakeholders at all levels of the spectrum is crucial. In order to successfully influence those involved, the leader must themselves be motivated which will help to enhance the effectiveness, growth and expansion of the change project (Coghlan and McAuliffe, 2003).

In sustaining momentum there must be an indication from those leading the change that it will improve things. Focus group discussions were continued following the implementation of all the elements of the change project. Face to face communication with staff and key stakeholders at regular intervals was necessary to continually monitor the progress. Negotiations with senior level management were ongoing. There continued to be levels of conflict among a certain number of senior managers especially in relation to the nursing documentation. The requirement for the documentation was regularly questioned. There was also the insinuation that this project was only authorised for the purpose of completion of a Masters Programme and therefore would be withdrawn once it was evaluated. Despite this aversion and negativity towards the process I as change agent with the assistance of the change team and with the support of other senior management, continued to communicate to the frontline staff /key stakeholders the progress of the project.
Mainstreaming

Feedback from the clinical nurse managers was positive in support of the computerised pop-up screen and the Mental Illness Triage Tool; however there were issues with the nursing assessment documentation. It was suggested staff would find it more user friendly if it was combined with the other nursing assessment documents in booklet form.

At the initial stage of the implementation process slight delays were noted with the triaging of patients however with constant supervision and encouragement from the change teams, the waiting times were reduced. The clinical nurse managers expressed how staff appeared more confident in their assessment of patients with mental illness and more assured in their interactions with the psychiatry services. Many clinical nurse managers felt there had been a reduction in the number of complaints and incidents regarding patients with mental illness. The elements of the change project have been taken on and improvements have resulted. Kotter (1996) suggests that the approach to change and its implementation are as important as the support from influential senior management.

3.6 Conclusion

This project focused on the implementation of a change in the triage and assessment of patients with mental illness in the ED. The change process was undertaken by utilising the components of the HSE (2008) change model. The model provides for a structured approach and helps to focus activities for the change agent and change teams. Recognition of the need for change and communication of the need in a clear concise manner is very important.

Involving staff from the outset is essential and reduces the levels of resistance for change. An establishment of trust helps in the transformation from the old to the new way of doing things. Change needs to be developed in such a way that it is understood and managed so that staff are able to cope with the transition. There needs to be a certain level of urgency about the need for change and therefore a comprehensive communication of the vision is
crucial. The change agent or change leader must consistently check with staff that they agree with the change and they should be involved in the planning and implementation of the change.

Finally it is important that if elements of the change are not working they must be revisited and restructured in order to maximise the success of the change process. Change should not be imposed on people but communicated in a way that they themselves will become leaders of the change project.

Chapter 4

Evaluation of the Change Project

4.1 Introduction

The evaluation of any change is an important component in the management of change initiatives and a concept that cannot be underestimated. Many people consider evaluation as something that occurs at the end of a project. Oermann and Gaberson (2006) believe that evaluation needs to be viewed as a continuous process and used as a tool to develop organisational efficiencies.

The process of evaluation depends on what you are attempting to evaluate the goal of which is to provide feedback on the impact of the project and to measure improvements. Many evaluation tools can be used to calculate these improvements. The tools used for the purpose of this project were questionnaires and focus groups. These tools established that improvements did occur following implementation of the project and will be discussed in the following section.
4.2 Evaluation Tools and Outcomes of the Change.

Evaluation of the change was analysed through both quantitative and qualitative approaches. These included pre and post implementation questionnaires (Appendix I and N) to probe for crucial information, focus group, interview and observational audit collection. The evaluation confirmed that: (a) nurses levels of confidence increased, (b) the time it takes to triage a patient as a result of the pop-up screen was reduced, (c) the triage tool helped to clarify the actions to be taken following triage (d) effective communication and stakeholder involvement ensures success of change initiatives.

The questionnaires were circulated to 65 staff and constructed to measure pre and post the change management project. The pre-implementation questionnaire consisted of four questions: two questions reflect the level of experience and qualifications of staff in the ED, one question concerns the number of staff with a formal education in mental health and the final question pertains to confidence levels regarding the triage and assessment of patients with a mental illness. Two results from the questionnaires are represented by pie charts, Appendix O represents formal education in mental illness and Appendix P compares confidence levels pre and post implementation of the change management programme. There was a 79% response rate to the pre-implementation questionnaire and an 85% response to the post-implementation questionnaire. The difference accounted for staff returning off various leave.

Pre-implementation results revealed that 66% of staff had no formal education in mental health, four staff had post graduate qualifications and three staff had a primary degree in mental health. It was also noted that of seven clinical nurse managers and two clinical facilitators none had a formal qualification in mental health.

Levels of confidence in triage improved following implementation of the triage tool and computerised pop-up screen. Pre change shows level of low confidence at 35% but following the change project low levels of confidence reduced to 23%. Questionnaires and interviews conducted with the clinical nurse managers and clinical facilitators indicated that they had noted that there was significant improvement in the triage and assessment of patients with mental illness.
The observational audit carried out in triage pre the implementation noted that patients triaged using the Mental Illness Triage Tool were given a higher triage category (Appendix Q) than those triaged using the Manchester Triage Scale. Finally triage times were reduced from six minutes to four minutes. This reduction according to staff was related to the computerised pop-up screen

While staff almost unanimously agreed that the computerised pop-up screen and the triage tool were of benefit to the department, the nursing assessment document was not greeted with the same level of enthusiasm. The design was not the issue; the fact was that nursing staff considered that there were too many nursing documents to manage. It was suggested that the design should be amalgamated with the original document.

Despite not accomplishing all the elements outlined in the Project Impact statement it was considered that the change management project was ultimately a success. Those elements not achieved are currently being considered by management (such as the contacting of psychiatry direct from triage and the retention of a mental health nurse practitioner) and negotiations are in progress with the relevant authorities.

4.3 Conclusion

The results of the questionnaires, focus group and interviews have provided considerable information on the benefits of the change project. Based on the findings it can be concluded that; the use of a well structured triage tool can benefit the assessment of the patient and significantly increase staff confidence by providing guidance in relation to the patient’s presentation. The development of a triage screen that requires only a “yes” or “no” response while still gathering significant information on the patient helps to cut down on triage times. These initiatives have led to improvements for patients and staff highlighting that although a project may be small it can have huge implications and benefits.

The next chapter discusses the strengths and limitations of the project and also recommendations for the future.
Chapter 5

Discussions and Conclusions.

5.1 Introduction

This change management project was based on the overall objective to improve the triage and assessment of patients with mental illness attending the ED. This thesis outlines the processes involved in the implementation of those changes to practice to achieve the desired goal. This change project was carried out in a busy ED in Dublin using the HSE (2008) change model which was used to structure this project and provide a framework for implementation of the various elements.

The success of this change project was achieved with the involvement and commitment of staff through their active participation and constant enthusiasm. The majority of staff took ownership from the outset citing communication and consultation as significant elements in their continued support of the project. The strengths and limitations will be discussed in the next section. Analysis of these elements allow for an objective assessment of the merits of the change project. The results of the questionnaires and focus groups outline the improvements that took place through the implementation of this project.

5.2 Strengths and limitations of the project.

Strengths of the project lie mainly in the fact that nursing levels of confidence improved over the course of the change management project as outlined in the evaluation section. Clinical nurse managers noted a significant improvement in the assessment and triage of patients. Finally the reduction in triage assessment times has had huge benefits to the department, patients and staff.
Limitations arise as the project was confined to one department. The data collection samples were small and the lack of comparative material limits the reliability of the studies. This is the first project of its kind to be undertaken in this particular department which sought to involve all staff. Therefore levels of enthusiasm and commitment may be misplaced. Finally assessing the true accuracy of the new triage systems would require review of patient’s journey through the ED and the outcomes for the patient. Due to time constraints and the scope of the project this was not possible. Nevertheless the project highlights the benefit of a change in practice and opens the forum for discussion for greater access to specialist care and the ongoing incentive to improve.

5.3 Recommendations for future improvements.

There needs to be a focused effort from the multidisciplinary team in providing a more integrated care pathway. Mental health service delivery needs to improve as there is documented evidence to suggest there is a persistent growth in demand and requirement for improved services (National Suicide Research Foundation, 2009). This increase in demand results in greater pressures for ED staff and patient flow.

The use of the mental illness triage tool has had considerable benefits in the assessment of patients with mental illness however there needs to be increased involvement from the psychiatric services. Although negotiations are in train regarding direct referral from triage, agreement needs to be reached as soon as possible to benefit the patient. This would result in improving the integration of patients with mental illness into the ED through accelerated referral to the required resources (Smart et al, 1999).

Some studies have demonstrated the benefits of a mental health nurse specialist as a huge benefit in the ED as their presence has been shown to lead to reduced waiting times, more patients were reviewed and this in turn reduced emotional outbursts and agitation (McDonough et al, 2004, Wand and Fischer, 2006).
There were benefits gained through the education of staff by the clinical facilitators and the liaison psychiatric clinical nurse manager therefore a recommendation to have regular in-service training would further enhance the assessment of patients with mental illness.

Finally there is a huge requirement to provide an acute admissions unit for patients with mental illness where they can access the appropriate services without delay and thus avoiding the experiences of a noisy overcrowded emergency department. However all these recommendations require investment of capital, which, in the current economic climate is not very accessible. Meanwhile ED staff and the mental health services need to collaborate in delivering an appropriate and effective service to patients with mental illness. Changing the present system is difficult but with a concerted effort and positive attitudes towards change the healthcare system can strive to deliver a better service for those with mental illness.

5.4 Reflections on the project.

I found the change management project in its entirety, a very challenging but a worthwhile experience. There were positive and negative aspects experienced during the process. The overwhelming support and encouragement from the frontline staff was unprecedented. The commitment and enthusiasm with which they took on the project was humbling. As with any new initiative there is always an element of resistance. At times this resistance was difficult to manage. Although I call it resistance it would possibly be best described as negativity but presented in such a way that the project would have no benefit for the department. In addition to this was the regular rhetoric that this project was only for the primary reason of fulfilling a Masters Programme was at times disconcerting. However I had the commitment of the principal stakeholders, the frontline staff and the ED consultants which made up the bulk of the support that I required.

Overall I found the experience most enjoyable and I look forward to my next project with enthusiasm as I am now more cognisant of the processes involved.
5.5 Conclusion

Improving the triage and assessment of patients with mental illness attending the Emergency Department was the principle objective of this change management project. The change process was carried out using the steps of the Health Service Executive Change Model (2008). I believe the project was a success as the objective was achieved.

The engagement of key stakeholders and relentless clear communication are two fundamentally important elements that must be cultivated. The success of the project was due to the constant communication of the vision and the empowerment of staff through change teams and champions of change.

The use of a structured framework helped to improve the assessment of patients with mental illness and accordingly increased staff confidence. In conjunction with this the introduction of the computerised triage pop-up screen reduced triage assessment times whilst obtaining the most relevant details from the patient.

This change management project set out to improve the triage and assessment of patients with mental illness. I consider the project a success as it achieved its objective through managing the change process in conjunction with the steps of the HSE change model.

‘Wise men change their minds,

fools never’

(Unknown)
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Accessed on 20th February 2011


Accessed on 20th February 2011

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http://www.ncnm.ie/items/1310/85/5212720792%5CInteg_Care_Path_2006.pdf


https://auth.athensams.net/?ath_returl=%2Fmy%2F&ath_dspid=ATHENS.MY

https://hseland.ie
## Appendices

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<td></td>
</tr>
<tr>
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<tr>
<td>N</td>
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<td></td>
</tr>
<tr>
<td>O</td>
<td>Questionnaire results – formal education in mental health</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Pre and Post Implementation levels of confidence</td>
<td></td>
</tr>
<tr>
<td>Q</td>
<td>Triage Category Allocation- Manchester Triage Vs Mental Illness Triage Tool</td>
<td></td>
</tr>
</tbody>
</table>
## Emergency Department Specialty Nursing Document

<table>
<thead>
<tr>
<th>Name:</th>
<th>Transfer from:</th>
<th>.................................</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Hospital, Garda station, Other)</td>
<td></td>
</tr>
<tr>
<td>MRN:</td>
<td>GP Referral</td>
<td>checkbox</td>
</tr>
<tr>
<td>DOB:</td>
<td>Referral Letter</td>
<td>checkbox</td>
</tr>
<tr>
<td>Arrival Date / Time:</td>
<td>Formal (MHA 2001)</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

### Presenting Complaint:

- [ ] ............

### Allergies:

- [ ] ............

### Accompanied by:

- [ ] Relative:
- [ ] Phone No:
- [ ] Friend:
- [ ] Phone No:
- [ ] Other:
- [ ] Phone No:
- [ ] Unaccompanied: Yes/No

### Location

- [ ] Zone 1
- [ ] Zone 2
- [ ] Resus
- [ ] Other

### Location Handed over to:

### MHA (2001) Application Forms

- [ ] Form 1 (Maroon) Spouse / Relative
- [ ] Form 2 (Orange) Authorised Officers
- [ ] Form 3 (Green) Garda
- [ ] Form 4 (Blue) Member of public/CNM
- [ ] Form 5 (purple) Fully Reg. Med. Practitioner

### Interventions:

- [ ] Medical Assessment
- [ ] Time........Hrs
- [ ] Bloods Req / taken
- [ ] Time........Hrs
- [ ] Medication Given
- [ ] Time........Hrs

### Discharge Details:

- [ ] Discharged
- [ ] Time........Hrs
- [ ] Date.............

### Follow up:

- [ ] GP
- [ ] CMHT
- [ ] Other
- [ ] NOK informed

### Admission Details:

- [ ] DTA
- [ ] Time........Hrs
- [ ] Ward:
- [ ] Time........Hrs
- [ ] Medical / Nursing Notes
- [ ] Admission Chart

### Escorted By:

- [ ] Garda
- [ ] Security
- [ ] Nurse
- [ ] Porter
- [ ] Other

### Nurse Signature:

- [ ] Date / Time:
# Appendix B

## Current Nursing Documentation

### Adult Emergency Department — Nursing Documentation

<table>
<thead>
<tr>
<th>WARD</th>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EYES OPEN</th>
<th>EYES CLOSED BY VEILING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Open</td>
<td>Eye closed by veiling</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best Motor Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obey Commands</td>
</tr>
<tr>
<td>Localize Pain</td>
</tr>
<tr>
<td>Withdraw From Pain</td>
</tr>
<tr>
<td>Return To Pain</td>
</tr>
<tr>
<td>Extension To Film</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>

### Pain Score (Please circle)
- No Pain
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

### Pain Score 1 hour Post Intervention
- No Pain
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

### Drug Therapy Immediately Prior to Arrival
- Oxycodone
- Morphine
- Ativan
- Haloperidol

### Presenting Complaints
- Chest Pain
- Shortness of Breath
- Abdominal Pain
- Headache
- Cough

### Next of KIN
- Name: [Name]
- Relationship: [Relationship]
- Tel. Number: [Tel. Number]
- Informed: Yes/No
- Reason (if not): [Reason]

### Pastoral Care
- Contacted: Yes/No

### Pain Score
- Time: [Time]
- Site: [Site]
- Intervention: [Intervention]

### Mobility
- Independent: Yes/No
- Needs Assistance: Yes/No
- Able to Walk: Yes/No
- Immobile: Yes/No
- Social Work Referral: Yes/No
- Occupational Therapy Referral: Yes/No

### Intervention
- 12 Lead ECG
- MSU sent
- HCG
- Peak Flow

### Temperature
- Oral: [Temperature]
- Axillary: [Temperature]
- Rectal: [Temperature]

### Blood Pressure
- Systolic: [Blood Pressure]
- Diastolic: [Blood Pressure]

### Pulse Rate
- [Pulse Rate]
Appendix C

**Recommendations in *World health report 2001:110-112***

- Provide treatment in primary care
- Make psychotropic medicines available
- Give care in the community
- Educate the public
- Involve communities, families and consumers
- Establish national policies, programmes and legislation
- Develop human resources
- Link with other sectors
- Monitor community mental health
- Support more research
Appendix D

The mental health nurse practitioner in the emergency department: An Australian experience

1. Provides expert mental health nursing care through direct contact with patients, family and significant others and through support, education and advice to other health-care professionals.

2. Incorporates an expanded, autonomous clinical role in decision-making, medication prescribing and in advising on or interpreting pathology tests and results.

3. Provides a link between mental health services, community organizations, general practitioners and mainstream medical services.

4. Actively promotes mental health awareness and primary prevention.

5. Facilitates access to medical care for people with mental health concerns.

6. Uses a repertoire of psychotherapeutic and psycho educational interventions with individuals to promote greater personal understanding and self-mastery.

7. Demonstrates a high standard of professional practice and clinical leadership that incorporates education and research.

Appendix E  Manchester Triage Algorithm for Mental Illness

Airway Compromise
Inadequate Breathing
Hypoglycaemia

RED

Altered Conscious Level
High Risk of Harm to Others
High Risk of Self-Harm

ORANGE

Significant Psychiatric History
Moderate Risk of Harm to Others

YELLOW

GREEN

Appendix F

Denison’s qualities of culture and leadership.

Adapted from www.denison.com
Appendix G

Health Service Executive Change Model (2008)

Appendix H

Kotter’s eight step change model

1. Establishing a sense of urgency
2. Creating a guiding coalition
3. Developing a vision and strategy
4. Communicating the change vision
5. Empowering broad-based action
6. Generating short-term wins
7. Consolidating gains and producing more change
8. Anchoring new approaches in the culture

Appendix I

Change Management Project Pre-Implementation Questionnaire

How long have you worked in the Emergency Department?

1-5 years ☐  5-10 years ☐  >10 years ☐

What position do you hold in the Emergency Department?

CNM ☐  Clinical Facilitator ☐  Staff Nurse ☐

Have you had any formal education in mental health?

Yes ☐  No ☐

If yes:  Postgraduate Qualification ☐  Primary Degree ☐

How would you describe your levels of confidence in triaging patients with a mental illness?

Low ☐  Moderate ☐  High ☐

Thank you for your time in responding to this questionnaire.
## Appendix J Project Impact Statement

<table>
<thead>
<tr>
<th><strong>Behavioural</strong>: describe current patterns of behaviour/attitudes of the key people involved with the issue</th>
<th><strong>Behavioural</strong>: what sort of behaviours would (ideally) be evident when the issue has been addressed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients presenting with Mental Illness to the Emergency Department (ED) are triaged using the same format as patients with a medical or surgical complaint. ED nurses may have little or no formal education training in Mental Illness. No set computerised triage system in place to document accurate and important details in relation to patient with mental illness.</td>
<td>Streamlining of patients with mental illness Reviewed by clinical specialist in mental health in a timely fashion Reduction in psychological distress for patient Mental health nurse specialist in the ED. Recording of accurate and relevant data on patients condition Improved system of information gathering for audit purposes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Structural</strong>: describe the way roles and responsibilities are currently organised</th>
<th><strong>Structural</strong>: describe how roles/responsibilities would be organised once this issue has been addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triage nurse assesses patient with mental illness using Manchester Triage System (MTS) Patient generally returns to waiting room if deemed not to be in crisis as per triage assessment Emergency department clinician reviews patient Decision to refer to psychiatry made following assessment Decision made for admission/discharge</td>
<td>Assessment done using Mental Illness Triage Tool in conjunction with MTS Liaison psychiatry contacted as per triage category with reference to Mental Illness Triage Tool direct from triage. Review by liaison psychiatry. If patient requires medical assessment review directly by medical team not ED. Decision made for admission/discharge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Cultural</strong>: describe “how things are done around here” now, e.g. accepted ways of doing things, implicit understanding</th>
<th><strong>Cultural</strong>: what will be “the way things are done around here” when the issue has been addressed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessed by triage nurse using MTS Allocated triage category Security informed if patient considered high risk Patient returns to waiting room Awaits ED clinician review Decision made to refer patient to liaison psychiatry Patient waits for psychiatry assessment</td>
<td>Assessed by triage nurse using Mental Illness Triage Tool in conjunction with MTS Appropriate triage category allocated Security informed if patient considered high risk Triage nurse liaises with liaison psychiatry Appropriate nursing documentation completed including recording of nurse assigned to take charge of patient. Patient directed to ‘quiet’ room away from noisy waiting room for review by liaison psychiatry</td>
</tr>
</tbody>
</table>
# Appendix  
K Mental Illness Triage Tool

<table>
<thead>
<tr>
<th>Triage Code</th>
<th>Description</th>
<th>Treatmentstudy</th>
<th>Typical Presentation</th>
<th>Emergency Department Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Determination in life (Self or others)</td>
<td>Immediate</td>
<td>Observed - Displays inhuman agitation or restlessness - Bizarre/disoriented behaviour - Violent behavior - Possession of weapon - Destuctive behaviour in ED (not+Giants inappropriate)</td>
<td>Supervision - Continuous visual supervision 1:1 ratio - Actions - Ensure Security/initial attendance as necessary - Alert the following staff members immediately and ensure prompt assessment of the patient: - OMM 2.2助理 - ED Medical staff - Ulaanbataar OMM - Ulaanbataar NO ED - Remove any potentially dangerous objects and/or substances from patient - Establish patient's past medical history - Ensure medical assessment is performed - Transfer patient to designated ward/hospital - ED not approved centre - Police should remain with patient</td>
</tr>
<tr>
<td></td>
<td>And/or Completion of involuntary application form and recommendation form as per Mental Health Act 2015 prior to arrival</td>
<td>Patient reports - Verbal Comment to do harm to self or others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Probable risk of danger to self or others</td>
<td>Very Urgent</td>
<td>Observed - Extreme agitation/restlessness - Physically/verbally aggressive - High risk of absconding and not waiting for treatment - Patient actively trying to self-harm and/or leave the department - Confusional to cooperate</td>
<td>Supervision - Continuous visual supervision - Actions - Ensure security in attendance - Alert the following staff members immediately: - OMM 2.2助理 - ED Medical staff - Ulaanbataar OMM - Ulaanbataar NO ED - Remove any potentially dangerous objects and/or substances from patient - Provide a safe environment for patient and others - Establish patient’s past medical history - Ensure medical assessment is performed - Transfer patient to designated ward/hospital</td>
</tr>
<tr>
<td></td>
<td>And/or Severe behavioural outburst</td>
<td>To be seen within 10 minutes</td>
<td>Patient reports - Refusals/indications/irritable/pyramidal - Self-harm/ fear of self-harm - Unable to walk safely - Threat of harm to others</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Possibility to self or others</td>
<td>Urgent</td>
<td>Observed - Agitated/irritability - Incoherent behavior - Not likely to wait for treatment - Withdrawing/communication - Echymosed or irritable moody - Disorientation/behavioural changes - Confused</td>
<td>Supervision - Close observation - Actions - Instruct the following staff members: - OMM 2.2助理 - ED Medical staff - Ulaanbataar OMM - Remove any potentially dangerous objects and/or substances from patient - Ensure security of patient’s physical appearance and location within the ward - Alert liaison psychiatry OMM if review deemed necessary by ED Medical staff - Evidence of increasing behaviours disturbances (1:1 observation if needed) - Establish patient’s past medical history - Ensure medical assessment is performed - Transfer patient to designated ward/hospital - If discharged ensure follow up arranged and NOK informed</td>
</tr>
<tr>
<td></td>
<td>Requires or requests restraint</td>
<td>Patient Reports - Suicide ideation - Hallucinations - Delusions - Paranoia/ideas - Thought disorders - Severe symptoms of depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Moderate distress</td>
<td>Standard</td>
<td>Observed/Reported - No agitation or restlessness - Intact without aggression - Cooperative - Gives coherent history - Incipient mental health disorder - Symptoms of anxiety or depression without suicidal ideation - Patient reports they are willing to wait</td>
<td>Supervision - Regular observation - Actions - Instruct the following staff members: - OMM 2.2助理 - ED Medical staff - Ulaanbataar OMM - Alert psychiatric registrar if reviewed deemed necessary by ED Medical staff - Treatment of increasing behaviours disturbances (1:1 observation if needed) - Establish patient’s past medical history - Ensure medical assessment is performed - Transfer patient to designated ward/hospital - If discharged ensure follow up arranged and NOK informed</td>
</tr>
<tr>
<td></td>
<td>To be seen within 120 minutes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

( * Does not infer referral)
Appendix L

Triage pop-up screen

Is the patient presenting with challenging behaviour?*
Yes □ No □

Is the patient expressing suicidal ideations?
Yes □ No □

Does the patient have an organised plan?
Yes □ No □

Has the patient been brought to the Emergency Department under the Mental Health Act (2001)?
Yes □ No □

Who is accompanying the patient? Please give details

MHA (2001) Application Forms with patient?
Yes □ No □

(Application forms for the detention of a patient under the Mental Health Act 2001)
Appendix M

Force Field Analysis

Driving Forces

- Improving service provision
- Required by staff
- Opportunity for staff to develop skills
- Change as part of Masters Programme

Restraining Forces

- Extra workload
- Increased accountability
- Increased responsibility
- Undertaken to fulfil Masters Programme
Appendix N

Change Management Project Post-Implementation Questionnaire

What position do you hold in the Emergency Department?

CNM [ ] Clinical Facilitator [ ] Staff Nurse [ ]

If CNM/Clinical Facilitator, do you feel there has been an improvement in the triage and assessment of patients with mental illness?

Significant [ ] Moderate [ ] No Improvement [ ]

If staff nurse do you think you’re level of confidence assessing patients with mental illness has improved?

Yes [ ] No [ ]

Did you find the change tools were affective in your management of patients with mental illness?

Yes [ ] No [ ]

Thank you for your time in responding to this questionnaire
Appendix O

Questionnaire results relating to percentage of staff with a formal education in Mental Health

- No formal education: 66%
- Formal Education: 13%
- Sick/Mat Leave: 11%
- No response: 10%
Appendix P

Pre and Post confidence levels in relation to triage of patients with mental illness.
Appendix Q

Triage Category allocation using Manchester Triage Vs Mental Illness Triage Tool

<table>
<thead>
<tr>
<th></th>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>pre</td>
<td>2</td>
<td>6</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>post</td>
<td>4</td>
<td>6</td>
<td>15</td>
<td>5</td>
</tr>
</tbody>
</table>