“Please can I turn the lights off to sleep?”
Improving the ED experience for patients with acute mental health issues

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Background:

Mental health (MH) patients commonly experience long waits in ED for placements, often over 24hrs.[1,2] RCEM developed a toolkit to aid with improving standard of care for these patients.[3]

UHCW ED sees >400 patients a day. Around 150-250 patients are referred to the MH team each month; 10% of these remain in ED beyond 24h awaiting a MH bed. Our team recognised that ED processes are not set up to deliver provision of comfortable longer-term care for these patients.

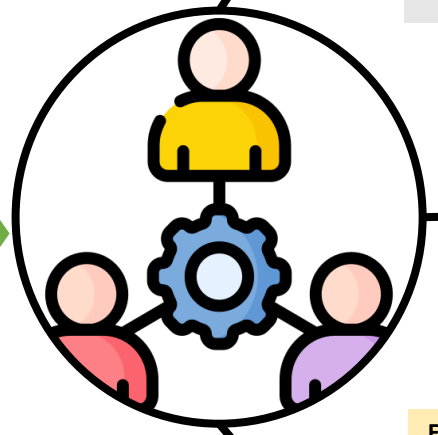
What we did:

Using an appreciative enquiry framework, we distributed an online survey to the UHCW ED MDT. Thematic analysis was used to interpret the responses.[4]

What we found:

119 responses

Across 5 teams & > 10 roles



What do we do well?

Trying our best with limited/strained resources
- Compassionate staff
- 2 designated mental health cubicles

Medical care
- A doctor is assigned all long-stay MH patients at morning handover

Formal processes
- Mental health (MCA/MHA) teaching in doctors' induction
- 24/7 MH service; AMHAT review within 1h (target)
- Capacity assessment → MCA / 1:1 staffing
- Mental Health triaging tool

Patient comfort & dignity
- "Sleepover project": eye masks and ear plugs overnight
- Washing facilities
- Hot food (beyond 24h)

What could be better?

Environment & facilities
- Reduce stimulation: quieter; windows; privacy; no antagonising behaviours
- Comfort: beds and furniture

Resources
- Entertainment resources for patients
- Information sheets for patients about processes
- Community pathways

Staff Training
- Training for HCAs
- Standardise practice
- Appropriate MCA use

Medications
- Prescribing & supplying medication in ED (not ED stock & delays with pharmacy)

Integration with Psychiatry services
- Concurrent assessments (not delaying MH assessments until patients are MFD)
- Trained mental health staff to care for patients (RMNs, trained HCAs)
- Psychiatry to staff new designated area

How can we get there?

Facilities
- Aim to develop a MH area away from ED, staffed with MH professionals
- Further fund the “Sleepover project”
- Provide safe entertainment options
- Share local MH unit facilities in the day

Staffing
- Increase staffing levels & consider volunteer roles (Mind, Samaritans)
- MH to be resident in ED & do daily ward rounds
- Employ MH trained staff to care for these patients
- Consider volunteer roles: Mind; Samaritans

Training
- Staff training: reduce stigma; change attitudes; de-escalation techniques; security staff training

Standardise practice
- Introduce guidelines / proformas
- Remove/reduce ‘gatekeeping’ assessments which cause delays
- Start MH treatments in ED

“The mental health patients in ED are in crisis and feel very vulnerable, so using the cubicles opposite the nurses station is detrimental because they hear themselves being discussed.”

“What we have is the opposite of a therapeutic environment when it comes to mental health patients”

“Security mannerisms need to be addressed. Some of the team are really good with MH, and some just like to antagonise and cause issues with them.”

What’s next:

1. Meet with stakeholders → 2. Implement suggestions / trials → 3. Evaluate & reassess

References:
1) Care Quality Commission. Pressures on services and patient pathways (2021-2022) 2023 [Available from: https://www.cqc.org.uk/publications/monitoring-mental-health-act/2021-2022/pressures-services-patient-pathways.]
2) National Health Service, England. Mental Health and A&E pressures. 2018.
3) Royal College of Emergency Medicine. Mental Health in Emergency Departments: a toolkit for improving care 2021.
4) Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006;3(2):77-101.