NATIONAL INSTITUTE OF CLINICAL STUDIES

EMERGENCY CARE COMMUNITY OF PRACTICE

Mental Health-Emergency Care Interface Project 2004–2006

Report

Sharing ideas and expertise to improve practice together

Acknowledgements

This report was prepared by Ms Sue Huckson and Ms Zoe Kelly from the National Institute of Clinical Studies (NICS).

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NATIONAL INSTITUTE OF CLINICAL STUDIES
Fawkner Centre
Level 5 499 St Kilda Road Melbourne VIC 3004
Phone: 03 8866 0400 Fax: 03 8866 0499
Email: admin@nicsl.com.au
Website: www.nicsl.com.au
ABN 60 095 459 804

About NICS

The National Institute of Clinical Studies (NICS) is Australia's national agency for improving health care by helping close important gaps between best available evidence and current clinical practice. Established by the Australian Government in 2000, NICS works to raise awareness of the important gaps between what is known, from the best available research, and what is actually done in day-to-day practice. By supporting health professionals to understand and overcome the barriers to applying evidence within Australian health care settings, NICS aims to improve the health experiences and outcomes for all Australians.

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1. Mental Health-Emergency Care Interface Project

The Mental Health-Emergency Care (MH-EC) Interface Project connected emergency and mental health staff from different organisations, allowing them to work closely together with the aim of improving the care of mental health patients in emergency departments.

The project commenced in September 2004, with an initial 21 hospitals selected to participate. A second wave commenced in February 2005, with another 20 hospitals selected to take part.

Why is this important?

The number of presentations of people with mental health issues to emergency departments has been increasing in the context of current mental health service delivery with a general increase in the prevalence of mental health issues within the community. The emergency department is often where people with a mental health problem seek access to health care, including mental health services. This increasing demand has created a climate where both emergency departments and mental health services seek a more co-ordinated approach based on best practice to improve care for people who present to emergency departments with a mental health problem.

Aim of the project

The aim of the project was to improve the processes of care based on best available evidence for people presenting to emergency departments with a mental health problem.

The project focused on improving the processes of care from the point of referral through to a plan of management for discharge from the emergency department in collaboration with community, primary care, mental health and tertiary care services. An expert group (see page 31) was established to develop the project objective and indicators.

Project indicators

	Definition	Why was this important?
Target 1	90% of people who present to an emergency department with a mental health problem are discharged within four hours	People with mental health issues waiting in the emergency department for long periods of time is unacceptable
Target 2	Reduce 'Did Not Wait' rate for people who present to the emergency department with a mental health problem to 3% or less	People with mental health issues who do not wait to be seen by a clinician may be at increased risk of causing harm to themselves or others
Target 3	Reduce unscheduled re-presentations to the emergency department for people with a mental health problem within 72 hours by 50%	To indicate that effective management plans have been put in place

2. Overview of the evidence

2.1. Triaging of mental health presentations in emergency departments

What is best practice?

Initial reviews of Australian literature revealed at least three triage scales in common usage (see Table 1). Studies[1,2,3,4] suggested that application of a specific mental health triage scale improves triaging of mental health patients, with subsequent improvements in waiting times and reduced frequency of patients leaving before being seen by a clinician. The use of such scales improves the confidence with which triage nurses are able to assess people presenting to the emergency department with a mental health problem.

The National Institute for Health and Clinical Excellence self-harm guidelines[5] and the New Zealand Guidelines Group suicide assessment and management guidelines[6] both recommend the mental health triage tool developed by the Area Mental Health Program, South Eastern Sydney Area Health Service.[7]

Why is this important?

Emergency departments are a common point of entry to access health services for people with a mental health problem or patients with physical illness who have co-morbid psychological problems complicating their condition. Emergency department triage is predominantly based on the assessment of presenting symptoms, while assessment of mental health conditions is based on observed and reported behaviours that indicate acuity of the presentation.

2.2. Medical clearance of mental health presentations in emergency departments

Best practice

Anecdotally, there is much variation in practice for medical clearance in Australia, resulting in long delays for mental health presentations to access appropriate services from emergency departments. Several studies[9,10,11,12] from the USA, including the guidelines developed by the American College of Emergency Physicians[13], provide evidence upon which medical clearance protocols can be based.

The Massachusetts College of Emergency Physicians and Massachusetts Psychiatric Society have developed a consensus statement[14] on medical clearance for mental health presentations to emergency departments with low medical risk. The statement recommendations include that:

- A typical physical examination in the emergency department is focal, driven by history, chief complaints and disposition, and is not a replacement for a general, multi-system physical examination; and
- Routine diagnostic screening and application of medical technology for the patient who meets the low medical risk criteria is of very low yield and therefore not recommended.

Why is this important?

The development of agreed medical clearance criteria provides the basis for timely and safe referral to appropriate mental health services. In addition medical clearance for low medical risk reduces unnecessary tests and procedures.

Table 1

Triage tools with description of behaviours to identify acuity of mental health presentations commonly used in the Australian emergency care setting

	Australasian College for Emergency Medicine Australian Triage Scale[8]	Mental Health Triage Scale Tasmania[1]	South East Sydney Area Health Service[7]
Triage category 1	> severe behavioural disorder with immediate threat of dangerous violence		> definite danger to life (self or others)
Triage category 2	> violent or aggressive > immediate threat to self or others > requires or has required restraint > severe agitation or aggression	> violent or aggressive > suicidal > a danger to self and/or others > has/may have a police escort	> probable risk of danger to self or others > severe behavioural disturbance > physically restrained
Triage category 3	> very distressed, risk of self-harm > acutely psychotic or thought disordered > situational crisis, deliberate self-harm > agitated/withdrawn > potentially aggressive	> very distressed or psychotic > likely to become aggressive > a danger to self and/or others > experiencing a situational crisis > very distressed	> possible danger to self or others > moderate behavioural disturbance > severe distress
Triage category 4	> semi-urgent mental health problem > under observation and/or no immediate risk to self or others	> patient has a long standing, semi-urgent mental disorder/problem > may have a supporting agent present	> moderate distress
Triage category 5	> known patient with chronic symptoms > social crisis, clinically well patient	> patient has a long standing, non-acute mental disorder/problem > no supportive agent present	> no danger to self or others > no acute distress > no behavioural disturbance

2.3. Appropriate sedation for agitated mental health presentations

Best practice

There are a number of well-designed studies[15,16,17] including a Cochrane review[18] comparing medications in common usage. The Cochrane review concluded that there is little difference between benzodiazepines and antipsychotics for the management of acute psychotic behaviour. However, there was a preference toward benzodiazepines due to the potential side effects of antipsychotics.

The American College of Emergency Physicians[13] recommend the following:

- Use a benzodiazepine (lorazepam or midazolam) or a conventional antipsychotic (droperidol or haloperidol) as effective monotherapy for the initial drug treatment of acutely agitated undifferentiated patients in emergency departments.
- If rapid sedation is required, consider droperidol instead of haloperidol.
- Use an antipsychotic (typical or atypical) as effective monotherapy for both management of agitation and initial drug therapy for patients with known psychiatric illness for which antipsychotics are indicated.
- Use a combination of an oral benzodiazepine (lorazepam) and an oral antipsychotic (risperidone) for agitated but cooperative patients.
- The combination of a parenteral benzodiazepine and haloperidol may produce more rapid sedation than monotherapy in acutely agitated psychiatric patients in emergency departments.

Why is this important?

Agitated mental health patients can be a risk to themselves and to others, including staff. Safe and appropriate restraint is an important aspect of care. Although every attempt to use verbal or behavioural strategies should be taken to manage patients presenting in an agitated state, medications may be required. The choice of agent(s) must take into account the efficacy of the agent as well as its safety profile.

3. The method used

The MH-EC project was the first major initiative to be undertaken by the EC CoP program. The project used a collaborative approach to improve care for people with a mental health problem presenting to an emergency department. The decision to use the collaborative approach was based on the success of the NICS Emergency Department Collaborative (May 2002 – May 2003).

For more information on the EC CoP, see appendix 1 (page 36).

Participation September 2004 – March 2006

In June 2004, NICS called for expressions of interest from Australian emergency departments (ED) with more than 20,000 ED presentations in the MH-EC project. Forty-one hospitals in total participated in the project. Twenty-one hospitals commenced the project in September 2004 forming Wave 1, the first group of hospitals to participate; 20 hospitals commenced in February 2005 (Wave 2).

Induction workshop

Multi-disciplinary emergency department and mental health professionals from participating sites came together at the start of the program to gain skills in improvement methods, project planning, network with peers and clinical leaders, learn the principles of implementing evidence to improve clinical practice and understand the aims of the project.

Resources and support

NICS supported project teams throughout the project through:

- Web-based communication system with features that allowed teams to:
  - report data against project targets on a monthly basis
  - generate individual progress reports to monitor performance
  - access shared resources such as clinical guidelines and mental health triage tools
  - discuss issues via an online discussion forum
- Regular group teleconferences
- Phone and email contact

Sites supported each other through:

- Sharing resources
- Sharing ideas
- Sharing skills
- Sharing knowledge

Data collection and data reporting

Each team was responsible for designing and introducing interventions into ED and MH practices. To measure improvement or performance in relation to stated project targets, teams were asked to report the following data items to the project website each month:

- Total ED presentations
- Number of MH presentations to the ED
  - Number of MH presentations discharged from ED within four hours
  - Number of MH presentations that did not wait to be seen in the ED
  - Number of MH presentations that re-presented to the ED within 72 hours of previous presentation

Individual reports

Individual reports included a graph for each of the three indicators against the project targets and performance against the group average. See figure 1 below for an example of graphs generated from data submitted to the project website.

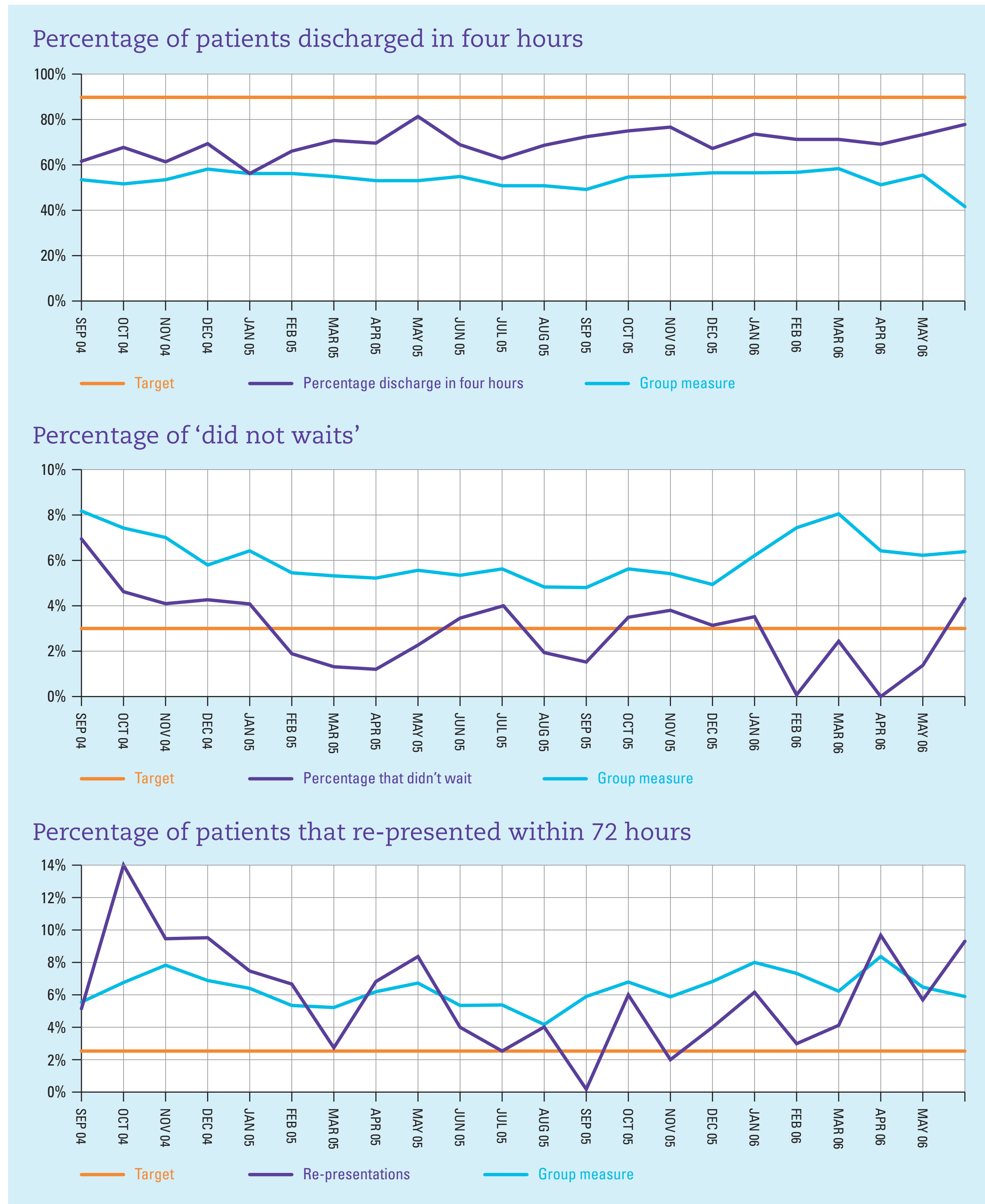
The project website enabled teams to submit qualitative data that related to improvement activities, team self-assessment and executive sponsorship of the project.

Responses to the following prompts or questions added value to the data collected.

- What improvement activities did you implement this month?
- What stopped you from achieving your goals this month?
- General comments
- Team self assessment
  - Formed a team?
  - Activity but no changes?
  - Modest Improvement?
  - Significant improvement?
  - Outstanding sustainable results?
- Executive sponsorship
  - Aware of the team's progress?
  - Actively engaged in project meetings?
  - Negotiates barriers on behalf of team
- Promotes the work of the team more broadly?
- Provides additional resources or support for the project team?

Figure 1

Example of graphs generated for individual team reports



4. Mental Health-Emergency Care Interface Project evaluation summary

The MH-EC Interface Project has been evaluated by Amos Consulting in partnership with RMIT University CIRCLE. The evaluation is based on descriptive, qualitative and quantitative data collected as part of a wider evaluation of the NICS EC CoP program. The following is a summary of the findings of the evaluation of the MH-EC Interface Project.

The MH-EC project provided a focussed initiative in an area of substantial need in the early phase of the Emergency Care Community of Practice (EC CoP) program development. During the 12 months of the project, participating sites saw:

- Over 1.3 million emergency department presentations; and
- Over 40,000 mental health presentations.

Project targets and results

Definition	Wave 1 (N=21)	Wave 2 (N=20)
Target 1 90% of people who present to an emergency department with a mental health problem are discharged within four hours	Variation in discharge within four hours was reduced across the 20 sites. The minimum value observed increased from 2% in September 2004 to 23% in July 2005.	Six rural sites met the 90% target in one or more months. One of those sites met the target in six of the 12 months.
Target 2 Reduce 'Did Not Wait' rate for people who present to the emergency department with a mental health problem to 3% or less	There was a significant reduction in the percentage of mental health patients who did not wait to be seen after triage ($p<0.05$) from 7.9% to 4.4%. Variation in performance reduced over time from 21% in September 2004 to 16% in July 2005. This effect equates to a reduction in the number of those who do not wait by over 500 patients in the 12 month period. 11 sites met the 3% target in one or more months; five sites met the target in four or more months.	Six sites were meeting the 3% target in the first month of the project. 13 sites met the 3% target in one or more months; of those sites one met the target in 11 months.
Target 3 Reduce unscheduled re-presentations to the emergency department for people with a mental health problem within 72 hours by 50%	Six sites met their re-presentation target for one month and only one site met their target consistently in 10 months.	One site met their target consistently in all 11 months post baseline, with a further five sites meeting their target in five or more months.

NICS support

NICS provided support to assist project sites in their improvement efforts including:

- Web-based communication system to link sites to support the sharing of resources and data collection.
- Provision of advice on ways to strengthen improvement efforts through teleconferences, direct telephone advice and email correspondence.

Sharing resources

- 102 resources, eg protocols, care pathways, and assessment tools, were available for download from the MH-EC project website (see page 30).
- 1,995 resources were downloaded. The most popular resources were clinical assessment tools, protocols and process maps that were developed by project teams.

Qualitative data: Main achievements

- Improvement in communication and understanding of issues between mental health services and emergency departments within the hospital.
- Better referral practices and an improved capacity of the hospital to address mental health needs.
- Sites clearly drew on the local data provided to NICS as evidence of improvement, and indicated that the availability of local data acted as an impetus for further change.
- The use of resources was associated with improved assessment and streamlined care.

What worked?

- Sites valued being part of a national project that had the capacity to lead to wider scale improvements in the care of mental health patients in emergency care.
- NICS added a legitimacy and support to an issue of national importance and local relevance.
- The website support and resources (including tools and protocols developed by others) provided by NICS were valuable.
- Sites found the availability of local data was an impetus for change. Local data could be used for comparison internally within the hospital or for external comparative purposes.

What were the barriers?

- ### Other competing priorities

  While it appeared that participating sites recognised the importance of improvements in the care of mental health patients in emergency departments, other priorities emerged during the project timeframe which reduced the importance of the project.

- ### Lack of time

  The MH-EC project was time limited and staff were aware of the need to submit data and work collaboratively across mental health and emergency care to identify and implement improvements. Some site representatives identified that the lack of time to address the issues and make improvements as responsibilities for the MH-EC project were additional to their existing work demands.

- ### Lack of spread

  The existence of program or project champions is an important feature that supports change. There was evidence that champions or project advocates maintained staff focus on improvement; however, sometimes the spread of their influence was limited. This lack of spread may influence the sustainability of improvements.

- ### Limited staff understanding of mental health issues

  Several sites commented that there was inadequate understanding of mental health issues among emergency department staff. This lack of understanding has implications for care provided to the mental health patient and may have influenced the scope and sustainability of referral and liaison practices developed through the project.

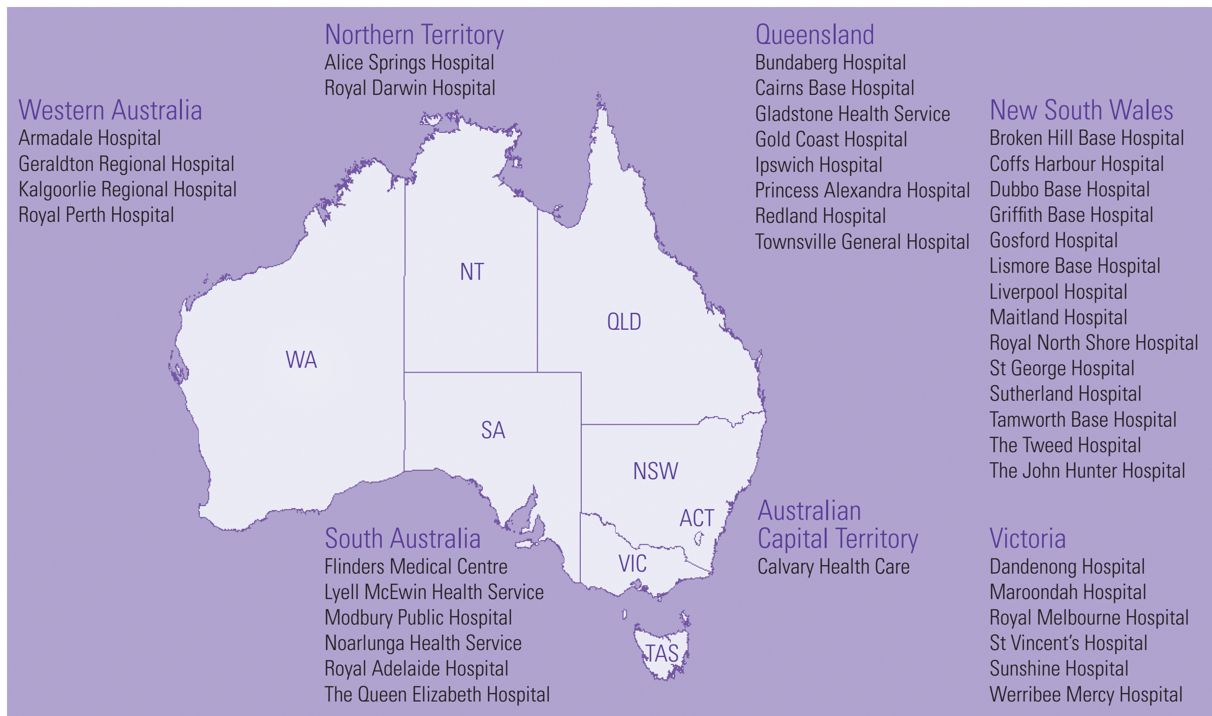
Weaknesses in the data noted by the evaluation team

- An insufficient timeframe for data collection. The nature of the change process and the time taken to engage stakeholders and initiate change in a complex and demanding environment can also pose challenges.
- Inadequate sensitivity of indicators. Aggregated level data are less sensitive to detect local level change in areas that may be important, but not captured by indicators.
- Hospital characteristics varied widely within and across Wave 1 and Wave 2, which compromised analysis.
- Lack of comparative measures. Differences in hospital context, size, throughput and seasonal variation made comparisons difficult.

5. Who participated in the project?

Expressions of interest were sought from interested hospitals around Australia to participate in the project. A total of 41 hospitals across Australia from metropolitan, urban and rural settings, with a total of 40,000 mental health presentations per annum, enrolled in the project.

The project was conducted in two waves. Wave one commenced in September 2004 and wave two in February 2005.



Establishment of state-based Mental Health-Emergency Care Community of Practice

Six South Australian hospitals joined the project as a consortium, and with support from the State Health Department established a local Community of Practice involving other key stakeholders, including the major mental health inpatient facility, and Ambulance and Police services.

6. In their own words... stories from participating project teams – Wave 1

Armadale Health Service WA

What worked well for us

- ✓ Patients presenting in an agitated state received early anxiolytic – this part of the project is currently being written up to be submitted for publication. Benefits of this guideline included:
  - The scoring system on the sedation guideline was predictive of admission
  - Staff valued the form as a prompt to assessment and documentation
  - The form was introduced with education sessions which were well received by staff
- ✓ The introduction of Mental Health Liaison Nurses into the ED
- ✓ Improved understanding and relationship between ED and MH teams

Broken Hill Health Service NSW

What worked

- ✓ Improved communication of data between ED and MH teams
- ✓ Increased dialogue regarding frequent attendees
- ✓ Mental health on the agenda in the ED
- ✓ Mental health education is now an integral part of ED in-service programs
- ✓ Introduction of processes that improve MH care
  - RAPID assessment to guide triage
  - Increased incidence of formal suicide risk assessment and associated documents
  - Ongoing quality improvement initiatives

What didn't work

- ✗ Inability to get regular meetings occurring, especially regarding frequent attendees, at the interface with other services, especially mental health
- ✗ No ongoing commitment to NICS project goals
- ✗ Outcome measures set by project were not indicative of changes that occurred in the department.
- ✗ Regular working party and steering committee meetings saw exchange of information but no assistance or help with associated tasks to prepare for or create change
- ✗ Information from meetings was not communicated to other relevant people

Barriers

- No commitment from ED to work on project …no champion from within
- Poor communication systems
- No commitment from psychiatrists/ED clinicians to be part of the project
- Changes to area health service; reshuffle saw loss of executive sponsors locally
- Loss of energy experienced by project coordinator

Cairns Base Hospital QLD

Our key achievements

- ✓ Enhanced working relationship between the ED and the Crisis Assessment and Treatment Teams (CATT). Relationships were traditionally good but to maintain and even improve the partnership during a period of change was particularly rewarding
- ✓ Raised ED staff awareness of consumers' mental health needs
- ✓ Reasonable success at meeting and maintaining the NICS targets
- ✓ Created a sense of pride amongst staff at how the ED and CATT were performing against NICS targets
- ✓ We now have a database which can be utilised in other organisational studies, eg the data has supported the need for a 24/7 CATT provision which has recently been approved
- ✓ The study raised the profile and relevance of "research"

What worked well

- ✓ Sense of partnership between ED and CATT
- ✓ Data collection process provided by the data manager. The data was always timely, informative and usable
- ✓ Data analysis was always a joint venture between ED and CATT clinicians. Trends were identified which have been useful to improve care

What were our barriers

- Sustaining the momentum of the project, some members of the project team focused on more pressing issues
- Finding convenient times for review meetings
- We probably had too many "senior" people in the original project team

Calvary Health Care ACT

What improvement activities did you implement?

- ✓ A training program has been implemented for ED triage staff particularly addressing mental health triaging. Mental health staff participated in this training
- ✓ A flow chart and triage form has been developed however it is not being used due to a number of problems. This work is still ongoing. The flow chart was developed from information found on the NICS website
- ✓ Our mental health consumer representatives have been involved in the development of the flow chart and triage model

What stopped you from achieving your goals?

- ✗ The Emergency Department computer upgrade has caused many problems in collecting data
- ✗ The "separateness" of Calvary Health Care ACT to the ACT Mental Health stream – we found that this governance issue did not help processes along

Flinders Medical Centre SA

Our key achievements

- ✓ Initiating medical clearance policy for the ED using resources available from the project website
- ✓ The first doctor who sees the patient, whether the emergency doctor or the psychiatric registrar, does the medical clearance
- ✓ Developing a protocol so nurses can initiate diazepam to an agitated patient prior to them being seen by a medical officer. This incorporated an agitation scale which is now able to be used for any purpose in the ED
- ✓ Introduction of 'did not wait' (DNW) policy for mental health presentations so follow-up is arranged, ie police involvement, psychiatric consult or crisis team

What worked well

- ✓ Monthly meetings between ED MH nursing and medical staff where data is discussed (4/24hrly wait, DNW and re-presentations) and any ongoing issues. This has led to improved communication and increased collaboration
- ✓ By collecting data it became apparent that the patients who came up in the DNW data then came up in the re-presentation data and were often acutely unwell, with a diagnosis of psychosis. Most of the patients who DNW presented outside the MH nurses' hours of work. Outcome of this included:
  - Strengthening the case for 24 hour MH nurse coverage in the department
  - Regular in-service to general nursing staff regarding psychosis
  - Nurse initiated benzodiazepine protocol
  - Daily printout of patients who DNW so follow-up is initiated by the MH nurse in the ED

What were our barriers

- With regard to medical clearance, rotation of medical staff, and having to "retrain"
- Generally spreading the ideas/changes through all staff groups and beyond the enthusiastic few is a challenge for sustainability, although we do OK

Gosford Hospital NSW

Our key achievements

- ✓ Protocol and process established for 'medical clearance' of MH patients aged 16–65 in the ED
- ✓ The development and adaptation of a triage tool 'Rapid Assessment of a Mental Health Person in Distress' for the ED triage staff to use. This was also integrated into the competencies for triage staff to complete before working within the role of triage
- ✓ The development of a pathway for 'The Clinical Management of Mental Health Patients Awaiting Disposition to the Mental Health Inpatient Unit'
- ✓ Cementing of work relationships between key individuals within MH and the ED teams

What worked well

- ✓ An important strategy that helped the project team identify the issues that confronted the interface between MH and the ED was hosting forums to brainstorm what clinicians identified as problems
- ✓ The forums had representation from MH and the ED clinicians, and also included our key partners such as Mental Health Inpatient Units, Security and Hospital Transport etc
- ✓ At the forums we identified 10 key issues, which we circulated back to the stakeholders and asked them to rate the issues
- ✓ The networking and sharing of resources with other NICS teams

Modbury Public Hospital SA

Our key achievements

- ✓ The ED's involvement in this project led to a number of changes implemented through the department, commencing at triage
- ✓ The initial data collected September 2004 identified the following gaps:
  - Lack of triage staff knowledge in prioritising MH clients appropriately
  - Lack of a risk assessment being performed
  - Lack of knowledge in correct usage of MH paperwork
  - Lack of information to discharge client with or for follow-up
- ✓ This information led the project team to formulate a mental health teaching up-skilling document so all staff in the ED could be trained in these areas
  - Training time of 4 hrs per staff member was secured from the hospital administration

What worked well

- ✓ Staff training with positive feedback from staff
- ✓ Improvements noted through data collection (as per submitted data)
- ✓ Staff understanding of MH issues
- ✓ Formatting of and implementing a risk assessment tool and MH care plan used by both medical and nursing staff

What were our barriers

- Access block from the ED into the MH system
- Staff changes (training was included in orientation when this was discovered)
- Bed block in the ED during peak demand times on the service
- Manual data collection (no electronic system in the department as yet)

Overall the involvement of the team in the project has led to a number of improvements and has proven to be a valuable resource for the department.

On completion of this project the ED will continue to maintain the statistical data, so we can continue to track improvements and barriers that may arise and indicate the need to re-train staff, or to look at alternative ways of management for this client group.

Noarlunga Health Service SA

Key achievements

- ✓ Increasing the 4 hour turnaround
- ✓ Decreasing the number of patients who stay in the ED for more than 12 hours
- ✓ Some decrease in DNWs
- ✓ Increased dialogue and cooperation with Flinders Medical Centre (closest hospital) including sharing of resources and protocols

What worked well

- ✓ Streamlining the flow of MH patients through the ED
- ✓ Modifying the role of the MH nurse (and empowering them to be able to make change)
- ✓ Putting the most experienced psychiatric registrar in the front line as a gatekeeper
- ✓ Using the back of the staff toilet door as a notice board – it's the only time people stop to read the notices!

What were our barriers

- Strong resistance from the ED medical staff to get involved, even though we tried to reassure them that the changes we were making would actually decrease their workload
- Resistance from the psychiatric inpatient unit to make change
- Little cooperation from the (previous) ED medical director

Princess Alexandra Hospital QLD

Our key achievements

- ✓ High levels of collaboration and improved relationship between MH and ED at senior level
- ✓ MH staff now employed by ED in ED; well received by ED staff
- ✓ Maintained DNW rate below 3% since May 2005
- ✓ MH patients being seen more quickly, thus decreasing their anxiety
- ✓ Staff report patients are less agitated and/or frustrated, with fewer physical and verbal threats
- ✓ Dedicated MH area within ED (designed as a quiet area for people triaged as Category 3, 4, 5 only)
- ✓ Reduced complaints from ED
- ✓ Less pressure now on Mobile Assessment & Acute Treatment team: they no longer need to service ED as frequently; now able to focus on offering more short term intervention to consumers in the community

What worked well

- ✓ Being part of a national project that gave us a framework to work on together
- ✓ Regular, focussed meetings
- ✓ Demonstrated level of commitment from MH through provision of project manager

What were our barriers

- Access block for MH beds
- Local project definition document was too ambitious
- Busy-ness of staff involved – unable to achieve what we set out to achieve. The four hour target was too stringent under our current staffing levels. This has however highlighted the need for more ED-MH staff, and the data collected via the NICS project has been used to demonstrate this

Royal Melbourne Hospital VIC

Our key achievements

- ✓ Enhanced ongoing interface between MH services and the ED, ie meetings, discussions, joint initiatives
- ✓ Ongoing monitoring of key KPIs, including length of stay in the ED with particular reference to patient flow/bed access blocks, monitoring:
  - Psychiatric bed availability
  - High dependency v low dependency
  - Short stay patients
- ✓ A month-long project undertaken looking at:
  - Presentation and management of patients with aggression and/or behavioural disturbance
  - Restraint practices in the ED
  - Utilisation and predictability of short stay beds for psychiatric patients in the ED
- ✓ Implementation of fast tracking of psychiatric patients and ongoing evaluation of fast tracking
- ✓ Submission for four additional beds co-located with Adult Psychiatric Inpatient Unit specifically to manage ED demand for psychiatric inpatients. Accepted and funded and due to open August 2006.

What were our barriers

- Project unfunded
- Unrealistic KPIs
- Excluded some patients from study due to limitations of diagnosis identified for project (were however included in internal evaluation)

St Vincent's Hospital VIC

Our key achievements

- ✓ Improved awareness and monitoring KPIs for both MH and ED management and staff
- ✓ Other achievements such as increased MH staffing in ED
- ✓ Plans for ED physical re-development for improved MH space and improved supervision of psychiatric triage occurred during this time period, but were attributable to existing and planned service improvement initiatives, not necessarily this NICS project

What worked

- ✓ Regular collating, monitoring and benchmarking of data (benchmarking could have been improved if more sites submitted data regularly or the data enabled easy comparisons between the waves not just within them)
- ✓ Existing strong relationship between ED and MH over many years meant this project was simply further continued collaboration on service system improvements
- ✓ Sharing of resources and information via NICS website helpful but perhaps not used by all sites as widely as it could have been

What were our barriers

- Multiple ED-MH projects occurring simultaneously with NICS project at St Vincent's meant that the NICS project did not have significant focus compared with other projects occurring at same time, particularly the DHS Clinical Innovation funded project "Improving the mental health consumer experience in ED", and psychiatric triage/CATT redevelopment and restructure
- Planned improvements to IT system to improve triage of MH patients superseded by DHS roll out of Victorian MH triage tool which meant time and effort was wasted in trying to make local changes that were later redundant
- Diagnosis definitions for KPIs meant that much of the work of MH staff in St Vincent's ED was not captured in the data, which was treated with some scepticism due to its narrow focus

The Queen Elizabeth Hospital SA

Our key achievements

- ✓ Working closely with MH team in ED. Strong and effective working relationships were developed
- ✓ Developing medical clearance protocols and focussing on "parallel assessment" rather than sequential medical clearance then psychiatric assessment
- ✓ Introducing "Mental Health shift" for ED doctors in order to fast track the management of MH patients
  - Waiting times did not improve as much as hoped, however positive feedback from division of MH. This improved communication between MH and ED staff and provided a person to liaise with
  - Educational opportunity for ED RMOs who spent a shift working closely with MH team
- ✓ Extending presence of ED-MH liaison nurse from 5 to 7 days a week. Now recruiting to extend hours beyond working hours

What worked

- ✓ Process map of MH patient journey through the ED highlighted complexities of path. Some of this was deemed unavoidable due to the many entry points but some queues were identified and addressed
- ✓ Audited the waiting times for police who accompany patients brought in under section 23 of the Mental Health Act (MHA). This is now a standing agenda item for ED-police liaison meetings
- ✓ ED-MH meetings acted as a springboard for the development of a current project which aimed to improve the management plan and availability for MH patients

What didn't work so well – some barriers

- Comparing different states was like comparing apples and oranges
- We were unlikely to reach project targets, however we were keen to try as we knew it would result in improvements, irrespective of project targets
- States or hospitals that have MH teams in EDs were always going to get closer to the four hour goals than hospitals that keep patients overnight to see MH team in the morning
- The re-presentation rate wasn't very helpful and one frequent presenter could completely distort the results
- Unfortunately the project lost momentum over winter as staff became busier with increased demand

7. In their own words… stories from participating project teams – Wave 2

Alice Springs Hospital NT

Our key achievements

- ✓ Established Consult-Liaison Mental Health Nurse position for Alice Springs Hospital
- ✓ Crisis Assessment Team identifies client groups that have stays in ED longer than four hours
- ✓ Improved communication across ED, Dual Diagnosis and Drug and Alcohol services
- ✓ Review of referral processes for MH clients including drug and alcohol issues
- ✓ Established a programme to identify clients admitted frequently to provide increased support clinically and socially to prevent admission or re-presentation to ED
- ✓ Reduced number of DNWs and re-presentations (these numbers remained consistent over the period of project)

What worked

- ✓ A work in progress, the Crisis Assessment Team will continue to assist with up-skilling ED staff in MH assessment and management

What were our barriers

- ED staff were reluctant to use the after hours number for health professionals needing assistance with Drug and Alcohol presentations
- Reduced availability of Drug and Alcohol staff to provide assessment service during business hours
- Poor understanding or inappropriate triaging of clients presenting with psychiatric symptoms or behaviour indicative of possible psychiatric condition
- Attitude of staff towards MH presentations at times; this we hope will improve with educational and supportive input from crisis team and Consult-Liaison nurse.

Bundaberg Base Hospital QLD

Our key achievements

- ✓ Developed a closer working relationship between MH service and with Department of Emergency Medicine (DEM)
- ✓ As a small ED we were able to demonstrate a timely response for the MH presentations

What worked well

- ✓ Getting together with the staff from the ED for the original workshop forged a good lasting relationship with key personnel in the department
- ✓ The website resources were very useful

What were our barriers

- Time constraints
  - Increased pressure due to current shortage of doctors and closed inpatient unit requiring additional work to transfer patients requiring admission
  - Project responsibilities were additional to current workload for part time Early Intervention (Suicide Prevention) Project Officer
- Support from key individuals engaging with the broader ED proved difficult
- We probably would have had more executive support under normal circumstances, but the current service issues became a priority

Geraldton Regional Hospital WA

Our key achievements

- ✓ A significant increase in staff knowledge regarding mental health assessment and risk assessment
- ✓ Increased staff confidence and competence in the assessment and management of MH clients
- ✓ Development of an innovative training package for generalist staff in Mental State Assessment using local actors in assessment workshops and augmented by a day with the MH duty worker in practice
- ✓ The forging of a strong mutually complementary relationship between MH services and ED staff
- ✓ Introduction of the Clinical Nurse Consultant (Mental Health) role enabling supportive practice for non MH trained health professionals and to act as a conduit between both service providers
- ✓ ED staff access to PSOLIS (Psychiatric Services Online Information Systems) enabling information sharing, providing a deeper understanding of client needs through easy access to past psychiatric history and management

What worked well

- ✓ Positive use of the NICS website to increase sharing of resources, knowledge, experience, problem resolution, and educational tools, eg the development of a MH triage scale as modified from an existing template
- ✓ Enhanced ability to network and benchmark practice and progress on a national basis

Gladstone Health Service QLD

Our key achievements

- ✓ Improved interdepartmental collaboration
- ✓ Access to the MH database in ED by MH staff
- ✓ Introduction of:
  - MH triage tool
  - Rapid assessment tool
  - Medical clearance tool
  - Management plans for consumers who frequently attend ED and consumers on an Intervention Treatment Order
- ✓ MH Clinical Pathway for MH presentations to ED
- ✓ Valid data collection

What worked well

- ✓ Weekly meeting with the project team
- ✓ Identified opportunity to combine the NICS MH-EC project with existing MH initiatives project outcomes
- ✓ Problem identification
- ✓ Access to NICS website for resources
- ✓ Collaboration with key stakeholders
- ✓ Collection and input of data

Griffith Base Hospital NSW

Our key achievements

- ✓ Trialled ED-MH fast track process utilising MH Access number
- ✓ Introduction of ED-MH triage tool
- ✓ ED nurses completing ED-MH Triage Workbook accessed from the project website

What worked well

✓ Having access to the resources and information on the website and opportunity to discuss issues with others on the teleconference

What were our barriers

- Initially there was good collaboration between the MH service and the ED; however, with the loss of the key MH clinician the responsibility of the project was left to one person in the ED
- Loss of a functioning team made the implementation difficult but despite that we were able to achieve some change

Ipswich Hospital QLD

Our key achievements

✓ Approval of additional clinical liaison nurse shifts (now 7 day week service)
✓ Established data collection methods
✓ Involvement of medical staff (ED and MH) in process mapping and opening channels of communication
✓ Identification of gaps and issues through process mapping of patient journey and ownership of actions to address

What worked well

✓ Data collection process – provided by the Decision Support Service and now used as a key performance indicator by IMHS services
✓ Process mapping of patient journey through ED

What were our barriers

- Late starting project – 8 month delay in assigning project officer
- Not having a dedicated resource to manage project. Difficult to sustain momentum of the project when project officer taking on a 1.5FTE workload (especially with accreditation!)
- Maintaining medical staff attendance at meetings

Plans for the future

> Resume pre-existing MH-ED Liaison forum, adopting NICS Steering Committee TOR & Issues Register
> Continue data collection
> Continue to access resources from NICS website

Kalgoorlie Hospital WA

Our key achievements

✓ Greater communication between ED and the Community Mental Health staff that includes increased understanding of the requirements of the mental state examination (MSE), physical assessment and relevant protocols for all ED and MH staff
✓ Education sessions to ED and hospital staff on MSE and risk assessment
✓ ED and hospital staff provided with laminated MSE and risk assessment prompt cards the size of identification tags
✓ Mental Health First Aid training provided for all staff in the region and funded by MH service
✓ Achieving a better than average DNW percentage
✓ Using the education of MSE and risk assessment within other hospitals within the region

What worked well

- ✓ Data analysis identifying the need for assertive follow-up and revised management plans for those people re-presenting within 72 hours
- ✓ Data analysis identifying the need for accurate data of MH presentations within ED being revised
- ✓ Initial meetings with ED staff
- ✓ Education sessions of staff
- ✓ Communication between MH inpatient service Kalgoorlie Regional Hospital ward staff

What were our barriers

- Lack of staff at times during the project making meetings and data collation/collection difficult
- Lack of accurate data collation and collection of data manually
- Loss of executive sponsorship due to resignations and sick leave
- Ability for staff to attend forum held within WA

Redland Hospital QLD

Our key achievements

- ✓ Improved understanding between both services was achieved and we made particular improvement with all Emergency Examination Orders presenting to ED – all seen within required timeframe in last four months (Jan–Apr 2006)
- ✓ We have now established new goals to improve an excellent service to our community

What worked well

- ✓ Opportunity to look at real data in depth to identify trends
- ✓ Service improvement opportunities arose as a result and included a number of new procedures and tools to guide clinical staff

What were our barriers

- Changing existing processes and increased activity in both areas – ED and MH

South East Sydney Illawarra Area Health Service (SESIAHS) (St George Hospital & Sutherland Hospital)

Our key achievements

- ✓ SESIAHS' key achievement has been the implementation of a planned, non-reactive predicted bed model to synchronise and sustain patient flow within the MH service across the larger geographical area
- ✓ The linkages between ED psychiatric emergency care centre (PECC) and the MH service has led to a wider spectrum of care options within the domain of emergency care
- ✓ Site-based processes service guidelines on routine communication and dispute resolution
- ✓ Implementation of patient flow coordinators to support timely communication, active problem solving and rapid operational response to ED demand
- ✓ Average number of MH patients in any ED in the SESIAHS awaiting access to a MH bed for longer than 24 hours has been reduced by 90%

What worked well

- ✓ Collaborative engagement of Mental Health and Emergency Service area directors
- ✓ Executive commitment to review clinical practices, patient flow and service interface
- ✓ Predicted bed modelling
- ✓ Priority management of MH patient presentation in the EDs
- ✓ Revision of work flow, timely decision making and discharge to transfer to appropriate services
- ✓ Capacity to utilise shared resources to support ED processes in the assessment, triage and referral of MH presentations
- ✓ Establishment of regular liaison meetings between ED and MH
- ✓ MH topics integrated into pre-existing ED education programme, provided by MH staff

What were our barriers

- Loss of key staff members to continue data collection and focus
- Limited capacity to engage senior ED clinicians
- Overwhelming operational ED and MH demand

SESIAHS integrated the NICS MH-EC project into the area health service redesign process and NSW statewide mental health project. This encompassed a review of clinical practice, patient flow and the establishment of a PECC at St George Hospital.

Sunshine Hospital VIC

Key achievements

- ✓ Strengthening relationships with other areas
- ✓ Learning about the difficulties that other departments were experiencing was very helpful
- ✓ Staff awareness of other departments' problems increased early. Close liaison led to good working relationships with key stakeholders. However, with the introduction of the triage rating scales project this liaison has lapsed
- ✓ The time for MH clients waiting for a bed improved
- ✓ Commencement of treatment to clients awaiting a psychiatric bed has improved
- ✓ Better understanding of the issues related to MH clients

What worked well

- ✓ Meeting regularly with good attendance from key personnel
- ✓ Gaining information from other services so as to not re-invent the wheel
- ✓ Development of paperwork for both police and ECATT relating to section 10 of the MHA
- ✓ Understanding the issues that impede client flow in ED

What were our barriers

- Numerous projects on at the same time
- Focus totally changed when triage rating scale was introduced (Victorian DHS project)
- Lack of time was a major barrier
- Time to meet and develop new initiatives has been difficult

8. Resources submitted by project teams

Alice Springs Hospital NT

- Medical clearance policy and education package

Armadale Health Service WA

- Guidelines for management of mental patients requiring sedation

Bundaberg Hospital QLD

- Management of mental patients in the emergency department flow charts
- Mental health triage form
- Follow up appointment card (green card)
- Staff ID sized tags with quick suicide risk and MSE information
- Suicide assessment flow charts
- Emergency Examination Order policy

Coffs Harbour Hospital NSW

- Inter-hospital transfer form for mental health presentations

Dubbo Base Hospital NSW

- Mental health admission process flow chart
- Mental health triage tool resource

Flinders Medical Centre SA

- Medical clearance protocol

Geraldton Health Service WA

- Mental health triage guidelines
- Mental health education packages
- Staff surveys regarding mental health knowledge and skills

Gladstone Hospital QLD

- Mental health triage resources for staff
- Rapid assessment form
- Medical clearance and sedation guidelines

Gosford Hospital NSW

- Rapid assessment tool
- Evaluation of rapid assessment tool
- Pathway for mental health presentation
- Medical clearance policy

Griffith Base Hospital NSW

- Mental health presentations and management process overview

John Hunter Hospital NSW

- Mental health triage flow charts
- Education and resource folder
- Mental health triage package
- Project presentation to Area Health Service

Kalgoorlie Hospital WA

- Staff surveys for mental health knowledge

Lismore Base Hospital NSW

- Medical clearance protocols
- Detailed process for emergency department presentations of mental health patients
- Resources related to assessment protocols

Lyell McEwin Health Service SA

- Emergency department flow chart for mental health presentations
- Medical clearance protocol

Maitland Hospital NSW *(see John Hunter Hospital – Hunter Health)*

Noarlunga Health Service SA

- Evaluation of emergency department mental health social worker position
- Diazepam standing orders in acute alcohol withdrawal
- Mental health presentation flowcharts

Princess Alexandra Hospital QLD

- Action research tool
- Project risk tool
- Process mapping resources
- Bulletins to communicate the project

Redland Hospital QLD

- New policies and procedures regarding management of mental health presentations to the emergency department
- Medical clearance protocol
- Rapid assessment of patients in distress at triage

Royal Melbourne Hospital VIC

- Mental health fast track guidelines and form

Royal North Shore Hospital NSW

- Process mapping flow charts for mental health presentations to the emergency department

South East Sydney Illawarra Area Health Service (SESIAHS) NSW

- Area health demand management plan
- Emergency Department-Mental Health service agreement
- Evaluation of bed management strategies 2005
- Structure for management of patient flow
- South East Sydney Area Health Service mental health triage guidelines and training manual (1999)

St Vincent's Hospital VIC

- Psychiatric triage guideline manual and policy
- Behavioural room assessment policy

Sunshine Hospital VIC

- Surveys for 'Did Not Wait' patients

The Queen Elizabeth Hospital SA

- Medical clearance protocol
- Mental health process flow
- Emergency department guard protocol regarding detention and guarding of patients

The Tweed Hospital NSW

- Medical clearance, and physical assessment protocols
- Inter-hospital transfer form

9. Resources provided by NICS

Quality Improvement articles:

- Translating research into practice: speeding the adoption of innovative health care programs[20]
- Developing and testing changes in delivery of care[21]
- Building measurement and data collection into medical practice[22]
- Physicians as leaders in the improvement of health care systems[23]

Presentations

- Suicide Prevention Program
- Management of Mental Health Emergencies
- Rod Anderson: Change Management
- NICS: Barriers to Implementation
- Overview of the Evidence
- Tools for Improvement

Tools and resources developed by NICS

- Proforma for project teams to report 'Most significant change'
- Consumer satisfaction surveys
- ICD 9/ ICD 10 conversion table for target diagnostic codes
- Barriers identification to implementation tool
- Project management made simple
- Project definition proforma

Guidelines

- Guidelines on self-harm developed by National Institute for Health and Clinical Excellence UK (NICE)[5]
- Guidelines for assessment and management of people at risk of suicide developed by the New Zealand Guideline Group (NZGG)[6]
- Massachusetts College of Emergency Physicians medical clearance consensus statement[14]

Other tools and resources

- Barwon Health (Victoria) Emergency Department Mental Health triage tool
- Department of Human Services (Victoria) emergency department mental health triage tool and worksheets
- Links to sites providing training programs for mental health
- National Health Service UK (NHS) checklists
  > Emergency care mental health checklists
  > Achieving timely 'simple' discharge from hospital
- South Australia Mental Health 2003–2008 policy documents

10. The Mental Health-Emergency Care expert group (2004–05)

Prof Jeremy Anderson

Head, Epidemiology and Biostatistics Unit
School of Population Health
University of Melbourne, VIC

Prof Chris Baggoley

Director, Emergency Department
Royal Adelaide Hospital, SA

Dr Chris Carroll

General Practitioner
Parkes, NSW

Dr Frida Cheok

Manager, Healthconnect Project
Department Human Services, SA

Mr Steven Gough

Director Operations
Rural Ambulance, VIC

Ms Rebecca Graham

Principal Consultant, Clinical Governance
Mental Health Services and Programs
Department Human Services, SA

Dr Aaron Groves

Director, Office of Mental Health
Health Department, WA

Dr Kate Howell

General Practitioner
North Eastern Division General Practice, SA

Mr Beaver Hudson

Senior Project Officer, Emergency Departments
Centre for Mental Health
NSW Health Department, NSW

Dr Greg Hugh

Centre for Mental Health
NSW Health Department, NSW

Ms Michelle McKay

Acting Nursing Director
Toowoomba Hospital, QLD

Mr David Miller

Executive, Director, Acute Services
Bayside Health, QLD

Dr David Spain

Emergency Staff Specialist
Gold Coast Health Service District, QLD

11. The project team

Program Director

Dr Jan Davies, Executive Officer, NICS

Emergency Care Community of Practice Program Manager

Ms Sue Huckson, NICS

Emergency Care Community of Practice Community Development Leader

Dr Michael Yeoh, NICS

Emergency Care Community of Practice Nurse Development Leader

Ms Margaret Ferma, NICS

Community of Practice Resource Investigator

Ms Marnie Hannagan, Project Officer, NICS

12. Glossary

ACEM	Australasian College for Emergency Medicine
CATT	Crisis Assessment and Treatment Team
CL	Consultation-liaison
CoP	Community of Practice
DHS	Department of Human Services
DNW	Did not wait
EC-CoP	Emergency Care Community of Practice
ED	Emergency Department
EDIS	Emergency Department Information System
FTE	Full time equivalent
KPI	Key performance indicator
MH	Mental health
MH-EC	Mental Health-Emergency Care
MSE	Mental state examination
NICE	National Institute for Health and Clinical Excellence
PECC	Psychiatric emergency care centre
NICS	National Institute of Clinical Studies
RMO	Resident medical officer
TOR	Terms of reference

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Appendix 1: About the Emergency Care Community of Practice

The Emergency Care Community of Practice

The NICS-sponsored EC CoP was established in 2003 to help connect the wide range of clinicians and health managers involved in the delivery of emergency care. It provides a mechanism through which health professionals can share their knowledge of how to effectively close evidence-practice gaps and improve patient care.

What is a Community of Practice?

'Communities of Practice' are networks that have been established to increase and promote the sharing and use of information and problem solving in groups with a common interest; groups who do similar tasks, have similar issues and are faced with similar problems.[19]

- ### Why was the Emergency Care Community of Practice established?

  The NICS Emergency Department Collaborative project (2002) established a network of health professionals with a keen interest in improving the quality of emergency care delivery based on best practice, which provided the basis for the EC CoP. Membership to the EC CoP is voluntary and open to all health professionals, managers and policy makers who have a role in emergency care across rural, remote and metropolitan areas.

- ### What are the objectives of the Emergency Care Community of Practice?

  > To assist the uptake of evidence-based practice in emergency care
  > To provide access to evidence-based research information and practical solutions relevant to emergency care
  > To identify and work on common challenges facing the emergency care environment (eg improving care for mental health patients)
  > To develop processes for making best use of good quality clinical care data

- ### What are the key elements of a Community of Practice?

  > Leadership to champion the Community of Practice
  > Having an identity the community can relate to, eg emergency care
  > Providing a range of opportunities to be involved
  > Making it easy to participate in the Community of Practice
  > Being responsive to the issues facing the community
  > Sharing a common interest, eg improving mental health care in emergency departments