2013-2014 Group Projects
Saskatchewan Institute of Health Leadership

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BREAKING THROUGH COMMUNICATION BARRIERS

GROUP PROJECT

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Group Project Goal
To Improve Holistic Patient Care through Improved Interdisciplinary Communication.

1. The Issue- To identify barriers that interfere with teamwork and prevent overall holistic patient care. Some barriers are as follows: Lack of communication, lack of respect among team members in regards to appreciation of scope of practice, hierarchy issues and morale issues in general.

2. Approach/Intended Outcome- Question - Why is there a lack of communication between Healthcare Providers?
Vision- To develop a standardized toolkit to improve interdisciplinary teamwork.
Benefits to Health Care System- Improve collaboration with all of the Health Care providers in the delivery of holistic patient care.
Overall Outcome- Our team would have an effective tool that would enable the patient’s health information to be available to provide the sharing of information to the benefit of the patient in all systems in healthcare. Each Health Care professional would feel valued in their role in the Interdisciplinary team by each sharing their piece of the information to complete the holistic patient profile.
Measured By- surveys, patient follow up surveys, interviews.

3. Environmental Scan- Hierarchy barriers within the ID team, lack of time and resources, lack of technological advances provincially and lack of money. Our ongoing environmental scan would be measured by the surveys, interviews and patient follow ups.

4. Today’s Input- The current state is that there are gaps in the communication and respect within our interdisciplinary teams.

5. Key Elements- The key elements we are focusing on are:
- Improved patient care through a stronger more “bonded” Interdisciplinary team.
- Interdisciplinary Team Building
- Interdisciplinary attitude, morale and hierarchy

Brainstorm for options and approaches to resolve challenge:
- team building sessions focused on respect of other’s scope of practice and role in the patient’s care
-each discipline taking turns within the team to “lead” the group or “rounds” on a rotating basis which may include an educational component of their field. A “job description” of sorts could be set out for each to follow when it is their turn to lead.
-use of white boards
-a standardized form used for all disciplines to share their component of patient care.
-standardized forms
-EMR provincially
-Using (appropriate) HUMOR to come together- make the team “fun” but the content of patient goals still be taken very seriously...

**Rationale for Approach:** Our approach that we wish to focus on is team building. This could be done by boosting morale within the team, educating one another, focusing on the patient’s health goals, motivating each other, respecting and appreciating each other’s role, supporting one another and ultimately working as a team for the patient.

**SURVEY OVERVIEW**

Our Saskatchewan Institute of Health Leadership team surveyed one hundred health professionals from nine hospitals and care facilities in Saskatchewan to identify barriers that are interfering with interdisciplinary team communication and collaboration as well as input on how to break these barriers to strive for improved patient care.

We received feedback from 76 nurses, 12 Therapists (PT, OT, SLP), 4 pharmacists, 3 social workers, 1 unit clerk, 1 special care aid, 1 clinical nurse leader, 1 management and 1 worker from health records. Of these, 81% of which either agree or strongly agree that there are barriers in interdisciplinary communication. Some of the many suggestion that were given on how to break down these barriers include increasing the understandings of each profession’s job role and thus increasing the communication in interdisciplinary tasks, setting mutual goals therefore leading team in a singular direction, interdisciplinary staff meetings, management spending time with staff to discuss issues and possible solutions, electronic medical records, to listen, respect and interact with all professions and encourage open lines of communication between disciplines, floor staff and management.

Of the health care workers that were surveyed, 27% do not feel like their professional role is understood by other professionals and another 16% were unsure of the same. Suggestions were given on how one could better this understanding and the following suggestions given: providing feedback, educating about one’s roles, expectations and boundaries as a professional, having staff spend a day following other disciplines, educate at large meetings and collaborate to find gaps in care, offering
support and opening up lines of communication and during orientation to health region they stress the difference and importance of each role should be presented.

Our team feels that patient care is directly affected by lack of respect and communication among disciplines and 65% of healthcare workers surveyed also agree. Suggestions that were provided to increase respect and communication include awareness of each disciplines practice, hold all staff members accountable to a standard of professional and respectful behaviour regardless of status and discipline, working as a multidisciplinary team and asking for input from other disciplines, fostering good relationships and open dialogue through networking events and courses on effective communication for all employees (including management).

Of those surveyed, 49% feel that hierarchy among colleagues is a concern in their facility. Feedback regarding how to overcome hierarchy issues is as follows: Create understanding of roles and responsibilities, focus on the team rather than each designation separately, share knowledge and experiences with colleagues, management should set standards on what's acceptable and what is not, treating others with respect and dignity and reinforcing the positive rather than the negative is fundamental in fostering a good team.

When asked if conflict is dealt with in an effective manner in their facility, 46% of health professionals disagreed or strongly disagreed. We asked for a plan of action to better deal with conflict in the workplace, suggestions that were brought forth include: Directly speaking to those involved, accept responsibility of own actions, encourage expression of feelings, encourage participation in conflict resolution workshops, have meeting between all involved to develop a plan to resolve conflict, standardization of how frustrations are acknowledged and addressed, senior management to step in before escalation and proposing solutions when problems arise.

A vast majority of those surveyed (68%) feel that their input is valued in the delivery of holistic patient care. Some ideas that were brought forth on ways one’s profession can increase impact on patient care are as follows: Voicing opinions, continuing education, lead by example, speaking up to ensure proper patient care and advocating for the patients, mentor younger/newer staff, giving patients clear information about ones role in their care and upholding standards and competencies outlined by association.

These and many other suggestions on breaking through the barriers that are interfering with interdisciplinary team communication and collaboration given by Saskatchewan’s health professionals can be found in Appendix A with the final results of our survey.
Based on the results of the survey our team decided to focus on developing a Toolbox to offer examples of beneficial ideas to increase staff morale, to team build at multi-levels, and to open lines of communication for all staff ultimately improving and impacting patient care.

Our fabulous TOOLBOX includes the following:

Team Building is so very important at all levels to boost morale.

Workplaces may want to start at the Managerial level. Respect among all employees is a basis to a healthy workplace. By sharing and instilling this with employees be it at the time of hiring or along the way at staff meetings, this philosophy can only benefit and enhance good patient care and staff morale. We found the following article “Respect for People” that simplifies this concept and can easily be shared with all. (See APPENDIX B)

Another beneficial workplace tool would be an employee specific “Team Alliance” form that the manager would review with employee and seal the alliance with a signature. The Alliance gives employees an opportunity to express how they feel about certain situations and what the expectation are at the workplace. This is an effective means to approaching conflict in the respected approach that the employee had stated works best for them if a conflict situation were to arise. (See APPENDIX C)

Employees can become leaders in their specific work areas. By doing so an employee may expect to see an increase in moral, motivation and a more positive approach to work by their coworkers. Any employee can introduce an interactive environment for their coworkers by using simple, quick tools. Ice breakers at the start of a shift to start the day with humor, role playing activities at staff meets for visual affects instead of always instruction. The “Minute to Win It” activity has proven to lift spirits and lighten the mood in a sometimes serious workplace. (See APPENDIX D)

All employees no matter what department they work can also learn to be leaders and share with others. Learning and changing in healthcare is inevitable. Sharing knowledge with others in a relaxed setting can bond disciplines within a facility. Using a “Lunch and Learn” concept has proven effective. Food always draws people together and if knowledge is shared and learned at the same time, it can only benefit staff and patients alike. (See APPENDIX E)

“All Staff” Meetings are another tool that facility managers can utilize to bring staff in all disciplines together. To be treated as an equal and valued member of the service delivery team in your facility can only enhance staff morale. (See APPENDIX F)
Team Building in general gives employees a sense of well-being, and a sense of being valued. This promotes a behavior or staff wanting to come to work and great job satisfaction. In return less sick time and a decreased workplace conflict all well enhancing work performance.

Our SIHL team felt that the thread of building better communication in all healthcare settings is what drew us to each choose this topic. We have shared personal experiences from our work lives to reiterate the need to break down barriers in work places and among our fellow staff members. Each of us feel that by stepping up our leadership roles and by using some of the ideas in the toolbox we will be slowly build up morale and break down the barriers of communication.

In Closing we would like to say that our team has enjoyed the path that this SIHL leadership journey has taken us on. By identifying the challenges of logistics, personal life and work life commitments along with the geographic barriers we have come together to overcome the team barriers and move forward. We have been able to tap into one another’s personal strengths to work effectively as a team to fulfill our team project requirements. Laughter has erupted on occasion, ideas have been bounced, friendships have been made, leadership skills have developed, learning curves have been climbed and personal journeys have expanded and exploded along the way. We have each stepped out of our comfort zones and have had growing experiences that may not have occurred had it not been for our leadership journey at SIHL. And we all feel that this is just the beginning…….
APPENDIX A

SASK INSTITUTE OF HEALTH LEADERSHIP SURVEY

Interdisciplinary Team Communication and Collaboration

Locations Surveyed:

Cypress Regional Hospital- 54
Moose Jaw Hospital- 25
Wadena- 9
Watson- 3
Central Park Lodge Care Facility-2
Regina General Hospital- 2
Lanigan Hospital- 2
Pleasant View Care Home-2
Wascana Rehabilitation- 1

RATING SCALE  1. *Strongly Agree*  2...3....4...  5. *Strongly Disagree*

A. There are barriers in Interdisciplinary communications.

1. Strongly Agree  ○
2. Agree  ○
3. Unsure  ○
4. Disagree  ○
5. Strongly Disagree  ○

Suggestions for breaking down these barriers are:

- Better explanations of scope of practice
- Increase roles of other disciplines in patient care and planning
- Effective communication tools such as: PSAG boards need to be updated everytime changes made
- Management taking time to spend with staff and discuss issues and possible solutions
- Roles and responsibilities clearly defined and updated as they change
- Open lines of communication between disciplines, floor staff and management
- Increasing the understandings of what others do and thus increasing the communication in interdisciplinary tasks
- Setting mutual goals therefore leading team in a singular direction
- Considering input from others and working together
- A sharing time to present info on the role of each discipline
- all staff meetings (multidisciplinary)
- Lunch and learn sessions
- Collaborating with monthly meeting that include all departments
- A visual board for interdisciplinary communication
- Charting accurately
Having an expectation of respectful workplace
Sharing of ideas and face to face communication
More consistent communication so that all treatment recommendations are followed by all staff treating patient
Inclusion in conversations that will affect floor staff before being implemented by people higher up
Less levels of management
More streamlined objectives across points of care
Group meetings and discussion
Written notifications/ memos
Management taking time to spend with staff and discuss issues and possible solutions
Having a way to determine which discipline is which (maybe specific colored uniforms)
Have all levels of departments involved in the issues affecting communication lapses
Getting input and suggestions from the front line workers
Listen, respect, interact
Employers being consistent in educational requirements across Saskatchewan
Inservices to better understand each discipline's role/ process
More thorough chart review (all disciplines document but each professional should be reading these notes to
Staff meetings with education
Build a team atmosphere
Electronic medical records would be beneficial
Monthly meetings to address issues within the team

B. I feel my field of work and my role is understood by other colleagues.

1. Strongly Agree  ○
2. Agree  ○
3. Unsure  ○
4. Disagree  ○
5. Strongly Disagree  ○

I could create better understanding and awareness of my field by:
Having professional association come out and speak to managers
The more we share responsibility the more understanding there is
By sharing information and care team goals and involving other disciplines in these goals
As a student in school or during orientation to health region they should teach the difference and importance of
Providing feedback, educating about one's roles, expectations and boundaries as a professional
Talk about what we do, get the message out there and start conversations with other disciplines to educate
Educate at large meetings, collaborate to find gaps in care
Providing easy to read info on a communication board for all staff to read and become informed
Having staff spend a day of orientation following other disciplines
Using social media/ youtube videos which can be watched when time allows, during orientation, etc.
Present self in a professional and respectful manner towards all colleagues
Represent profession on collaborative committees
Better communication with the staff and taking the time to know the people you are working with
Increased casual interactions to get to know one another
Educate and advocate
Create awareness ie posters, ads, wear big pins
Listening and looking; We all have 2 eyes and 2 ears but only one mouth for a reason
Compliment team members on safe delivery of patient care and let them know they are appreciated for their efforts. Offering support and opening up lines of communication will help foster a collaborative environment.

**Disciplines.**
1. Strongly Agree  ○
2. Agree  ○
3. Unsure  ○
4. Disagree  ○
5. Strongly Disagree  ○

Suggestions to overcome these barriers are:
- Being open and willing to communicate directly with all health team members in your profession as well as other disciplines.
- Working as a multidisciplinary team and asking for input from other disciplines.
- Awareness of each discipline's practice.
- Patients and staff members being taught the difference and importance of each discipline; one is no more important than another, one can't function properly without the cooperation of the other.
- Working together to improve the stance of the client.
- Clear definitions of each job role supported by senior management.
- Productive, respectful communication.
- Hold all staff members accountable to a standard of professional and respectful behavior regardless of their status.
- Having a common care plan and shared documentation between all disciplines.
- Education on job roles, skills, and abilities of each position.
- Communication needs to be implemented in teachings when doing education at all levels.
- Educating staff in having "hard conversations".
- Fostering good relationships and open dialogue through networking events.
- Emphasizing teamwork.
- Respect shown from the top down.
- Working as a team and finding a method of communication that fits the facility, patient, and team needs.
- Communication courses for all employees, including management.
- Remembering that we are all here for the benefit of the patient, they come first.
- Follow through on referrals and consultations.
- Team development.

**D. Hierarchy among colleagues is a concern in this facility.**
1. Strongly Agree  ○
2. Agree  ○
3. Unsure  ○
4. Disagree  ○
5. Strongly Disagree  ○

Suggestions to overcome hierarchy issues are:
- Understanding scopes of practice and having each staff member working to their full capacity.
- Those with higher ranks should come spend more time among staff, even just by joining in on a morning huddle.
- Education of different roles.
- Respect and knowledge breaks down hierarchy issues.
Leaders must set a positive example
Reinforcing the positive rather than the negative is fundamental in fostering a good team
Everyone to be treated and treat others with respect and dignity
Being consistent and respectful in leadership roles will lessen push-back
Voice concerns that can lead to a productive discussion and outcome
Create understanding of roles and responsibilities
Focus on the team rather than each designation separately
Work as a team and share knowledge and experiences
Need to be more aware of what’s going on within each unit, listen to staff concerns with interest
Equal playing field and everyone on the same level, working as a team
Clear roles between RN’s and LPN’s
Management needs to set standards on what’s acceptable and what is not.
Treat others how you want to be treated

E. In this facility, the approach to conflict is dealt with in an effective manner.
1. Strongly Agree  ○
2. Agree  ○
3. Unsure  ○
4. Disagree  ○
5. Strongly Disagree  ○

I can help to develop a plan and problem solve to better deal with conflict by:
Directly dealing with those involved
Contacting/informing management or supervisor
Management taking more lead and ensuring communication when conflict arises
Encourage participation in conflict resolution workshops
Senior management to step in before escalation
Complaints need to be followed up on in a timely manner
Having open dialogue with co-workers
Have open communication and welcome feedback from staff, creating this open environment makes it easier and more likely issues will be brought forth
Hearing all sides of the story
more direct interaction with management
Conflict management training and a type of personality training such as color spectrum workshop
Offering to mediate a conversation between individuals that are unable to resolve conflict on their own to deal
Foster a positive rapport with colleagues, even when disagreements always be consistent and respectful
Follow the zero bullying policies
Coaching and explanations of "why"
Documenting and ensuring that the appropriate people are aware so it can be addressed
More solid presence from management with day to day organization to observe and direct care
Not getting involved in situations that do not involve one's self
Improving understanding and communication with the involved disciplines and families
Being approachable
Speaking up when appropriate, avoid being confrontational or aggressive, choose words wisely when dealing
Accept responsibility of own actions, encourage expression of feelings and avoid resentment
Having an open concept, dealing with the problem head on
Have debriefing session following critical incidents ie. Codes, deaths, difficult interpersonal interactions
Increased transparency in the disciplinary process
Standardization of how frustrations are acknowledged and addressed
Proposing solutions, not complaining
Have meeting between all involved to develop a plan to resolve conflict

F. I feel my input is valued for holistic patient care in this facility.
   1. Strongly Agree  ○
   2. Agree  ○
   3. Unsure  ○
   4. Disagree  ○
   5. Strongly Disagree  ○

I can improve the role my discipline plays in patient care by:
voicing opinion
Continuing education
Participating in daily rounds with other disciplines
Speaking up to ensure proper patient care and advocating for the patients
Offering support to others, making their voices and concerns heard
Role model; display to others what is expected of them; lead by example
Promoting and bringing forth ideas and point of view of my discipline
Being included in planning and decision making
Being confident in/promoting own scope of practice and inform others of capabilities
Taking opportunity to give input
Mentoring younger and newer staff
Always be aware of the patient's whole being
Giving patients clear information about ones role in their care
Upholding standards and competencies outlined by association
finding time to spend more time with each patient and get to know more about them. Knowing background of
Providing evidence based practice
Keeping up to date on policies
Advocating for our discipline

Thank you for your time!
1. **Be present and listen actively - ask questions to understand.** Good listening means giving the speaker your full attention. Non-verbal cues like eye contact and nodding let others know you are paying attention and are fully present for the conversation. Avoid interrupting or cutting others off when they are speaking. When you hear something that you don’t understand, ask questions for your understanding.

2. **Acknowledge clients & coworkers with a greeting.** Notice those around you and smile. This acknowledgment, combined with a few sincere words of greeting, creates a powerful connection. Practice courtesy and kindness in all interactions.

3. **Encourage each other.** Encourage your co-workers to share their ideas, opinions and perspectives. Find ways to say “thank-you” and let them know you appreciate their work, especially when someone goes out of their way to assist you.

4. **Share information.** When people know what is going on, they feel valued and included. Be sure everyone has the information they need to do their work and know about things that affect their work environment. Sharing information and communicating openly signals you trust and respect others.

5. **Find ways to recognize the contribution of others.** Share the responsibility for praise and recognition of each other and our accomplishments. Commit to spreading positive news and goodwill, refrain from gossip and destructive conversation.

6. **Speak up.** It is our responsibility to ensure a safe environment for everyone at SHR; not just physical safety but also mental and emotional safety. Create an environment where we all feel comfortable to speak up if we see something unsafe or feel unsafe.

7. **Give and receive feedback respectfully:**
   a) describe the situation
   b) express its impact
   c) check your assumptions
   d) invite the other person’s point of view
   e) mutually agree on where to go

8. **Be open to trying new things and standard work.** We need to be continuously improving the way we do our work. Share your ideas for improvements at daily huddles and in Kaizen events and build on each other’s ideas. When new ways of doing work are introduced follow the new standard work— and keep bringing ideas for improvement to the team.

9. **Be a team player – give and receive help.**
   a) share work. When you are finished your tasks look at how your co-workers are doing with their tasks and step in to help them complete their tasks. When someone steps in to help you with your tasks say Thank-you for sharing the work and helping you do your best work.

10. **Be patient with self and others.** We are all here to do our best work. Sometimes we will make mistakes. Mistakes help us figure out how we need to work differently and help us learn. When someone makes a mistake, ask them if you can give them some feedback and then provide it respectfully. Mistakes are an opportunity to grow and develop.
Designing Alliances with Individuals

(Used at Hope’s Home)

1) Why have you chosen to work in this field?

2) What do you consider to be your strengths, gifts and goals?

3) What do you love about your job?

4) What would you love to contribute to Hope’s Home to make your job fulfilling?

5) What is your working/learning style?

6) What kinds of supporters/teachers do you best respond to?
7) How can we support your learning and growth?

8) What is Hopes Home Mission statement?

9) Identify the scope of your role and define boundaries. Where does each person begin and end in their functions? Ex “My role as your Director is to give you feedback on what’s working and not working in your performance.”

10) Can we give each other permission to make mistakes, ask dumb questions, get it wrong, fail or succeed?

11) What do you need to feel safe and comfortable in our working relationships?
12) What you need to feel safe and comfortable contributing your passions/gifts?

13) If things get messy (assumptions, misunderstandings etc.) how would you like people to respond to you? Ex you make a mistake and someone wants to approach you on it.

14) Assumptions… ask your facilitator
Silence

Type of activity: Icebreaker
Participants: 6-500
Timing: 5-10 minutes
Key themes: Communication, Trust

Overview

This icebreaker aims to focus attention and to dispel nervous tension at the start of a presentation, meeting or training session.

Pre-Work

None.

Equipment and Layout

None.

Running the Activity

1. Introduce yourself and say you are about to start your session. Give it a big build.
2. Then stop talking and remain silent for at least 30 seconds, walking around the room or looking at your notes.
3. At the end of 30 seconds, thank participants for their patience and, with a big smile, ask them what they learned in the last 30 seconds.
Rings a Bell

Type of activity: Icebreaker Discussion Starter
Participants: 6-100
Timing: 15-45 minutes
Key themes: Communication, Teamwork

Overview
A simple and fun activity, ideal as an icebreaker or discussion starter. A good way of ensuring that all mobile phones are switched off at the start of a meeting.

Pre-Work
None required.

Equipment and Layout
Participants can remain seated or standing.

Running the Activity
1. Ask each participant to introduce themselves to the group. As part of their introduction they should demonstrate their mobile phone ring tone. They should then explain the reason for their choice or ring tone (or lack of interest in a ‘personal’ ring tone), and offer some comment as to what this might suggest about their personality or style.

2. The discussion and feedback among the group will be at the discretion of the facilitator, depending on the group composition and whether the activity is used simply as an ice-breaker or as a starter for a discussion.
MY DREAM TRIP

Type of activity: Icebreaker  Energiser
Participants:  6-50
Timing:  15-30 Minutes
Key themes:  Trust, Communication, Motivation, Teamwork

Overview
A light-hearted introductory activity, which encourages participants to find out a bit more about their work colleagues. Working in pairs, participants are asked to describe how they would spend their time and money if they were given one month away from usual work and domestic routines and responsibilities with an unlimited budget. These Dream Trips are then shared with the group as a whole.

Pre-Work
Spend time thinking about your own dream trip so that you can give it as an example if required.

Equipment and Layout
Can be carried out in any format, but tables set up for teamwork encourages communication.
Travel books and holiday brochures can provide a useful source of ideas if the group need prompting.

Running the Activity
1. Explain that this exercise will help us to understand and get to know one another better by revealing some of our ideals and motivation.

2. Tell the group that they will have ten minutes to write a travel itinerary for their ‘Dream Trip’

3. Ask them to imagine that their employer is so pleased with their performance that they have been awarded a month of paid leave and an unlimited travel budget. In addition, a team of domestic staff and child carers are available to take care of their responsibilities at home so they can choose whether or not to take their families with them.

4. Reiterate that the itinerary must contain as much detail as possible, including who would be travelling, by what means, air, sea or train and in what class. Explain that you want them to include...
By conducting “Lunch n’ Learn” sessions in a facility, learning, sharing and growing can enhance interdisciplinary bonds and knowledge. This noon hour learning opportunity is hosted each time by a different Department, on the topic of their choice, to share information that may help others understand their roles better or just to learn something new and random. It is held over lunch hour, and can be informal where each staff member can either their own lunch, and learn at the same time. It could be as short as 15 minutes or more in depth. The hosting department may choose to provide some food or a dessert...food always draws people together!
“All Staff” meetings can be held where everyone in the facility be it big or small...from housekeeping, maintenance, nursing, administration, therapies etc.gather together to be informed by Management of news that impacts each employee. This can be an information session as well as a “bonding” session using some of the group type ice breaker activities, stressing that “all staff” are equally important on the team and are all at work for the common goal of improved, efficient patient care. There can be an “open-mike” opportunity for staff to ask questions and get answers directly thus diminishing chances of “rumor mill” type activity in the work place. Being transparent and open with staff is a beneficial and effective tool in improving morale in the workplace. Each person can feel a sense of belonging in this setting to be included as an equally valued staff member as the person sitting beside them. Management is also given an opportunity to review “company” policy and reiterate Goals and Values that everyone should be adhering to in the facility. A win-win situation for all!
You can have all the procedures and processes in the world, but without good communication, your team or operation is going nowhere.”

Author unknown

The Key Elements of Interdisciplinary and Community Teamwork.

In health care, the patterns of communication are affecting team performance. Research shows sociometric analysis in diversified workplace teams found similar patterns (Roberts, 1979). To solve this growing problem, studies have shown that face to face interactions and communications help build trust in teams. The trust is what leads to engagement, which, in turn, contributes to team success. Effective communication is the key to team success (Choi, 2013).

Health care as we know it is good at making a group, but is unable to work as an effective team. The root cause of an effective team is great communication. Communication is defined as attention to five behavioural cues: words, tones, gestures, postures, and facial expressions.

Other elements which affect team performance are personality dynamics, level of familiarity, trust, respect, group morale based on job content, management style, company culture and incentives and rewards for getting a job done efficiently. Without good communication within a team, none of these other elements even begin to play out within a group. Communication is the glue that binds a team together and engaging communication means greater depth of personal connection. Communication creates a team with increased morale, spirit, enthusiasm, performance and overall respect for others.

The process would be to define a specific group to comprise of a workable team. Once the group is chosen one option to approach better communication is to have engagement outside the formal work setting. This could be a simple as revising the team member’s coffee break schedule so that everyone breaks at the same time.

Now in healthcare, this may be a bit challenging, but with creativity it could work. In the acute care setting, one floor could relieve another floor with minimal staff on each floor. In outpost, the clinic could be closed for 15 minutes in the morning and afternoon. This break time would allow staff members more time to socialize with their teammates, away from the clinic or floor setting. This may go against efficiency practices, but it may actually work. This practice may actually increase staff satisfaction as well as open up the lines of communication.
The rationale for this approach is spending time outside the workplace setting may develop and encourage mutual trust between team members. In doing this, energy, confidence, camaraderie and collective strength will occur and this is imperative for a team to overcome obstacles and conflict. It has been shown that effective team building should be done continuously if you want the team to be successful and it needs to be part of the companies' culture. The team building exercises should not be competitive – as this can break down the team and tear the team apart.

Short term strategies are to initially get to know your co-worker in a different setting. Once a relationship has been established, then long term goal is to develop long-lasting friendships. People working at the same workplace have similar interests (healthcare) and most likely have similar interests. At least there is a starting point in which to have a conversation (e.g. “wasn’t that wound in room 7 healing nicely”).

The leadership approach is for the team to become a “we” and not an “I”. The team will then form a common commitment and purpose (Katszenbach & Smith, 1993). Building strong relationships within the team will enable the team to succeed. Effective teams that work great together or click have shown that communication plays a crucial role in the success of the team – communication was shown to be the #1 predictor of a team's success – and has proven to be the most important as all the other factors combined – individual intelligence, skill, personality and substance of discussions.

Quality Assurance (QA) is the concept that includes the assessment or evaluation of the quality of care; identification of problems or shortcomings in the delivery of care; designing activities to overcome these deficiencies; and follow-up monitoring to ensure effectiveness of corrective steps. Two principles included in QA are: "Fit for purpose", the product should be suitable for the intended purpose; and "Right first time", mistakes should be eliminated. QA includes management of the quality of raw materials, assemblies, products and components, services related to production, and management, production and inspection processes.

An affective model of change is the Plan-Do-Study-Act cycle. This has been proven time and again in healthcare to measure change. It is a flexible method that works well in this situation. Because it is a cycle, a problem can be inputted into the system at any time in the cycle and
be analyzed. In utilizing this model, one can add-on 3 other strategies to establish if what was being studied actually made improvements in the workplace. What is the aim of the study (will better communication increase the strength of the team?), what factors will be measured to show the change was an improvement (over time is the team more cohesive?) and what changes can we make that will result in an improvement? (Increase the interaction outside the workplace with other team members).

With all of the above in mind, there is an increasing pressure on health care professionals to meet targets and to demonstrate improvement. The decisions regarding what to monitor are complex and numerous. In the end, the research boils down the root cause of good teamwork is great communication.


Home First-Working to Keep Our Senior’s at Home Longer

Savannah Hodgson, Alicia Pilsner, Karen Scherle, Frank Suchorab

March 31, 2014
Continued advances in science and technology and improvements in social conditions have increased life expectancy around the world. As the population of seniors rise throughout Canada, health care systems will be challenged to meet the growing needs of this population and sustain services as we know them. Seniors want to age at home in their own communities. A Home First philosophy, recently implemented in the three largest cities in Saskatchewan, supports seniors aging at home by making every effort to have appropriate supports in place. This philosophy better supported by the use of appropriate technology would allow seniors to remain at home while receiving the care they require.

**Canadian Perspective**

The Canadian population is aging and people are living longer than ever before. As early as 2015 it has been predicted, that Canadians over the age of 65 will outnumber those age 14 and under (CIHI, 2011). Concerns have been raised that the current health care system will be unable to meet the health care needs of this aging population. In a recent IPSO Reid poll that was sponsored by the Canadian Medical Association where 1000 Canadians, 18 years of age and over participated in a phone survey, only 41% of respondents felt that hospitals and long term care centres in their geographical area would be able to handle the health care needs of seniors that were unable to live in their home (Eggertson, 2013).

Research has also shown that seniors are more frequent users of the health system compared to other segments of Canadian population (Rotermann, 2005). This increased usage relates to the higher likelihood of seniors to suffer from a chronic illness and the potential of having a chronic illness correlated positively to an increase in age (CIHI, 2011). Understandably,
this increased likelihood of chronic illness and increased usage results in greater cost per capita when compared to adults aged 20-45 (CIHI, 2011).

Having a health care system that is responsive to seniors will be paramount as Canada’s population ages. More than 90% of seniors live in private households, as most prefer independence. Some need formal support and it is estimated that 1.2 million Canadians receive home care services at any given time, 800,000 of these people being seniors (CIHI, 2011).

Adopting and making efficient use of new and existing technologies and changing the philosophy in which care is provided will help maintain this independence and care outside of institutions will help the adaptation of service delivery, assisting in the creation of a sustainable health care system in the future.

**Saskatchewan Perspective**

Saskatchewan is a province with a high proportion of elderly residents. One in seven people is currently 65 years of age or older. In the next coming decade this variation of this population will only narrow, by the year 2028 approximately one in five Saskatchewan residents will be 65 years of age or older. In the decades to come the needs of this population will become more of a need and concern. The real demographic pressure will begin in 2021 when the first wave of baby boomers becomes age 75 until about 2046 when those born in 1961 become 85 years of age (Saskatchewan Ministry of Health, 2011).

Senior residents of Saskatchewan have expressed the desire to remain in their home and to live there for as long as possible. Their goal is to live healthier lives and remain living independently in their community. In Saskatchewan resources are lacking to allow for this to be a very successful opportunity for our senior residents. There is currently research and new
initiatives being implemented to improve in this area and provide more supports and services for our residents so they can remain in their own home (Saskatchewan Ministry of Health, 2011).

Saskatchewan’s publicly funded, publicly administered health care system provides a range of health services to support seniors in their community. The goal of these services is to provide assistance in helping seniors remain healthy and independent in their communities and homes. Available insured services that are provided to Saskatchewan residents are: hospital, medical, public health, mental-health and addiction services (Saskatchewan Ministry of Health, 2011).

In addition to these services there is also the Ministry of Health’s home care program. This program provides in-home services to Saskatchewan residents. The goal of this program is to also allow the resident’s of Saskatchewan to live independently, longer, and in the comfort of their homes. These services include palliative care as well as supportive care, which may otherwise lead to hospitalization or long-term care admissions (Hollander, 2006).

As in any program there have been weaknesses identified with the current home care program identified by the residents of Saskatchewan, a few have been listed here:

- there is the challenge of providing consistent and comprehensive services in a sparsely populated, mostly rural province;
- there is a challenge with recruiting and retaining care staff;
- there is a need for enhanced information systems, analysis and accountability;
- all dimensions of health care need to communicate together more efficiently
• home care needs to be looked at in the broader systems perspective.

In review of these stated concerns it displays that accessibility, qualified staff and retained staff, old communication styles, communication gaps, and narrow focus are the barriers to this programs success (Hollander, 2006).

In Saskatchewan if a community member is no longer deemed as safe or competent to live in their home independently they will be assessed and transferred into another care system. This system is long term care services. While the majority of residents in special-care homes are seniors, this represents about only 5% of the seniors’ population in Saskatchewan. As we saw with home care there have been issues found in our long term care facility environment as well. A CBC article in November 2013 stated that family members of long term care residents are upset and frustrated with the care provided in these facilities. Despite Dustin Duncan, Saskatchewan's Minister of Health, creating 700 jobs in recent years there are still concerns with the overall quality of service provided to seniors living in care homes (Langenegger, 2013). According to the research, Saskatchewan has a very large fund for long term care services. The services provided at these facilities are not all poor but there are continued concerns in this area in terms of the facilities. A major initiative is to transform the institution environment into a “home-like” environment that family and friends feel welcomed and enjoy visiting, and where the residents feel safe and at home (Ross, 2010).

In all of Canada, Saskatchewan has the third lowest funding for home care products and service but has the third highest number of long term care beds in the country. Why? This shows that the residents of our province are not being supported enough to remain in their homes to live healthy and independent lives. The new initiative known as Home First in Saskatchewan
attempts to address this by providing services and supports to enable seniors of Saskatchewan to live healthy lives and remain in their homes (Ross, 2010).

**Home First Model/Philosophy**

Evidence, both nationally and internationally, supports the concept of providing care in the home and studies have shown that when properly targeted and managed, care in the home can control the demand for more costly hospital care and long term care (LTC) while also upholding an individual’s independence (LHIN Collaborative, 2011).

Seniors are usually more satisfied and comfortable in a familiar setting and tend to heal more quickly when care is received in one’s own home and community. As well, getting better at home reduces pressures on hospitals and long wait times in hospital emergency rooms and reduces the risk of infections that can be picked up while in hospital (torontocentrallhin.on.ca, 2014).

According to a Toronto Central Community Care Access Centre study, 37% of people in long-term care homes do not need to be there. With some additional support, they could live at home or an alternate community setting (torontocentrallhin.on.ca, 2014).

Home First is an evidence-based, person-centered philosophy focused on keeping patients, specifically high- needs seniors, safe in their homes for as long as possible with community supports. When a person enters a hospital or an emergency department with an acute episode, every effort is made to ensure adequate resources are in place to support the person to ultimately go home on discharge. Under Home First, transferring patients from hospital to a long term care home is considered only after all other community options are considered (LHIN Collaborative, 2011).
The Home First Philosophy effectively and proactively considers options for post-acute care by involving and engaging the patient and family in decision making. It requires a focus on providing the right care, at the right time, in the right setting, and at the right cost, to ensure successful transition back to the home setting (LHIN Collaborative, 2011).

**Home First Principles**

1. All efforts will be made to discharge the individual back home where longer term planning can happen.
2. All discussions regarding LTC or other community options will occur outside of acute care.
3. Clinicians will always consider home as the first option as opposed to immediately designating LTC as a solution for the individual.

**Ontario Home First Model**

Ontario Home First Model was first introduced in Ontario by the Mississauga Halton Local Health Integration Network (LHIN) in 2009 to address significant patient flow issues within hospitals that were resulting in increased numbers of patients designated as Alternate Level of Care (“ALC”-patients waiting in one level of care but requiring another appropriate level of care). ALC patients who are discharged home are often high needs seniors who require more intensive case management to ensure the necessary supports are in place to maintain their health and safety at home. This requires more in-depth assessments, frequent follow-ups of patients at home and resource-intensive packages (Starr-Hemburrow, et. al., 2011).

In 2009, the Ontario Hospital Association reported that 15,858 acute care beds (19% of acute care beds) were occupied by ALC patients. Fifty five percent of ALC patients were awaiting placement in long term care. When the number of ALC patients increases it affects the
ability of the hospitals to flow all patients through the system which then limits the hospital’s ability to admit and treat acute medical and surgical patients. Since 2009, Home First has been introduced in each of the 14 Local Health Integration Networks (LHINs), with each being at a different stage of planning or implementation (LHIN Collaborative, 2011).

The Ontario Home First philosophy supports that:

1) Life changing decisions are better made in the home.
2) People can choose to live at risk at home and in the community.
3) Institutionalized care presents risks that are not as prevalent in the home setting.
4) Individuals and families have a role in patterning with health care providers to care for their loved ones.
5) Patient’s evaluations are based on needs and without any bias towards age.

In the programs first two years (2009-10 and 2010-11) 3300 seniors benefited from Home First. There was a significant increase in the number of high-risk frail seniors who were able to remain in the community. There was a 45% reduction in the number of seniors waiting in the hospital for long term care and the demand and waitlist for long term care was reduced (torontocentrallhin.on.ca, 2014). In 2010-11, one Ontario Community Care Access Center discharged 400 plus individuals home using the Home First approach. Many of those individuals would have remained in hospital waiting for a long term care placement (Canadian Home Care Association, 2010).

Saskatchewan Home First

In March 2013, as part of the 2013-14 Budget, the Saskatchewan Government announced a $2 million investment in a new Home First/Quick Response Home Care pilot project that will
help provide seniors in Regina and area with services and supports to remain safely in their home longer (Government of Saskatchewan, 2013).

The project, which became operational in October 2013, focuses on seniors who go to acute care or emergency departments in Regina. The Saskatchewan initiative aims to:

1. Enhance and improve home care’s response to crisis and intensive short term services needs in order to sustain seniors and others in their homes;
2. Encourage early discharge from acute care to community options;
3. Prevent unnecessary admissions to emergency rooms, and;
4. Engage additional service providers in the system to support seniors in their homes;
   provide the right care, at the right time, in the right place and ease the load on acute and long term care areas of the system.

In order to respond to service requests from the Emergency Department (ED) in a timely and effect manner a Home Care response to Home First service was created. This process enables Home Care to receive, process and organize services for clients in the ED within an hour of receipt of the request (Regina Qu’Appelle Health Region, 2013).

The Regina project initially has been operating out of the General Hospital where services are available seven days per week. Home Care Nursing staff and ED social work staff have been integrated to form a Home First Assessment Team. This team works to promote a think “home first” philosophy using a multidisciplinary assessment and care planning approach. As soon as urgent/emergent care has been provided, the Assessment team engages with the client and ED team to assess, plan, request and deliver health care to clients in their home (Regina Qu’Appelle Health Region, 2013).
The Home First Quick Response Care pilot project in Regina strives to advance the following objectives:

Objective 1: To ensure that all individuals (65+) with complex needs and their caregiver, receive care and support to live independently in the community for as long as possible.

Evaluation indicator 1.1 – Percentage of referrals to home care following administration of the contact assessment.

Evaluation indicator 1.2 – Discrete number of home care clients in the region will increase by 5% per year.

Evaluation indicator 1.3 – Average length of time between service request receipt and coordinated assessment in community.

Evaluation indicator 1.4 – Average length of time between service request receipt and beginning of recommended services.

Evaluation indicator 1.5 - By 2015, increase number of clients with MAPLe (Method of Assigning Priority Levels) scores of 4 or 5 living in the community supported by Home Care.

Objective 2: To develop enhanced community based services to support individuals (65+) with complex care needs returning home.

Evaluation indicator 2.1 - # of clients administered the contact assessment that returned to the ED (for the same concern) within 48 hours of original service request.

Evaluation indicator 2.2 - By 2015 80% of clients surveyed are satisfied with assessment and services received.

Evaluation indicator 2.3 - # of clients receiving Home Care services in excess of 25 hours/week.

Evaluation indicator 2.4 # of units/hour of Home Care service provided (5% increase)

Evaluation indicator 2.5 # of service requests to: nursing, supportive care, in-home respite, meal services and therapies.
Evaluation indicator 2.5a- Average length of stay for clients in receipt of enhanced community services.

**Objective 3:** To support transition planning processes from acute care by identifying potential alternative level of care patients early.

Evaluation indicator 3.1- # assessed and transferred to the community with intervention services.

**Objective 4:** Promote a shift in culture that commits to care options outside acute care/hospital services.

Evaluation indicator 4.1- Positive response rate for all surveyed.

Evaluation indicator 4.2- By 2015, decreasing the number of presentations to Program Access Committee from hospital for individuals assessed as potentially requiring long term care placement.

Evaluation indicator 4.3 -Production and implementation of an awareness campaign to support senior in their homes. Produce a client brochure # of presentation to public, staff, stakeholders.

Piloting these programs will allow Saskatchewan to analyze the benefits for hospitals and emergency rooms, but also assess whether these programs are effective at taking pressure off the long-term care system by giving seniors more supports to continue living safely and independently at home (Government of Saskatchewan, 2013).

In November 2013, a Home First project was announced for Saskatoon and in February 2014 one for the city of Prince Albert was announced. There is a standard criterion that is consistent across the three health region projects; however there will be variations on how Home First is implemented across the regions based on 1) existing regional structures 2) strength of existing stakeholder relationships and current processes 3) and the availability and attributes of similar Quick Response services in the region. Research was done in regards to similar programs nationally and internationally. The Saskatchewan projects are not exactly like any one
project but components are fashioned after other successful projects such as Ontario’s Home First Program (Government of Saskatchewan, 2014).

With the introduction of modern day technology and the positive impact technology can have on care, the Home First projects should include a focus on technology and make use of the devices and tools that seniors can use to help them communicate and connect with family, friends and service providers, improve and maintain their health and live independently for much longer.

**Technology**

The introduction of telecommunications technologies in the healthcare environment has led to better accessibility to healthcare providers, more efficient processes and greater overall quality of health care services that can be provided to the client while at home (Varshney, 2007). There are a couple of technology software programs that add to quality, safety and management of health care in Saskatchewan. The Pharmaceutical Information Program, also known as PIP, is a secure computer system that contains information about a patient’s medications that have been prescribed and dispensed. PIP is used by authorized healthcare providers in their treatment and decision-making process (Saskatchewan Ministry of Health). Another program is the Saskatchewan RIS/PACS initiative which implements a common shared Radiology Information System (RIS) and Picture Archiving and Communications System (PACS) infrastructure for the province. The PACS element is a computer system that interfaces with the medical imaging device (i.e., X-Ray, CT Scan, MRI, ultrasound, etc.) to attain the image in a digital format. Once the image is captured, it can be stored, manipulated and transmitted over a computer network. The RIS component interfaces with existing hospital information systems to capture patient
demographic and study (digital exams) orders. Once the information is captured, authorized health care providers in Medical Imaging departments use the information to schedule and complete the exam. As exams are completed they are interpreted by an authorized radiologist and the results are recorded in the RIS. The RIS interfaces with the PACS component to link images from the study and the interpreted results making them available to authorized users - typically referring physicians (Government of Saskatchewan, 2012).

Current and emerging wireless technologies can improve the overall quality of service for senior patients in both urban and rural areas, reduce the stress and strain on healthcare providers while enhancing their productivity, retention and quality of life and reduce the long term costs of healthcare services (Varshney, 2007).

There are many technologies designed to specifically focus on senior care and empower the seniors to better manage their conditions while at home. There are also technologies that allow children or caregivers of the senior to monitor their behaviour. New systems allow for everyday habits of getting up, eating properly and taking medicine to be monitored at a distance (Bertolucci, 2012). Patients can play a more active role in their own care and health care providers are supported with the necessary resources to better assist their patients. When hospital stays are shortened or totally avoided the need for home care services increases and technologies can assist in the care provided.

There are many technologies out there that allow the provider quicker access to information and required medical information that can be made available at any place any time using sophisticated devices. One such technology is Procura software. There are key features to
each aspect that enhance the quality of care that patients receive that are available 24hrs a day, seven days a week.

Procura software gives staff the tools they need to document and communicate so they can spend more time with the patient. Procura has a comprehensive clinical solution that helps the health care provider make the most of valuable nursing resources. It helps decrease the time a nurse spends charting in numerous locations and provides a program where charting is accessible, clear and concise to those using and reading it (goprocura.com, 2014). This reduces the risk of errors and miscommunication, thus providing a more accurate assessment of the patient, saving time between health professionals.

The use of technology has the opportunity to change drastically how healthcare can be delivered and have many positive result such as keeping senior patients aging at home in their communities. There are however, many challenges with the introduction of technology in the healthcare system. Some of the challenges that especially apply for Saskatchewan are:

1. Lack of wireless coverage and mobile networks in rural/remote areas.
2. Reliability of the wireless infrastructure.
3. Privacy and Security of personal health information
4. Cost Effectiveness of the technology- are there significant clinical effects to support the cost of the technology implemented?
5. Acceptance by the patient and healthcare provider to use the technology – what is the learning curve for those involved, especially with our senior population?
Conclusion

Healthy aging is everyone’s goal. Although, it is recognized that the longer we live, the more likely we are to suffer from one or more chronic conditions. This fact combined with the well documented increase in our aging population is currently challenging health care delivery systems in Canada. A shift in policy needs to take place to see the focus go from long term and acute care services to more of a focus on care that can be provided in the community. The Home First philosophy that is recently being piloted in Saskatchewan is an initial step to getting more supports in the community and a change in the way of thinking. There is also the opportunity to enhance these services with technology that can empower seniors to manage their own care, inform family and caregivers and supply health care providers with point in time information on the patient’s medical record or medical best practices. The focus needs to be on providing the right care, at the right time, in the right setting, and at the right cost.
References


Observations on Meeting the Needs of Mental Health Patients in Urban Emergency Departments

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1 Executive Summary
It is one of the goals of the Government of Saskatchewan to eliminate wait times in emergency departments by 2017 (Saskatchewan Government, 2012). Patients with mental health issues are one of the groups of patients who access the emergency department¹, and this target applies to them as well as to cardiac patients.

Most of the patients who access the ED for mental health related problems live in the cities of Regina and Saskatoon. They are also shown to present with a low level of acuity based on standard the CTAS (Canadian Triage and Acuity Scale) tool. The average wait time for mental health patients across the two cities is 12.5 hours, longer on average than for any other presenting condition.

The goal of this discussion is to identify the problems within the current state of patient flow in the ED from a mental health patient’s perspective and from a system perspective, to provide an overview of promising practices from other areas in the world, and to present some recommendations for improvements to help eliminate wait times for mental health patients in the ED.

Stigma is still experienced by mental health patients accessing care through an ED, and is still affecting the processes used by the acute care system to first assess the patient, and then to treat the patient in a timely respectful manner.

Our current standard of triage scales does not include sufficient specificity or sensitivity to mental health conditions to positively affect wait times in the ED. On the other side of the equation, too high a standard for medical clearance set by the psychiatric inpatient units may be creating unnecessary wait times in the ED for diagnostics that are not critical to the patient’s treatment once admitted to the unit.

The mental health patient’s voice needs to be heard and understood in relation to reducing stigma, improving the patient’s experience in the ED, and recommending improvements generally in the ED.

¹The term Emergency Department, and its abbreviation, “ED”, have been used throughout this paper to refer to an emergency room in a hospital, as well as an emergency department in a hospital, and the use is interchangeable to mean the same thing.
Recommendations also include replication of existing improvements made in Saskatoon to other EDs – these are process improvements that are achievable, and inexpensive to replicate, and would position EDs to achieve a “0 waits” target in the future.

2 Introduction
A priority of the Saskatchewan Ministry of Health is to reduce Emergency Room wait times by March 2017 for Saskatchewan people. Many factors contribute to waiting times in the Emergency Room - a shortage of acute care beds, staffing shortages, limited community care resources and a lack of integration of community and hospital-based resources (Canadian Association of Emergency Physicians [CAEP], 2009). For mental health patients, the wait time is longer in the emergency room than for any other presenting condition (average wait time of 12.5 hours versus 9.5 hours).

This paper will explore current efforts in the province to address this issue, the barriers and enablers to finding solutions, and how the patient/client voice is contributing or can contribute to the solutions. We have limited the scope of this discussion to mental health patients presenting at the two large urban centres, Regina and Saskatoon, and for whom a voluntary or involuntary admission to the inpatient mental health unit is necessary.

2.1 Purpose (why are we doing this including collective leadership challenge)
Our team shares a common interest in understanding the mental health patient experience of care in the Emergency Room. There is work occurring in the province to address ED wait times; some of the team members have been involved in rapid process improvement initiatives (RPIWs) in Mental Health; some of us have a keen interest to improve the patient voice in quality improvement initiatives; and some of us have had personal experiences with friends or family with mental health issues who access the ED. We hear and recognize that the only person who truly has the full picture of his or her health care journey from beginning to end is the patient, and we are curious as to how that voice has been incorporated in the mental health emergency room wait time improvement process.

2.2 Background and Context:
One public service in Saskatchewan that everyone has accessed at some point in their lives is health care. This may include accessing services through an emergency department. Over the last few years, the government has been focused on making improvements in the health care system to increase access to primary health services, surgical wait times, and to reduce wait times for emergency departments. Some
of these improvements have specific targets attached to them. In 2012, the Government of Saskatchewan “committed to eliminate wait times in emergency departments by 2017.” (Saskatchewan Government, 2012, p. 59). While the Plan for Growth documents does not include detail around what elimination of wait times in the ED entails for specific presentations, it is clear that this target applies to all patients in all emergency departments.

As part of the work to achieve this target, the Saskatchewan Emergency Department Waits and Patient Flow initiative was established. This initiative has worked with the emergency departments in Regina and Saskatoon to measure who uses the ED, map out the current patient flow to determine what the issues are in terms of wait times, and determine what improvements can be made to reduce wait times in the ED. Here are some of the results of that work from both locations:

- In 2012-13, there were 212,164 visit to the EDs in Regina and Saskatoon, representing 123,676 patients. Only 17% of all admissions to an ED were eventually admitted to hospital for further treatment. The average time a patient spent waiting for admission to another area of the hospital was 9.5 hours (Tustonic et al, 2013, p. 17).
- Of the patients accessing the ED, many of them fall into the category of non-urgent care
- Health Quality Council has done data analyses to determine who the most costly users of hospitals are in general, including those who access the hospital acute services through the emergency department. This is called hotspotting. Databases included in determining the costs include: hospital services, medication costs, physician services, and ED services. Early data from hotspotting analyses indicate that those who comprise the 1% of total hospital costs are a very small group of people, and that most of these reside in Regina and Saskatoon. Of these frequent users, a specific subgroup of patients with chronic conditions and/or a mental health condition has been analyzed separately. These account for a huge proportion (almost 57%) of the top 1% of hospital cost users (Health Quality Council, 2014).

The purpose of this paper is to examine how mental health patients who access the emergency department for the purpose of a voluntary or involuntary admission to the inpatient mental health unit could benefit from improvements in the ED to eliminate wait times in the ED. The same issues that affect patients accessing the ED for any reason are also experienced by those who access the ED for mental health issues, and the wait times for those patient who are under court order to be assessed in the inpatient mental health
unit, or who voluntarily want to be admitted to the inpatient unit are similar. Here are a couple of their stories.

3 The Patient Experience

Case One – Involuntary Admission

A 60 year old male with a history of mental health issues and numerous previous admissions to the inpatient unit was brought to the ED by police and EMS (Emergency Medical Services) staff under authority of a court order for assessment and possible admission to the inpatient mental health (MH) unit. A family member met the police at the patient’s residence to assist with compliance, and then met the patient, police, and EMS at the ED of Regina General Hospital. Because the patient was brought in by EMS, and once registration had occurred, little time was spent at the triage desk, and he was moved into a hallway on the gurney.

Once more information was gathered from the police and patient; he was then moved to one of the two designated mental health rooms (locked rooms) and transferred to a hospital bed. A nurse came to talk to the patient, and a set of vitals were taken. This was as about 6:30 p.m. The attending ED physician came to assess the patient at about 9:30 p.m., and following the discussion with both the patient and family member, ordered a number of investigations, since the presenting problems included physical complaints as well as his mental health issues. In the meantime, the patient became agitated with waiting for an outcome that could not be avoided (the court order required a 72 hour assessment in the inpatient unit), abusive toward the family member, and fearful of what would happen once admitted. The attending resident psychiatrist was the last person to talk to the patient and family member, and this occurred at approximately 10:00 p.m...The resident then paged the on-call psychiatrist to confirm that the patient should be admitted to the inpatient unit. The on-call psychiatrist came to the ED, reviewed the chart, spoke with the resident, and admitted the patient. From arrival in the ED to admission to the inpatient unit took approximately five hours, even though the patient was there as a result of a court order that committed to admission of the patient to the inpatient MH unit for the purpose of a 72 hour assessment.

Further assessment in the inpatient unit in the first 72 hours confirmed that the patient would be admitted to the inpatient unit for a period of three weeks. It is not certain how many of the physical investigations being done during the evening were returned to the ED for analysis by the physician, or reviewed by the
attending psychiatrist (this was not clearly communicated to the patient) – and further investigations were ordered during the patient’s stay in the inpatient unit. In the end, none of the physical complaints were found to be contributing to any physical problems. The police officers and EMS staff who accompanied the patient to the ED were required to stay in the ED until the patient was transferred to the MH unit. (Permission to use these events provided to the author on February 24, 2014).

Case 2 – Voluntary Admission

A twenty-three year old male with previous mental health conditions, including suicidal intent, was brought to the Regina General Hospital ED by his parent. The psychiatric nurse who usually worked in the ED on weekends had finished her shift at 3:30; the patient arrived at the ED at 4:00. Triage time was minimal as there were very few other patients in the waiting room. He had indicated to the triage nurse that he was suffering from depression and was having suicidal thoughts.

He was moved to one of the two designated mental health rooms in the ED. A nurse talked to the patient, get some medical history, and do a set of vitals within the first half hour upon admission. From that point to the first visit by an ED physician took 5.5 hours. This physician wanted to explore some of the issues associated with a medical condition the patient also had, which, though it could have contributed to his depression, was not the primary cause of his suicidal thoughts or presentation to the ED. Multiple blood tests were then ordered over several intervals of time. The patient had indicated to the ED physician that he wanted to be admitted to the mental health inpatient unit, since he could not guarantee to anyone that he could keep himself safe. The attending psychiatrist was not paged until 1:00 am, duration of 9 hours after admission to the ED. The attending resident psychiatrist contacted the on-call psychiatrist even before talking to the patient. The on-call psychiatrist met with the patient, and the patient was subsequently admitted to the inpatient unit at 2:00 am, where he stayed as a voluntary admission for 72 hours. From arrival in the ED to admission to the inpatient unit took approximately ten hours.

None of the diagnostic tests done in the ED were relevant to the patient’s mental health treatment in the inpatient unit, though staff did coach the patient about proper care of this condition. (Permission to use these events provided to the author February 22, 2014)

The patient experience is more than a patient’s satisfaction with services and treatment. Patient experience encompasses:
- **Safety** of the services provided;
- **Equity** of access to services;
- **Quality** of the care provided;
- **Satisfaction** with the care experience;
- **Timeliness** with which care is provided

Patients and their families can provide valuable insight into what works and what does not. Research suggests that fully engaging patients and families into the experience of care can greatly improve patient outcome.

### 4 Environmental Scan


It is important to note that when benchmarking Canadian performance against other countries, Canada ranks last on the list of 11 countries when compared with others in the category of hospital waits over four hours. Over 50% of Canadians experience average waits of four hours or more (CIHI, 2012).

Of all ED visits, only 17% of patients need to be admitted to the hospital for further treatment. Currently, these patients have to wait an average 9.5 hours for an inpatient bed. In Regina, the average wait in the ED for a mental health patient is approximately 12.5 hours.

### 4.1 Stakeholder Consultations – Key Issues identified

A stakeholder consultation and environmental scan undertaken as part of the ED Waits and Patient Flow Initiative “Environmental Scan and Literature Review” indicated that the long wait times and volume of people presenting in EDs are issues caused by multiple “failure points and bottlenecks in the system” related to patient flow across the continuum of care that included admission, transfer to inpatient care and returning to the community or transfer to other care facility after ED care was provided (Tustonic et al, 2013).
The following **key issues** have been identified by stakeholders:

- Primary Care Options in Community (the ability of the patient to find a regularly-accessible primary health care provider for their everyday health care needs)
- ED Operational Efficiency (the efficiency of the flow of patients through the ED)
- Hospital Overcapacity (the rate of admissions required to a department above its daily bed census)
- Standardized Care Plans and Discharge Planning
- Alternate Level of Care days in Acute (the number of patients using beds in the ED designated as ALC while waiting for placement in Long-term Care)
- Lack of Community Resources for Complex Patients (patients with multiple or complex care needs inability to access community-based resources for care)
- Common Language and Framework for Patient Flow

(Tustonic et al, 2013, p. 19).

A framework was needed to conceptualize the patient flow and this model was adapted in Saskatchewan from the Asplin model. It illustrates the patient flow and identifies some of the root causes for ED wait times and the phases in which they occur. (The model appears as Table 1.)
Table 1 Saskatchewan ED Waits and Patient Flow Framework (Tustonic et al, 2013)

Wait times in the emergency department are a symptom of deficiencies that occur across the continuum of care. As such, solutions will need to be sought in each phase of the patient’s journey through the system.

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<th>Phase I</th>
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<th>Phase III</th>
<th>Phase IV</th>
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<td>Emergency Department</td>
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**Phase I Root Causes**
- Flow of patients into ED
  - Volume and nature of demand (patient characteristic, needs, level of acuity);
  - Demand for care increased due to aging population (this is an international trend);
  - Typically need more care in ED
  - Small increase in the number of elderly patients creates a large increase in demand

**Phase II Root Causes**
- ED Capacity – Staff Shortage
  - Nurses, junior medical staff, specialty doctors
  - In England, it was estimated that 27% of waits over the official 4 hour target were due to patients waiting for specialist opinion
  - Patients waiting for inpatient admissions, tying up staff and space (their waits impact further on all patients in the ED);
  - Poor physical design and shortage of physical space, equipment, computers, systems
  - Difficulties in accessing medical notes (charts), tests, results and ancillary services
  - Time spent on discharging or arranging follow-up appointments

**Phase III Root Causes**
- Lack of inpatient bed xis, due to
  - Lack of service provision (rounding, cancelling or rescheduling treatments, awaiting for tests)
  - Delays in cleaning
  - Delays in inpatient discharge
  - Increased demand for beds

**Phase IV Root Causes**
- Discharging patients safely into the community
  - Lack of community care options
  - Lack of psychiatric care xix (mental health and addictions options)
  - Poor access to transport

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4.2 Current State: Data

Regina and Saskatoon have already undertaken improvement initiatives for individuals presenting with mental health issues to the ED. Saskatoon has made some improvements that will be discussed later and Regina has been focussing on “hotspotting” in the first round of data collection and targeting of improvement initiatives.

Saskatoon Mental Health Emergency Room visits

In a report presented to the Ministry of Health, “Who goes to emergency for the treatment of mental health problems... and why? A preliminary summary report” (Meng & D’Arcy, 2013), some interesting data were presented. The report noted that:

- 6,235 emergency visits representing 3,824 unique patients occurred in Saskatoon in 2012 with the primary reason and diagnosis stated on admission related to a mental health problem.
- Most of the patients were between 11 and 60 years of age.
- Substance use accounted for 34% of visits, neurotic disorders for 25% of visits, and mood disorders for 21% of visits.
- 72.8% of patients had a single visit in 2012.
- 27.19% of patients had more than two visits in 2012.
- 6.35% of patients accounted for 26.4% percent of emergency department visits for mental health problems.
- 34 patients had 10 or more visits to emergency for explicitly mental health problems in 2012.
- 38.45% of these emergency patients were enrolled with Saskatoon Health region’s Mental Health and Addictions Services (MH&AS) in 2012.
- For those who frequently visited the ED, substance use and abuse disorders, schizophrenia, mood disorders, and neurotic disorders were the major diagnoses for repeat visitors.

Using the information gathered in this report, the Saskatoon Health Region undertook a Rapid Process Improvement Workshop (RPIW), and since implementing the improvements, has reported a 50% reduction in wait times for mental health and addiction patients at the Royal University Hospital, as well as decreasing the number of patients who left the emergency department without being seen. More information about this work is presented later in this document.
Regina Mental Health Emergency Room Visits

Leadership from the Regina Qu’Appelle health region completed a study of patient presentations to the emergency department titled *Mental Health Presentations to Emergency Departments in the Regina Qu’Appelle Health Region: A One Year Retrospective Analysis of Cases from April 1 2012 to March 31 2013* (RQHR, 2013). This review was intended to identify the frequent visitors to the ED and identify common characteristics. Data from their report indicates:

- In 2012-13, there were 5,942 ED visits representing 3,751 unique patients with psychiatric diagnoses. Most of these visits were made to the Regina General Hospital ED
- A small proportion of patients accounted for a disproportionate number of visits. Approximately 4.9% of patients accounted for 24.7% of the visits made to the ED for psychiatric reasons. This is very similar to data presented for Saskatoon hospital EDs.

The high frequency users of the ED at hospitals in Regina (4 or more visits per year; 5%) account for almost 25% of ED visits by patients with psychiatric conditions in one year.

Further information about the high frequency users of the ED include:

- Patients are generally between the ages of 18-64
- Include a high proportion of mental disorders due to alcohol use
- These patients are more likely to be homeless or live in shelters
- They are less likely to have a family physician
- They are more likely to be under the care of a psychiatrist, but less likely to see one when presenting to hospital
- They are more likely to arrive alone and by ambulance
- They are more likely to be discharged to a non-acute facility or leave against medical advice
- This group of high frequency users has a higher proportion of patients taking anti-anxiety, antipsychotic, and antidepressant/anti-anxiety medications, and are more likely to present to the ED with an issue related to their medication.

It is interesting to note that both Regina and Saskatoon patients who present to the ED department with mental health issues and who also have a low socio-economic status are more likely to be admitted to
hospital than those who have an average or high socio-economic status. For both Regina and Saskatoon, hospitalization rates for mental health among the group with low socio-economic status were much higher than the national average while the rates among the higher socio-economic group were less likely to be hospitalized than the national average. In both Regina and Saskatoon the greatest number of people presenting to EDs with mental health and addiction issues presented only once and were not hospitalized. It is not clear if needs were met with the one visit to emergency and they were referred on, or if needs could have been met in the community if services were available without coming to emergency (Tustonic et al, 2013).

4.3 Current State: Emergency Department Triage

**Emergency Use of the Canadian Triage and Acuity Scale (CTAS) and Possible Implications for Mental health clients**

Triage can be most simply described as a process of sorting or prioritizing. In the emergency department, triage takes the form of formal or informal assessment at and immediately following registration in order to ensure that patients with the highest level of acuity are seen in a timely fashion. The research on mental health patients accessing the ED in Regina and Saskatoon clearly shows that most of these patients are presenting with a low level of acuity from a medical, physical health perspective, using a standard scale to ascribe an acuity level score.

In Canada, there is a widely agreed upon standard scale for assessing and prioritizing patients who present to the emergency department. The Canadian Triage and Acuity Scale or CTAS ranks patients from Level I to Level V. The following describes this triage scale with a note for each level on where or what types of mental health presentations would typically fit:

- **Level I** patients are those most urgent presentations to the ED who need immediate resuscitation or are at risk of losing life or limb. There are no mental health presentations in this category.

- **Level II** patients present to the ED with a potential threat to life, limb or function that require rapid medical intervention or delegated acts. Mental health presentations in this category include patients presenting with intentional or accidental overdose, acute psychosis/extreme agitation, and severe drug withdrawal.
Level III patients are those with urgent conditions that could potentially progress to a more serious problem requiring emergency intervention, including significant discomfort or affecting ability to function at work or activities of daily living. Mental health presentations in this category include those with acute psychosis and/or suicidal ideation.

Level IV patients are considered semi-urgent, presenting with conditions that are related to patient age, distress, or have the potential for deterioration or complications and could benefit from intervention or reassurance within 1-2 hours. Mental health presentations in this category include those who are suicidal/depressed but not agitated.

Level V patients are those who present to the emergency department with an acute but non-urgent condition or with a chronic problem with or without evidence of deterioration. The CTAS scale notes that investigation or interventions for some Level V illnesses or injuries could be delayed or even referred to other areas of the health care system. The majority of mental health presentations to the ED (e.g. chronic or recurring depression, difficulty coping, impulse control, behavioural disturbances or disorders) are triaged as Level V. These patients choose the ED for a variety of reasons, including lack of availability of viable health care options in the community, lack of awareness of other resources available within the community, socioeconomic and cultural issues (CAEP, n.d).

Since CTAS scores do not consider mental health issues with any sensitivity or specificity, it will be suggested later in this paper that some attempt to include mental health-specific triaging scales be considered.

4.4 Improvements to Current State
The following presents some of the details of the Lean work done by the two urban health regions (Regina Qu’Appelle and Saskatoon) in mapping mental health patients’ progress through the emergency room.

4.4.1 Saskatoon Royal University Hospital - Diagnostics, Medical Clearance and Emergency Psychiatric Nurse (EPN) Assessment
- When a patient presents to ED, they will register and be triaged simultaneously.
- The Triage Nurse will keep her assessment brief and will then place the patient in an ER bed.
- The patient will wait to see the ED physician. While waiting, the patient will receive care from an ER nurse to keep the patient comfortable and safe. The nurse will take vital signs, communicate the plan,
and provide blankets and food if needed. Any blood work will be done at this time prior to being seen by the ED physician.

- Next, the ED physician will see the patient. The ED physician will perform an assessment focusing on: subjective information (onset of symptoms, severity of symptoms, history of or chronology of symptoms, any current treatment). Objective information (vital signs, any physical findings, age of patient). The ED physician typically orders blood work at this time (CBC, Renal and Liver panel). The physician will also perform a mental health assessment.

- The physician will then make a diagnosis. If the patient requires medical attention, the patient will receive medical management.

- If it is clear the patient has a psychiatric issue and requires admission to The Dube Centre (inpatient mental health unit), the ED physician will call the on-call psychiatrist directly. The patient may wait up to 1 hour, but will continue to receive care from the ER nurse.

- If appropriate, the ED physician can discharge the patient. If the patient requires more complex discharge planning, a referral will be made to the Mental Health Team consisting of a psychiatric nurse (1200 – 2349 hrs.), social worker (0800 – 1200 hrs.) or a community mental health nurse. This will be done via the EPN.

- The EPN will focus their assessment on discharge planning.

- The EPN will provide medication management, teaching, and get a prescription for the patient. The EPN will provide further education regarding coping and supports.

- The EPN will make arrangements for follow up such as the Transition team, the psychiatrist, family and community resources.

- The ED social worker will connect the patient with financial and community resources.

- The ED social worker will assess the need for shelter, food and arrange transportation and may refer to community resources to aid independent living.

- Should the patient require admission, he or she is kept in the ER until a bed is available at the Dube Centre. The ER nurse will provide a direct report to a nurse in the Dube Centre. The Unit Assistant then porters the patient to the Dube Centre (with security if necessary).

- The total wait time as reported in the SHR November 2012 RPIW (Improve Care for Mental Health Patients Coming in RUH ED) was 3 hours, 35 minutes. Of interest, prior to the improvements made and waste eliminated with the RPIW, the wait time was on average 6 hours, 10 minutes. (See Table 2 in Appendices).
4.4.2 **Wait Times Regina General Hospital - Diagnostics, Medical Clearance and EPN Assessment**

- When a patient presents to ER, he or she first registers at the registration desk.
- The patient is then directed to wait in line at the Triage desk until called by the Triage Nurse.
- The Triage Nurse will ask the patient basic questions about the reason for the visit such as "what brings you here today." The nurse will then record a brief note on the patient's ER sheet outlining the concern and may or may not take the patient's vital signs at this point. The nurse will assign a CTAS score.
- The patient is then directed to sit in the waiting room until called.
- When the patient is called from the waiting room, he or she will be taken to an examining room. The Primary Nurse may take vital signs at this point if not done previously by the triage nurse.
- The ER physician will see the patient, perform an assessment focusing on: subjective information (onset of symptoms, severity of symptoms, history of or chronology of symptoms, any current treatment) and objective information (vital signs, any physical findings, age of patient). The ER physician typically orders blood work at this time (CBC, Renal and Liver panels).
- The physician will then make a diagnosis.
- If the patient requires medical attention, the patient will receive medical management. If it is clear the patient has a psychiatric issue and all assessments indicate the patient is medically clear, the physician will refer the patient to the Emergency Psychiatric Nurse (EPN).
- The EPN follows a template –“Emergency Mental Health & Addiction Nursing Data Base”, to collect the following areas of information: History of Presenting Problem, Collateral information, Mental Status Exam (appearance, behaviour, mood, affect, speech, thought content, thought process, perceptions, cognitive function, insight/judgement, energy level/interest/motivation, isolation, sleep, appetite), Risk factor assessment - (thoughts of indicators of self-harm, thoughts or indicators of harming others) including plan, history, family history, safety. At this point the EPN will outline a safety plan with the patient, Personal History (childhood development, family environment, dependents at home/ability to care for same, social/relationship history, cultural factors, legal history/family history -MMHD, educational history, vocational history, financial history, sexual history, history of abuse (physical, verbal, emotional, sexual).
  - Psychiatry history
  - Medical history
• Current medications

- The EPN will now formulate a clinical impression and plan. The plan will consider level of aggression/violence factors, level of abnormal distress/impairment, supports and timely access to services.
- At this point the EPN may decide to refer the patient to be seen by the hospital on-call psychiatrist. It is likely the patient will wait again.
- Once the patient is assessed by the psychiatrist and it is determined they require admission (following admission criteria – see Disposition Tool in appendices), the EPN contacts the unit to provide a report. The EPN or porter (with security if needed) will take the patient to the unit.
- The RQHR Kaizen Operation Team followed 10 mental health clients through RGH ER during the week of July 22, 2013. The average wait time was 12.5 hours. It is interesting to note the average wait time for a non-mental health client is 6 hours. (See Table 3 in Appendices).

4.4.3 Where does the same problem exist and how are they dealing with it?

As noted previously, there are many reasons that patients wait for extended periods of time in the ED. Wait times for mental health patients are longer and patients face some additional challenges. These challenges may include the sensitivity of the triage instrument used in emergency for mental health problems, the stigma that mental health patients encounter, the availability of trained staff in emergency departments and the awareness of community resources by hospital staff and patients, and the availability of, and access to these community resources. It is possible for us to learn from successes in other jurisdictions, but our research has not found one site that has one answer. The Environmental Scan and Literature Review (Tustonic et al, 2013, p. 5-6) has identified a number of sites that have made improvements that Saskatchewan can learn from, but the report noted that no singular place has achieved sustained improvement at a multi site system level. Having said that, the common success factors were identified from the improvement sites include:

- A state-of-the-art patient triage and tracking system, to monitor patients and ‘juggle’ hospital beds in real-time;
- Staggered staffing in EDs, according to peak volume times, adjusted daily;
- Rapid assessment protocols/zones that assist with prioritizing work;
• **Multi-skilled teams** including highly trained doctors, nurses, physician assistants, NPs, Allied Health Professionals (including geriatric nurses, physiotherapists, etc.) and patient greeters;

• **A streamlined admission process** to assist getting the sickest patients to a hospital bed sooner (rapid admission units);

• **Psychiatry Emergency Care**, including a separate Psychiatric ER and/or separate psychiatric emergency rooms;

• **Fast Track** services;

• **Throughput (Patient Flow) Teams**, to review data and process coordination between the ED, radiology, lab, admissions and environmental services (housekeeping) departments;

• **Newly constructed EDs**, utilizing patient flow and lean methodologies, with no waiting rooms; and

• **Explicitly stated targets and shared accountabilities**, including leadership teams and boards.

Australia has posted some interesting information about mental health presentations to their EDs on their mental health website. Australia uses the Australasia Triage Scale in their EDs, which has been developed to increase sensitivity to mental health and addiction issues. Mental health ED occasions of service appear similar to Saskatchewan data, however it is reported identifying time sensitivity as part of the triage process (ACEM, 2013).

• There was an estimated 243,444 ED occasions of service with a mental health-related principal diagnosis in 2010–11.

• Three categories of principal diagnosis comprised more than two-thirds of mental health-related ED occasions of services. These were neurotic, stress-related and somatoform disorders; mental and behavioural disorders due to psychoactive substance use; and then mood (affective) disorders.

• Over 80% of mental health-related ED occasions of service were classified as either semi-urgent (patient should be seen within 60 minutes) or urgent (patient should be seen within 30 minutes). Less than 1 in 10 were emergency (patients should be seen in less than 10 minutes) and about 1 in 100 required resuscitation (patient requires immediate care).

• Almost two-thirds (62.3%) of the mental health-related ED occasions of service were recorded as being resolved without the need for admission or referral. Most of the remaining third of mental health-related occasions of service were admitted to hospital (34.6%).
Mental health-related ED occasions of service were more likely to be classified as urgent and more likely to result in an admission when compared to all ED occasions of service (Australian Government, n.d.).

In February of 2013, the Emergency Nurses Association in the United States published a White Paper titled *The Care of the Psychiatric Patient in the Emergency Department* which discusses issues that the mental health patients experience when presenting in the ED (ENA, 2013). The paper also compares the triage system used in the United States, the Emergency Severity Index (ESI), to the Australasian Triage Scale (ATS) and the CTAS.

Both Canada and Australia have developed acuity systems for the triage of patients with mental health related symptoms (Bullard, Unger, Spence, & Grafstein, 2008, Mental Health and Drug and Alcohol Office, 2009). The Australasian Triage Scale (ATS) and the accompanying Mental Health Triage Scale (MHTS) (2009) is more specifically constructed for the acuity designation of mental health presentations than either the ESI approach or the Canadian Emergency Department Triage and Acuity Scale (CTAS). According to the Australian reference guide, the higher the potential for something to go wrong, the higher the triage rating should be. It lists the following factors as those that should be considered: risk of aggression, risk of suicide / self-harm, risk of leaving, and risk of a physical problem / medical diagnosis. Unlike ESI, but similar to many other triage scales, the Australasian mental health triage scale includes time parameters within which the patient should be evaluated (ENA, 2013, p. 4).

The report provides a very detailed discussion of factors that impact the mental health patient experience of care, which includes the time sensitivity of the triage scale, stigma, training of mental health professionals, the use of standard guidelines and the general volume of ED presentations for service. The paper also discusses the issue of mental health patients receiving medical clearance before mental health assessment. The paper suggests that earlier research on the common components of regular triage in emergency showed little positive impact on mental health patient treatment. However, more recent research suggests that medical clearance should take place before the mental health assessment. Given the two client experiences presented in this paper, it would seem that communication with the patient and family about the results of the medical assessment is not optimal.
There does not appear to be a clear solution for improving the mental health patient experience of care in the literature. Common themes, however, identify the sensitivity of the assessment tool including time parameters for evaluation and care, the stigma experienced by mental health patients presenting in the ED, the training of ED professionals, availability of community resources, and hospital overcrowding as common themes. It appears that, unique to the mental health patient, is the sensitivity of the assessment tool in triage, the longer than average wait times for assessment when medical clearance is required, and the stigma experienced when presenting for service. These areas may present priority opportunities for improvement.

5 Analysis & Patient/ client participation in finding solutions

“I invite you to not only listen to my words but hear what I say”
- Sarah Rose, Saskatoon RPIW

Are current processes meeting the needs of mental health patients in urban emergency departments? Answer: No.

Why not? There are gaps in the processes for patients that present to the ED for mental health concerns as their primary concern, or as a secondary concern.

Stigma is defined as “the negative attitudes toward people with mental illness, and the negative behaviours that result” (Mental Health Commission of Canada, 2012). While small strides have been made to reduce stigma, and while celebrities and the media are beginning to bring mental health issues into the light, society in general continues to treat mental health issues as a taboo subject, as an indication of poor choices, and/or as weakness. Is this why mental health patients appear to be low on the priority list of areas of health care that deserve attention and improvement? The stigma that is evident in society is also present in our current health care systems.

A key area that requires consideration is that of the compartmentalization of patient care needs by health care providers. Unfortunately, care providers, including physicians and nursing staff, tend to treat the primary condition. While we talk of holistic care and treating the whole patient, care providers in acute
care too often appear to be compelled to focus on the main diagnosis or the presenting problem. Even a trained health care professional may have difficulty sorting out the differences and interrelated components of the individual’s condition (e.g. severe diabetes), circumstances (recent job loss), challenges (depression), and context (a child in trouble with the law) (McMaster University, n.d.). More research is needed to better understand how stigma affects help-seeking by patients (Mental Health Commission of Canada, 2012).

Is the current triage system working for all patients? If the registered nurse (RN) at the triage desk does not typically perform mental health assessments, the mental health needs, whether the primary reason for presenting to ED or a secondary concern, may be ‘placed on a backburner’, or minimized at best. Also, if the patient still requires ‘medical clearance’ before his or her mental health needs can be addressed, other strategies, such as the Mental Health Crisis Response Centre recently opened in Winnipeg, may not be totally effective. Reports by CBC and Global news in October 2013 stated the Centre was not having the success it had hoped. In fact the number of mental health patients attending emergency had increased from the previous year. Between June and Sept. 2012, there were 895 patients with a mental health complaint and 936 during the same time period in 2013. Some reports stated that the requirement for a patient to be medically cleared led them to seek services at the ED instead of at the Mental Health Crisis Response Centre. The Winnipeg health authority also reported the decline in available psychiatrists and other staff willing to work evening and night shifts contributed to the issue (CBC News, 2013).

The question of privacy and confidentiality for mental health needs in the ER has also been raised. Is treating these clients ‘discreetly’ the required approach? All clients presenting to the ER triage desk should have their privacy protected and their confidentiality maintained, and care providers do not know what kinds of conditions about which patients may be more concerned about privacy than others. For example, one patient may be very concerned about not having someone know about their cancer treatments; while another may not be so concerned that a bystander has heard them mention their anxiety concerns. All patients should be afforded respect for privacy and confidentiality in their care.

The time spent waiting for ‘old charts’ or an electronic record for mental health patients, in particular, remains a concern. The previous records for mental health patients are more critical for both ER physicians and psychiatrists, as the mental health history may need to be reviewed prior to determining the best treatment. For physical ailments and especially when life threatening, the condition is treated without as much attention paid to previous health history. The very nature of mental health issues may mean that
the oral history of these clients is less trustworthy. Whether this is a fair assumption or not, it may create another reason to treat these vulnerable clients differently, and in fact, less than.

Dr Gina Browne, a researcher with the School of Nursing at McMaster University, has found vulnerability as a key determinant of health. The term implies inequality in a person’s characteristics, personal resources or environmental supports (McMaster University, n.d.). Browne emphasizes the latter two areas can alter the degree of an individual’s resilience, which affects their use of health care services. She goes on to say that these people who are hurting often seek out services that are not necessarily the ones that will/can solve their problem. Thus accessing the emergency department may not be the best option and other strategies must be considered.

The Public Health Observatory (Saskatoon Health Region, 2014) has described vulnerability in the form of a deprivation index, where education levels, employment, income and other measures of determinants of health were scored. In Saskatoon, hospitalizations due to mental disorders have indicated a high to moderate inequality over time, between those from more deprived and less deprived portions of the populations in that city. This research has recommended that mental health remain as one of the top health care equity priorities.

6  Recommended Strategies and Actions

6.1  Recommendations

In light of the fact that mental health patients experience longer wait times than other patients who present to the emergency department and the fact that Saskatoon HR implemented effective, sustainable changes, we would recommend replication of Saskatoon Health Region RPIW #21. This RPIW’s focus was to improve care for mental health patients presenting at Royal University Hospital ED.

Replication involves taking a successful project and duplicating the results in another location. Sharing knowledge across the regions can be cost and time saving. Replication is the extension of achieved improvements. This lean step extends improved system processes, tools and methods across an organization. The main benefit of replication is that benefit analysis need only be done once....move the process to other sites and configure or tailor for that site’s particular needs.

An interesting recommendation came from the above RPIW from Dr. Monika Hooper, a Saskatoon Health Region psychiatrist. The recommendation was for a rapid response service:
A rapid response team would provide multidisciplinary, outpatient assessment, treatment and consultation services. Patients would receive timely assessments, consultation and follow up for a maximum of a month if needed. Referrals could be made by ER physicians, on-call psychiatrists of family doctors and an assessment would occur within 2 weeks of the referral (Saskatoon Health Region, 2012).

Care providers in the ED need to be able to provide effective care to mental health presentations, until such time that care can be transitioned to mental health clinicians and/or specialist services. Patients in the ED will often require medical clearance prior to receiving psychiatric assessment. If medical clearance is required, then a clinical pathway should be developed for medically clearing patients presenting with a mental health issue while at the same time requiring a minimum of diagnostics to reduce wait times. Psychiatrists in Regina and Saskatoon hospitals could be surveyed to determine what they would consider ‘indicators of disease’ they would not accept in the inpatient unit. Clinical pathways for further medical clearance in the inpatient unit could then be applied. No other department in the acute care setting requires medical clearance by the ED prior to admission to the unit. Why should mental health be treated differently? In addition, if all laboratory and diagnostic services are available to patients throughout the various departments of the hospital, then these services should be available to mental health patients through the inpatient unit as well.

For those patients who require admission to the inpatient unit as a result of a court order, admission to the unit should not require any time in the ED. Daily bed census in the inpatient unit would have to be monitored and communicated to police so that apprehension and transport would only occur when beds are available in the unit – effort would be required to hold a bed for any court ordered assessments, or alternatively, a rapid response assessment unit could be established in the inpatient unit for 72 hour assessments.

In some circumstances, the ED can be an appropriate point of entry to the health care system for patients experiencing a psychiatric or medical emergency. However, the ED is often used as a last resort when a mental health patient is in crisis or has a lack of other available options. Improving access to community mental health services and supports, primary health care, and community-based psychiatric care for both short and long-term needs are all keys to reducing unnecessary ED visits, and thus improving wait times in the ED.
Patients presenting to the ED with mental health concerns commonly experience stigma, regardless of whether they are seeking medical or psychiatric care. This stigma can translate into delays in receiving services and increased wait times. Treatment of mental health patients as no different than patients with other chronic conditions accessing other departments in the hospital in a timely fashion, or without medical clearance, would go a long way in ‘normalizing’ the disease among health professionals, and reducing stigma.

Ontario has done some pilot work in EDs, looking at innovative strategies to improve wait times for patients presenting with mental health issues, including community-based crisis workers and discharge planners located in emergency rooms and inpatient settings, peer support, case management and improving community-based crisis response programs.

Valid and reliable triage scales that include specificity and sensitivity to mental health need to be developed or borrowed from other jurisdictions in order to improve the ED experience for mental health patients. Visits are oftentimes inaccurately reported due to coding as either a psychiatric or medical diagnosis when in reality patients may have both concerns. Research into the best ED triage scale for mental health patients is newly emerging and Saskatchewan could contribute to this body of knowledge as they implement improvement initiatives.

Patient experience of care
The work group was unable to find much information about the mental health patient and family experience of care in ED process improvement work except in Saskatoon. It appears that this could offer additional insight for improvement initiatives if a plan to systematically gather the information was established. The current focus on “hotspotting” may address the needs of the highest cost visitors, but the majority of mental health patients presenting to emergency visit once and are not admitted to hospital. We know little about their experience of care, whether their needs were met and if this population is visiting emergency because there is nowhere else to go.

7 Leadership and team insight
7.1 Learning from the work - The GROUP EXPERIENCE
Working on group projects can be challenging and beneficial at the same time. There is the anxiety of putting your trust in others that they will be just as invested as you are and that the job will get done. Then there is the benefit that each member comes with different experiences, skills and knowledge that lends to diversity and a variety of viewpoints and ideas. Our differing professional backgrounds made for a diverse and positive learning environment.

Arranging group meetings took a lot of planning, time and commitment from the group. We were fortunate that our group members were all from Regina so we didn't experience any geographical challenges. It was difficult to arrange meetings at times due to everyone's busy personal and professional lives. Fortunately our group decided to meet with a majority if need be. Everyone not in attendance at meetings was supportive of meeting outcomes. This made the process run smoothly so that we did not have to revisit decisions and waste time.

Our group project proceeded smoothly and the process was without conflict. We were fortunate to have a group of individuals working on the project who were reasonable, honest and open to communication and new ideas. Leadership was shared on a monthly basis. This gave everyone the opportunity to utilize leadership skills and allowed for the group to experience different styles of leadership. Workloads were assigned evenly and all individuals worked hard to meet deadlines as they had been established by the group members. Interpersonal relationships at all times were constructive and respectful.

The collective dedication and commitment from the group members ensured that timelines were met and the group was very satisfied - in fact a bit surprised - with the end result. A shareware based software product (Dropbox) was chosen to facilitate ease of sharing documents, research, etc. - another surprise to most of us.

This was a very positive group project experience. The group’s diversity, knowledge and common interest in our project contributed to a very fulfilling and valuable learning experience.
8 References


Additional Resources:

Harry, M., Mann, P. M., De Hodgins, O. C., Lacke, C. J., & Hulbert, R. L. (2010). *The Practitioner’s*

Saskatoon, ED Waits and Patient Flow Provincial Kaizen Operating Team, October 2013. The report analyzes data on visits to emergency departments for an explicit mental health problem in all 3 hospitals in Saskatoon over one year period: January 1<sup>st</sup> to December 31<sup>st</sup>, 2012.
9.1 Appendix 1 - Table 2 – Royal University Pathway

MENTAL HEALTH PATIENT PATHWAY THROUGH RUH E.R.
9.2 Appendix 2 - Table 3 – Regina General Pathway

MENTAL HEALTH PATIENT PATHWAY THROUGH RGH E.R.

- Patient presents to Triage Nurse
- Primary RN Assessment
- ER Physician Assessment
- EPN Assessment
- Psychiatrist Assessment
- Diagnostic Tests
- In Patient Admission
- D/C with Community Referral
9.3 Appendix 3 – Regina Qu’Appelle Disposition

Disposition Decision Checklist Tool for Mental Health Patients in the Emergency Department

Name of patient: __________________________ Patient’s gender: m / f
Date of assessment: ________________________ MRN: _______________________

<table>
<thead>
<tr>
<th>Risk of Harm</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of Harm to Oneself</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>Serious</td>
<td>Extreme</td>
</tr>
<tr>
<td>Risk of Harm to Others</td>
<td>None</td>
<td>Fleeing</td>
<td>Static</td>
<td>Serious</td>
<td>Extreme</td>
</tr>
<tr>
<td>Clinical Diagnosis</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Depression</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>Serious</td>
<td>Extreme</td>
</tr>
<tr>
<td>Acute Psychosis</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>Serious</td>
<td>Extreme</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>Serious</td>
<td>Extreme</td>
</tr>
<tr>
<td>Other:</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>Serious</td>
<td>Extreme</td>
</tr>
<tr>
<td>Patient Status / Treatment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Functional Status</td>
<td>Extreme</td>
<td>Serious</td>
<td>Moderate</td>
<td>Low</td>
<td>Minimal</td>
</tr>
<tr>
<td>Engagement</td>
<td>Optimal</td>
<td>Positive</td>
<td>Limited</td>
<td>Minimal</td>
<td>Support</td>
</tr>
<tr>
<td>Treatment and Recovery History</td>
<td>Full Response</td>
<td>Significant Response</td>
<td>Moderate Response</td>
<td>Poor Response</td>
<td>Minimal Response</td>
</tr>
<tr>
<td>Recovery Environment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Level of stress in patient environment</td>
<td>Extreme</td>
<td>Highly</td>
<td>Moderate</td>
<td>Mildly</td>
<td>Low</td>
</tr>
<tr>
<td>Level of support in environment</td>
<td>High Support</td>
<td>Good</td>
<td>Limited Support</td>
<td>Minimal</td>
<td>No Support</td>
</tr>
</tbody>
</table>

Disposition Decision (Adult Mental Health Patients)

☐ Diagnosis appropriate for admission to Inpatient Mental Health Unit.
   Please outline particulars.

☐ Patient admitted to the Inpatient Mental Health Unit. Although care in the community would be appropriate, it is not available.
   Please outline particulars regarding the community services required for appropriate care.

☐ Patient discharged to pre-existing community support.
   Please outline the particulars of the community-based support.

☐ Patient discharged with newly initiated support in the community.
   Please outline the particulars of the community based care.

☐ Patient discharged requiring no follow-up in the community

☐ Please check if you have given the treatment card to the patient

Completed By: ____________________________
   (Psychiatrist, Resident, EPN):

[Signature]
WHAT LIES BENEATH…..

PSYCHOLOGICAL HEALTH IN THE WORKPLACE

Wendy Ahenakew, Sabrina Fullawka, Shirley Nelson, Fara Nygaard
3/1/2014
INTRODUCTION:

As a working adult we will spend the majority of our waking time in the workplace. Attridge (2008) found that employees spend 20% less time with family than they did 20 years ago. Work is necessary not only to meet our most basic needs such as housing, food, and clothing but it also allows us to enjoy the finer things in life such as purchasing material things and doing activities that add joy to our lives and that of our loved ones. With so much of our time spent at work meeting these needs; it is impacting our psychological and emotional wellbeing.

Various research studies have been conducted on the impact of psychological and emotional health in the workplace. The National Standard of Canada for Psychological Health and Safety in the Workplace (2013) reports that the workplace is a major contributor to a person’s wellbeing. However, their research also found that in any given year, 1 in 5 Canadians experiences a mental health problem or illness, costing the economy more than 50 billion annually. The Mental Health Commission of Canada (2013) defines, mental health, mental health problems and illnesses as:

“Mental health is a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community. Mental health problems or illness represents a range of behaviours, thoughts and emotions that can result in some level of distress or impairment and the ability to live independently. Mental health problems and illnesses range from anxiety and depressive disorders through to schizophrenia and bi-polar disorder, and are often associated with a formal medical diagnosis. The type, intensity, recurrence, and duration of symptoms mental health problems and illnesses can vary widely from person to person, as well as by type of problem or illness.” (MHCC, 2013, pp. 3-4)
HYPOTHESIS:

In this paper we will review the research on the impact of psychological and emotional health in the workplace. We hypothesize that it is a necessity for leadership to support policies that encourage optimal employee mental health to maintain productive work environments and benefit the general public. We will provide research on leadership qualities and styles that engage employers and employees to achieve the necessary changes in organizations that support this hypothesis. We will also discuss the Hoshin model implemented in all health regions and explore how this reflects on mental and emotional health in the workplace.

CURRENT RESEARCH ON PSYCHOLOGICAL SAFETY IN THE WORKPLACE:

Current research in the Psychological and Safe Workplace (2013) suggests that the work environment may increase the probability of an emotional disorder or may exacerbate an existing mental illness. There can be some specific contributing factors to a psychologically unsafe workplace in the following situations: job demands and requirements for effort beyond skill level, lack of job control or influence by information withholding from workers, lack of reward, unfairness in recognizing and accommodating employees needs and lack of technical and practical support.

According to the National Standard of Canada for Psychology in the Workplace (2013), mental health illness is the number one cause of disability in Canada. Moira (2014) found stress; anxiety and depression were the predominant mental health illnesses impacting employees. Attridge (2008) similarly adds mental health conditions such as bipolar mood disorder, social anxiety and phobias, schizophrenia, and suicide. His research further indicated that employees with mental health conditions may also have dual conditions and health comorbidity such as
WHAT LIES BENEATH........

alcohol and drug addictions and/or chronic medical conditions. They also reported severity and chronicity of mental health conditions are worsened when drug and alcohol are present. These dual health conditions and comorbidity are more difficult to diagnose, more resistant to treatment, and more likely to recur. (Attridge, 2008, pp. 5-6)

Although there are many factors that contribute to an individual’s psychological and mental wellbeing, the workplace plays a significant role in how one deals and copes with mental health. Job stress and workplace conditions significantly affect employee mental health. (Attridge, 2008)

In Attridge’s findings, he states the indirect costs of mental health-related absence and productivity losses were greater than direct costs. Attridge (2008) discovered more employees are absent from work due to stress and anxiety than from physical illness or injury. Further studies uncovered that mental health conditions and addictions are the highest cause of disability in Canada and account for two-thirds of all disability claims. (Attridge, 2008 pg.14) CCMC (2014) states employers could avoid 10% to 25% of the cost of mental health disability claims if issues of psychological safety are addressed. If not addressed, they estimate it will cost Canadian businesses 198 billion over the next 30 years. Moira (2014) gave an estimated cost of 51 billion annually with 20 billion from loss of workforce productivity.

The question remains; are employees receiving assistance from their places of work to deal with mental health issues? Moira’s (2014) research indicates that 20% of employees who develop depression seek help, 10% receive a correct diagnosis and treatment, and of those, 10% receive prescriptions for an antidepressant. 81% do not take the medication and of those, 48% do not stay on the medication to achieve benefits. Attridge found “Approximately two-thirds of employees with mental health conditions do not get any treatment and of the third who do seek
care; most often this assistance is from their primary care doctors who are untrained to treat mental health concerns.” (Attridge, 2008, pg. 5)

Even though the above studies are based on general working populations in Canada, we believe this issue is prevalent within health care settings and therefore it is important leaders address employee mental and emotional wellbeing in health organizations. Health organizations account for a significant amount of employees in the province and these employees are providing direct or indirect mental and emotional care to the general public. There is no documented research regarding the actual cost to health regions of mental health related issues for employees however supporting data regarding general population suggests it could be a high cost to health care organizations.

LEADERSHIP STYLES THAT SUPPORT PSYCHOLOGICALLY SAFE WORKPLACES:

There are many contributing factors to psychological wellbeing at work. Attridge found ten elements that contribute to psychological well-being at work. These elements are “…transformational leadership, workload and pace, work schedule, role clarity, job future, autonomy, workplace justice, reduced status distinctions, social environment and extrinsic factors.”(Attridge, 2008, pg. 19) For the purpose of this paper we will focus on the element of leadership styles and discuss the ways these styles can positively impact employees.

Cashman describes leadership as “…anyone who is authentically influencing to create value is leading. Some may influence and create value through ideas, others through systems, yet others through people, but the essence is the same. Deep from their core, leaders bring forward their talents, connect with others, and serve multiple constituencies.” (Cashman, 2008, pg. 24) He
also goes on to say that there are as many styles of leadership as there are leaders. Various kinds of leadership can be found in different types of organizations. Leadership has evolved over the years with many organizations revisiting the effectiveness of a top down structure where people lead to manage versus lead to motivate and support. We will focus on transformative and transactional leadership styles and how these leadership styles are supportive to the mental health and wellness of the employees.

Transformative leadership is a level of leadership whereby leaders inspire and support people in their organization. Burns (1978) described transformational leadership as a process where leaders and their followers raise one another to higher levels of morality and motivation. Bass (1985) expanded on this further in his book “Leadership and Performance Beyond Expectations”. He spoke about transformational leaders being models of integrity and fairness. He described leaders that set clear goals while maintaining high expectations. Through transformational leadership employees can be encouraged, supported and recognized for the work that they do. He focused on moving people to look beyond their own self-interest; to look to the future of the organization and the beneficiaries long after the employee may be retired from the organization.

Transformational leadership encompasses aspects of charismatic leadership in that the concepts of inspiration and motivation are very important beyond mere exchanges and rewards. Transformational leadership works especially well in close supervisory relationships versus distant ones. (Bass, 1985) This would be true of many health care settings where health care workers of various professions are within a medical unit or department.
A member of our team asked the following question of 50 healthcare/healthcare related employees within one of the Health Regions:

In your opinion, what do you require from your leadership to reduce your workplace stress? The top 6 answers were:  1. Do not micromanage me. Give me clear direction (my role, the rules) and allow me to work within those parameters 2. Don't bully/intimidate me. Don't lose your temper when something doesn't meet your expectations 3. Hold people accountable and treat everyone fair. Deal with (discipline) employees who are not performing up to standard. 4. Before you discipline me for job performance, consider all the factors (is it possible the workplace is contributing to the poor performance i.e. unreasonable workload, policy). 5. Allow some autonomy/flexibility. Trust me to work on a project independently, give me something interesting to work on. 6. Don't forget to praise me. Instead of telling me only what I could or should be doing better, also talk about what I am doing well. (focus more on strengths instead of weaknesses). What type of leadership excels at finding a balance in these areas? Researchers have found that transformational leadership can have a positive effect on the group. (Riggio, 2009)

Riggio (2009) indicated that through his research employee groups led by transformational leaders exhibited better performance and job satisfaction than employee groups led by other types of leaders. The reason, he suggests, is that transformational leaders believe that their followers can do their best, leading members of the group to feel inspired and empowered.

Kouzes and Posner discuss the five practices of exemplary leadership. These practices include: Model the Way, Vision, Challenge a Process, Enable Others to act, and Encourage the Heart.
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These characteristics can all be found in the transformational leadership style. (Kouzes and Posner, 1987, pp.21-24)

The first practise, model the way, speaks to leading and living what you say. In order to do this one must be clear about guiding principles. This requires leaders to stand by their beliefs, have a voice and follow through with actions. The second practise is, inspire a shared vision. This involves leadership believing in the vision of the organization and sharing their desire to make the vision occur through change, partnership and by enlisting others in the common vision. Employees must feel that the leadership understands what their needs are and that they will work to support them. Thirdly, the leader needs to be willing to challenge the process. This entails willingness of the leader to search for opportunities for growth, change and improvement by listening to staff and researching and acting upon change based on front line feedback within the organizational structure. The fourth practice involves enabling others to act. Leadership works with staff to be a team, create trust and maintain strong relationships. “Leaders make it possible for others to do good work.” (Kouzes & Posner, 1987, pg. 21) Lastly, the leadership encourages the heart of the staff by genuineness, recognition and by showing appreciation for contributions. Saying thank you for a job well done and showing personal interest in employees builds the foundation of trust and the give and take of commitment on a personal and professional level. These practices all fall within the realm of transformational leadership. Persons acting in a role of leadership can be found at all levels of an organization. “Leadership is a set of skills and abilities that are available to all people working within.” (Kouzes & Posner, 1987, pg. 24)

Transactional leadership is based more on reinforcement and exchanges between the leader and the follower. Rewards are provided by the leader as positive reinforcement however there is not an emphasis on encouragement for followers to be innovative and creative. This type of
leadership focuses on practicality of meeting specific targets and objectives. In some settings, it is necessary for this type of leadership as it allows for adherence to standards however does not promote innovation and creativity. Transactional leadership is not based upon the strength of the relationship between the leader and the team; rather it is based upon what the team members can “receive” which means less cohesion and more individual payoff. (Kouzes & Posner, 1987, pp. 21-24)

The Saltsa report (Nyberg, Bernin, & Theorell, 2005) references Bass (1985) who wrote about how transactional and transformational leadership dimensions can complement rather than contradict one another. He highlighted that both styles focus on reaching a goal however transformational leadership is centered on change and influence of the environment to motivate employees towards a long term goal from within whereby transactional leadership is focused on motivating employees by punishments and rewards (wages, benefits).

Nyberg, Bernin, & Theorell (2005) reviewed numerous studies based both in the US and Europe looking at the effects of leadership on employee health and well-being. They found that several studies pointed to the possibility that leadership may be a possible source of health and well-being however the magnitude of the impact varied across studies. Some studies indicated that lack of decision-making authority and lack of co-worker support were powerful predictors of sick leave. Some of the studies revealed that leadership did not impact burnout once stressors like job strain, lack of social support, conflict at work and continued employment risk were threatened. Our team would question, is not the types of leadership and the practices of the said leader influential in mitigating job strain, social support, and conflict resolution? Apparently in this study this was not the case. Other studies quoted in the Saltsa report (2005) showed that
both transformational and transactional leadership correlated with high job satisfaction
highlighting that inspirational motivation leadership behaviours were especially important.

Nyberg, Bernin, & Theorell (2005) summarize “…with respect to the health and job satisfaction
of subordinates, a good leader shows consideration towards subordinates, initiates structure when
needed – especially in stressful situations, allows subordinates to control their work environment
through empowerment structures and opportunities for participation.” Furthermore, a good leader
“…inspires employees to see a higher meaning to their work, provides intellectual stimulation,
and is charismatic”.

CONNECTING TO HOSHIN KANRI - BETTER TEAMS:

As a team, we feel leaders in health organizations should possess transformational skills to lead
employees through all the changes recommended by the government. This is a great
responsibility given the number of employees and systems within each health organization.
Health employees report feelings of stress and burden with the overwhelming amount of
systemic change. Leaders with transformational skills would be aware of the employee state and
focus on employee psychological and emotional health to ensure this issue is a top priority.

In 2013-2014, Saskatchewan Ministry of Health implemented a strategic plan to improve health
care delivery in the province. The Hoshin Kanri was adopted to implement this strategic plan.
This approach involved staff from all levels identifying four priorities for the system, “…using
current data as a guide for decision making.” (Ministry of Health, 2013-2014, pg.3) The
information gathered from this data assisted the Ministry to develop a plan that was organized
into four strategies that are currently being implemented. These four strategies are: Better Health,
Better Care, Better Value and Better Teams. The focus of the better team strategic plan is to “…build safe, supportive and quality workplaces that support patient- and family-centered care and collaborative practices, and develop a highly skilled, professional and diverse workforce that has a sufficient number and mix of service providers.” (Ministry of Health, 2013-2014, pg.4) It is a broad statement with high expectation.

Although this Hoshin addresses the importance of building safe, supportive and quality workplaces our research found that this plan does not have specific programs that mandate policies to ensure the psychological well being of employees. A member of this team contacted a leader at the ministry of health to inquire about the policies in relation to the Hoshin of better teams supporting employee mental health. The information provided indicated that there are not policies specific within the Hoshin to support or strongly encourage individual health regions to focus on employee mental health. The ministry office has implemented policies for their employees however this is not within the larger provincial team. Services such as EFAP are available to staff however transformational leadership training to support psychological health of employees is not currently provided.

In support of this finding, a member of our team engaged in discussion with a leader of a health region inquiring about the Hoshin and how it may relate to employee mental health. He described the better teams pillar as a diverse team of health care providers working to meet the health needs of clients and patients. This further highlights the focus of the leadership within the province and the health regions that the Hoshin is client and patient focused rather than employee focused. This leader was not able to identify specific policy within that region that addressed psychological and emotional wellbeing of the employees. He spoke of policies that
address situations that may impact psychological health such as violence prevention, respect and dignity and other OH &S policies. However, aside from the provincial wide service of EFAP there are not identifiable policies and services available relating specifically to the response of leadership to focus on employee mental health.

Our team questions, is leadership more focused on improving patient care and reducing the escalating costs of health care delivery than it is on prioritizing the psychological and mental wellbeing of those who are delivering the care? According to one team member’s discussion with a leader, there is a policy from The Ministry of Labour Relations and Workplace Safety in Saskatchewan that was developed and implemented in September 2013 to address psychological health and safety. This policy is currently being used only at the ministry level.

**LEADERSHIP RECOMMENDATIONS:**

In January 2012 a report commissioned by the MHCC titled Psychological Health and Safety – An Action Guide for employers was released. This report outlines in detail the policies, procedures and supporting data necessary to implement psychological health and safety for employees within various sectors of our country. Further supporting this document is the January 2013 Psychological Health and Safety in the workplace – Prevention, promotion and guidance for staged implementation also commissioned by the MHCC. Both of these documents speak to the urgency and importance of employers across the province, and indeed across the country, to address this important issue.

Mental Health Works (2014) provides some excellent guidance and policy on ways for leaders to work within a transformational framework to support employee mental health. Underpinning this issue is the need for leaders to become educated regarding mental illness and how to be
WHAT LIES BENEATH........

watchful of changes within employees that may indicate the employee is experiencing difficulties with their mental health.

Mental Health Works (2014) states that employers have a responsibility both to the individual and the organization to take action if they suspect mental health issues are present. In a transformational role employers “…may be able to provide the employee with an opportunity to get the supports, professional help, and workplace accommodation they need so that they can continue working productively.”

In direct relation to this is the need for employees to be aware of their own state of mental health and how this may affect their ability to function at work. MHW provides resources that leaders could utilize to educate employees about recognizing mental health issues within themselves. This information also speaks to how employees can talk to their employer and co workers about their mental health and how to advocate for themselves if they are in need of accommodation or support at work (Mental Health Works, 2014).

In closing, we would like to encourage leadership to mandate health regions to develop and implement psychological and safety policies regarding the mental health of their employees. We encourage leaders to educate health regions regarding transformational leadership and to foster this style to lead its employees successfully into the future of health care in Saskatchewan. Health leadership’s investment in psychological health and safety of its workers will have numerous benefits far beyond the current health status of the province. According to the MHCC report of Psychological Health and Safety in the Workplace (2013), “…workplaces with a positive approach to psychological health and safety are better able to recruit and retain talent, have improved employee engagement, enhanced productivity, are more creative and innovative,
and experience higher profit levels. Other positive impacts include a reduction of several key workplace issues including the risk of conflict, grievances, turnover, disability, injury rates, absenteeism and performance, or morale problems.” (MHCC, 2013, pg.1)

If health regions do not address employee mental and emotional health in the workplace they will be contributing billions of dollars to the loss of productivity in the coming years and in addition “…the societal impact is in the billions of dollars. The emotional impact on families and individuals is incalculable.” (Alberta Health Services, 2011)
REFERENCES:


WHAT LIES BENEATH.......
WHAT LIES BENEATH.........