International Journal of Nursing and Health Care Research

Sultana M, et al. Int J Nurs Health Care Res 6: 14890

www.doi.org/10.29011/2688-9501.101490

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Research Article

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Factors Affecting the Psychiatric Patients' Wait Time at Erie Shores Health Care: A Qualitative Enquiry

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Citation: Sultana M, Varacalli F, Janisse MR, Sharrow JG, Johnson K, et al. (2023) Factors Affecting the Psychiatric Patients' Wait Time at Erie Shores Health Care: A Qualitative Enquiry. Int J Nurs Health Care Res 6:1490. DOI: https://doi.org/10.29011/2688-9501.101490

Received Date: 08 December, 2023; **Accepted Date:** 19 December, 2023; **Published Date**: 22 December, 2023

Abstract

Background: Erie Shores HealthCare (ESHC) is a rural, resource-poor, publicly funded, 72-bed hospital serving South-West Ontario region. Psychiatric patients' timely access to care is an important indicator for the quality of care at the ESHC. This qualitative inquiry focused on the wait time of the psychiatric patients attending the ESHC emergency department. The primary objective was to interpret healthcare providers' (informants) perspectives on possible factors affecting the wait time of the psychiatric patients, awaiting transfer or clinical care, at the hospital.

Methods: A series of in-depth interviews were conducted with the informants following Thorne's Interpretive Description approach. Thematic analysis was conducted to analyze and to interpret interview transcripts. **Results:** Emerged cross-cutting themes were: 1) admission process, 2) transfer process, 3) patient factors, 4) staff factors, and 5) available resources. Informants also recognized a knowledge gap in frontline workers on currently available mental health resources in the area. **Conclusion:** This qualitative inquiry has allowed Erie Shores HealthCare develop a one pager practical for frontline health workers in a rural setting to navigate the available community resources. Further research can validate our findings and may allow other rural hospitals to seek solutions to similar issues.

Keywords: Psychiatric patients; Emergency room; Wait time; Qualitative enquiry

Introduction

Although post-stroke apraxia is a common and disabling higher-order neurological deficit, there is no standardized evaluation method or treatment for this condition [1,2]. The existence of limb-kinetic apraxia has been questioned in the past [3,4]. Hemiparesis, impairment of elementary motor and sensory innervations in the brain, is the most common symptom of stroke. On the other hand, in apraxia, patients lose learned and skilled movements due to higher-order motor deficits, despite preserved elemental motor and sensory innervation; [2]. herefore, the effective rehabilitation approach for patients with apraxia can be different. We report a case of bilateral limb-kinetic apraxia that occurred after a left postcentral gyrus hemorrhage, extending subcortically and anteriorly. The impaired motor control in this case was distinctly different from hemiparesis and manifested bilaterally from the left hemisphere lesion.

According to published work, psychiatric patients waited

10 minutes longer for physician assessment compared to other patients [4,5] in rural settings and ER wait time for psychiatric patients awaiting an inpatient bed is over three times longer than non-psychiatric patients [5,6]. In addition, rural ERs have limited ER staff available with mental health training [7,8].

Administrative data from the ESHC revealed that patients requiring psychiatric assessment and transfer to acute psychiatric facilities experience an increasing wait times during the pandemic and post-pandemic era. For example, the average wait times for patients seeking psychiatric assessment at ESHC-ER increased from 5.4 hours in 2017 to 9 hours in 2022. The internal data also revealed that at least 3 out of 509 patients waited over 12 hours at the ESHC-ER in 2022. This rural small hospital has rapidly and consistently experienced an increase in patient volumes and acuity since pandemic most likely due to expanded catchment area by 65,000, a 15% increase in migrant population, and closure of a local Urgent Care Center, Emergency Medical Service (EMS) diversion agreement in partnership with Essex Windsor EMS (EWEMS) and Windsor Regional Hospital (WRH), and lastly a lack of access to primary care during the COVID pandemic (ESHC, 2022).

The usual trend of ER in rural hospitals was a relatively busy influenza season and a quiet Winter before the pandemic hit Canada [9]. Unfortunately, ER operated at peak occupancy for weeks at a time during the COVID pandemic [10] offering little recovery time for care providers. The dominos effect led to staff burnout, increased sick calls and staff shortage leading to much longer ER wait times [11,12]. Longer ER wait times have been plaguing Canada's health care system and may continue to exhaust Canadian emergency services and providers for years to come [13].

The overwhelming feeling of isolation and lack of resources is much more pronounced among the psychiatric patients in rural than in urban areas [14]. ER visits often offers ready access and outpatient monitoring to care for unexpected situations related to mental health such as drug overdose, mental health flare-ups, or crisis episodes [15]. Frequent ER visits by psychiatric patients are often due to, 1) poor self-care and lack of social support accompanied with lack of access to the continuum of care; 2) trust in urgent care provision; and 3) satisfaction with the urgent care received in terms of getting a priority care in areas separated from the other patients and genuine interest of the professional who attends them [15]. Psychiatric patients and their caregivers often do not seek direct and exclusive access to a psychiatrist, rather to a healthcare provider who can guide them access available resources in the community to facilitate their continuity of care in Mental Health [16].

No published qualitative enquiry on factors affecting psychiatric patient wait times in rural Canadian ER setting currently exists to the best of our knowledge. The aim of this enquiry is to explore the ESHC staff (informant) perspectives on 1) the factors that contribute to a longer wait time and 2) possible solutions replicable in similar settings.

Materials and Methods

A series of semi-structured interviews were conducted as the method for this study based on the authors' paradigm position (constructivism) using an Interpretive Description approach [17]. The inquiry was conducted as an element of operational research and did not collect any patient information warranting ethical approval from the local Research Ethics Board (REB). However, the organization's Office of Research approved the study following ESHC Academic Research Committee approval. The subsequent sections delve into the justification for the chosen study design.

In the 1960s and 1970s, the qualitative inquiry reformist movement challenged the idea of a single truth and introduced the idea of multiple realities in the philosophical approach to knowledge [18]. Unlike quantitative research, qualitative research provides distinctive facets of experiences, thoughts, and feelings of the individuals being investigated [19]. However, qualitative methods do not always meet the demand of pragmatic research of health sciences despite an intellectual agreement of subjective realities [20]. While social science capitalizes on health phenomena to answer elemental questions related to the core nature of human experience, health science focuses on solving everyday problems of patients or understanding the effect of a particular health intervention [21]. Interpretive Description [17,22,23] is suitable for health science as it can address real-world utility in health science, while adopting theoretical integrity in social science. We will refer the individuals interviewed for the enquiry as "informants" from this point onward. The interpretation of the informants' observations and experiences was subjective and was open to interpretation, co-constructed by the authors and informants. Considering the process of knowledge generation (a logical relationship and accommodation from multiple perspectives of individuals all appertaining to a phenomenon), we incline towards labelling the inquiry as phenomenological constructivism in congruent with Mach (1959) [24]. However, unlike Merleau-Ponty's phenomenology [25], the authors did not bracket their thoughts and perceptions, rather participated actively to co-construct knowledge. The constructivist paradigm takes a more naturalistic and relativist stance by recognizing multiple meanings and subjective realities [26].

The informants' perspectives were based on their observations, experiences, and perceptions shaped by their relationship with psychiatric patients awaiting care at ER, their professional stance, and their subjective values. The enquiry aimed to explore (1) an actual real-world question (what are the factors contributing to longer wait times?), (2) possible solutions to overcome this challenge at the ESHC (how can we overcome this challenge?), and (3) replicability of the solution in similar context

(can other rural hospitals replicate this solution?). Therefore, the methodology is closer to be hermeneutical and dialectical in congruent with applied health research.

Informants

Thorne (2016) [17] pointed out that individual interviews involving multiple people under multiple circumstances are useful in gaining insight into clinical issues. The ESHC staff members (nurses and administrators) had opportunity to observe typical days at the ER when psychiatric patients come for their care and to provide them care based on their symptoms, their state of mind, and to transfer them to the appropriate department/facility. Since the ESHC staff (clinicians and administrators) are positioned to provide a direct account of their observations/experiences with the phenomenon, we invited them to participate as informants for this study. Discerning the importance and diversity in terms of the knowledge each informant possesses, requires deliberate considerations [27]. In a qualitative inquiry, therefore, it is prudent to presume every voice provides a distinct perspective, and none has full comprehension of the topic of interest [17].

Recruitment

We approached the Director of Inter-professional Practice & Research at the ESHC to identify possible informants. The criteria used to identify possible informants were: 1) staff attending the psychiatric patients at ED; 2) staff ordering transfer of those patients; and 3) staff keeping record of wait time and reasons for any delay. We conducted one-on-one interviews with the staff (N=5) agreed to participate, an acceptable sample size to conduct interpretive description [17].

Interviews

The informants were interviewed during the month of March in 2023. We acknowledge our bias towards staff being incompetent ensuring timely management of psychiatric patients. Therefore, we consciously avoided leading the informants for sharing any perceived staff incompetency in managing such patients. The interviews extended an hour in a quiet room, away from the patient care area to allow the informants to relax. The informants spoke without any interruption with larger gaps to continue speaking following Green and Thorogood's (2018) recommendations. At the end of the interview, we verbally summarized the informant's account and sought his/her confirmation of the interpretation to avoid any discrepancy. Two interviewers were involved in the process to minimize subjective interpretation and to improve data validity. The interview data was saved in a laptop with a unique code and was shared in an encrypted Google drive folder with the informants to allow for verification of the data.

Quality of data

According to Thorne (2016) [17], the evaluative criteria for data quality typical in interpretive description are 1) epistemological integrity, 2) representative credibility, 3) analytic logic, and 4) interpretive authority.

To achieve epistemological integrity, the research question needs to be consistent with the stated epistemological standpoint and the interpretation of data sources need to follow that question [17]. Our research question invited multiple co-constructed truths and the data interpretation was rooted in the constructivist stance, hence achieved epistemological integrity. Representative credibility refers to involving individuals positioned to observe/experience a phenomenon from multiple angles of vision [17] in line with the concept of triangulation [28]. Our informants were frontline caregivers and administrators, rightly positioned to comment on the phenomenon. In addition, we verified the interpretation of the interviews with the informants to reach representative credibility.

According to Thorne (2016) [17], analytic logic refers to sufficiently visible inductive reasoning throughout the work so that the reader can either confirm or reject the credibility of the evidence. Based on the relevant literature [29-32], we performed an intellectual audit trail and provided a thick description of our work to achieve analytic logic.

The interpretive authority is often achieved by reflexive accounts of the author revealing his/her own bias or experience to help the reader to separate the subjective truth from the shared truth [28,33,34]. We were conscious of our own biases and declared our epistemic position to aid the reader distinguish our constructs from the informant's constructs with sufficient clarity.

Data Analysis

The potential hazard in qualitative data analysis is to create patterns out of pieces of information (e.g. words, gestures) already hardwired in our minds as being meaningful [17]. What we consider meaningful is based on our own personality/experience/disciplinary orientation/biases/curiosities. Therefore, two authors (FV, MRJ) analyzed the data independently. They discussed their own interpretations with each other to ensure all constructs were considered and understood proficiently.

According to Bailey (2008) [35], relying entirely on transcript data is a potential risk of losing insight arising from the nuances, pauses, tone and deliverance of informants' discourse. We used the interview transcripts, and interviewers' own observations when analyzing the data to avoid this potential pitfall. We used NVivo© software [36] to help organize the data.

A thematic content analysis approach defined as "a method for identifying, analyzing and reporting patterns within data" [37] was used. Our explicit epistemological position aided consistency and cohesion in thematic analysis following the recommendation of [38]. We followed four basic steps: 1) preparation and organization of the data, 2) reduction of the data, 3) data interpretation, and 4) data representation during data analysis following [39].

Results

According to the informants, five themes emerged describing the possible factors contributing to a longer wait time at ESHC-ER: 1) admission process, 2) transfer process, 3) patient factors, 4) staff factors, and 5) available resources (Figure 1).

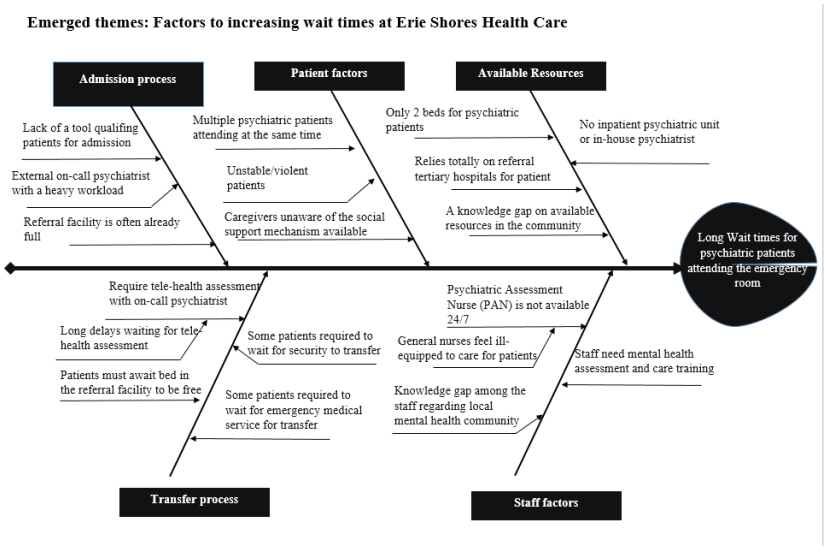

Figure 1: Emerged themes describing the contributing factors to increasing wait times at Erie Shores Health Care.

Admission process: Since ESHC does not have in-house psychiatrists, the diagnosis and admission decision for psychiatric patients rely on WRH's on-call psychiatrist's tele-health assessment [40]. The process gets even complicated when the on-call psychiatrist is hard to reach. The WRH on-call psychiatrist is often overwhelmed by their own patient population and often cannot respond to ESHC staff's enquiry in a timely fashion. Figure 2 describes in detail the current patient admission and transfer process at the facility.

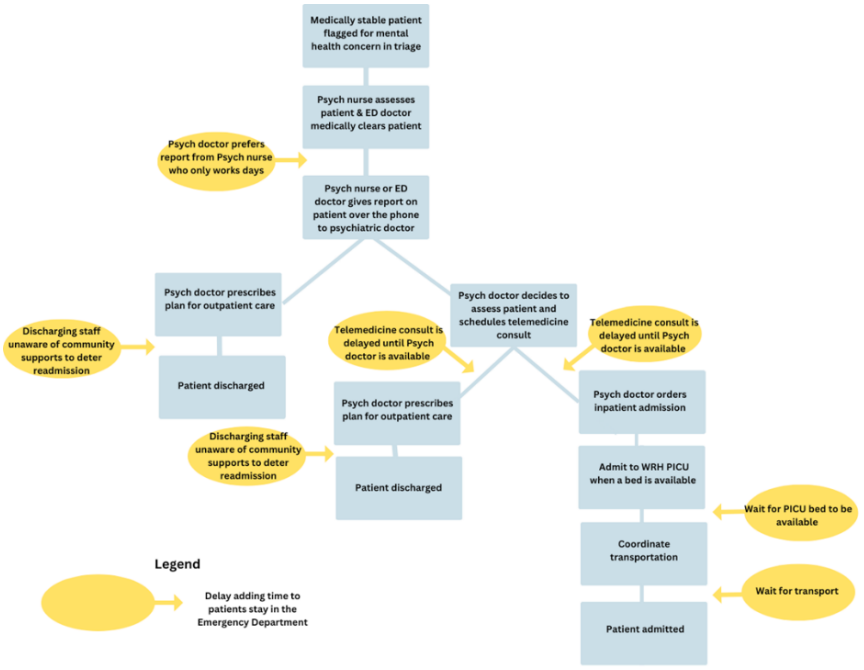

Figure 2: Current patient admission and transfer process at Erie Shores Health Care.

Transfer process: Apart from waiting for the tele-health assessment by WRH's on-call psychiatrist, sicker patients have to wait for a free bed at WRH Psychiatric Intensive Care Unit (PICU) or Chatham-Kent Health Alliance-PICU. The WRH- PICU has only eight beds and often they are full. For an example, there were 509 ER visits for psychiatric diagnoses in 2022 alone. Out of the 509 patients, 59 of them were admitted to ESHC, and the rest of them were transferred to another facility. The actual travel to be transferred also adds to longer wait time as patients often wait for Emergency Medical Service (EMS) transfer or security transfer once WRH notifies ESHC about a free bed.

Patient factors: Apart from transfer factors, patient himself/herself often contributes to a longer wait time when multiple psychiatric patients attend ER at the same time, or the patient is unstable/violent. The informants mentioned that they are often unaware of the complex social elements, such as emotional support for patients and caregivers in order to improve self-care of this population. They realize that knowing the social support mechanism available to the patient is equally important to ensure the decision matrix guiding the ER staff to find more efficient options for resolving situations perceived as urgent for this particular population. For example, the population served by ESHC includes Caldwell indigenous community, migrant agricultural workers, and Mennoties community with varying culture and language. Frontline workers often struggle to communicate about the emergency at hand and referral pathways. Moreover, migrant workers are not covered by government health insurance that adds further complexity in providing the best care plan.

Staff factors: On the same note, staff factors significantly contribute to a longer wait times when a Psychiatric Assessment Nurse (PAN) is not available 24/7. The current PAN at ESHC works only during the day time. Therefore, if a psychiatric patient comes to ER at night, he/she has to wait until the next morning to be assessed by the PAN. Besides, neither the ER physician nor the ER nurses at ESHC have formal training on psychiatric assessment allowing no respite to the PAN.

The majority of the informants believe that there is a knowledge gap among the staff regarding local mental health community resources. This knowledge gap has caused staff to feel unsupported by community partners as they do not know where to direct their patients, resulting in recurrent non-emergent mental health ER visits and increased ER wait times. A possible solution can be creating a one-page, easy-to-navigate education material with all appropriate resources within the Leamington area. They emphasized the importance of updating the material every year and ensuring the accessibility of the material. For example, the hard copies of the education material should be kept at the main ER desk and soft copies made accessible in the electronic medical record folders.

All informants agreed that ESHC needs a dedicated staff trained on psychiatric evaluation to act as a mental health community resource "champion" for the ER staff, and to train ER staff how to complete a psychiatric assessment on a regular basis. The informants also believed that the ER staff training activity should be integrated into the extended mental health care training offered to all new clinical hires as part of a sustainability plan. They realized that patients' access to a social worker would be beneficial in supporting or facilitating positive patient experience in ER. However, ESHC currently has no social worker on site.

Available Resources: The ESHC-ER has only 15 beds and only two of them are reserved for psychiatric cases, not to mention that these two ER beds are almost always full contributing to a longer wait time for patient assessment. Besides, this rural hospital does not have a Psychiatric Unit or a Psychiatrist. Therefore, ESHC has to completely rely on the resources available in the neighboring hospital (WRH) that contributes to even longer wait time.

All informants agreed that a handout describing the available community resources to find crisis and mental health supports practical for frontline health workers in a rural setting may add value to the available hospital resources. This handout also can help reduce the knowledge gap in the frontline workers.

Discussion

The themes emerged based on the informants' perspectives (admission process, transfer process, patient factors, staff factors, and available resources) when describing the possible factors contributing to a longer wait time at ESHC-ER, were inter-connected. For example, admission process relies on patient and staff factors as well as available resources, whereas, transfer process is also closely related to those factors and influence wait times for patient admission in either in ESHC or in tertiary facilities. The general agreement on having a one pager describing community resources was timely and practical for the frontline workers.

Statistical data from 2006/2007 show that there has been a 75% increase in the number of psychiatric patient ER visits in North America [41]. Additionally, in 2013/2014, there were 3 or more repeated visits in the ER for any psychiatric reason, comprising 39% of the total ER visits [41] validating our hospital data.

Similar to our informants' perspectives, studies evaluating factors contributing to longer wait times to access mental health related services across Canada include not knowing where to go for help [42], shortage of mental health professionals, culture and language barriers, inequities due to geography or demographics (e.g., youth, rural communities, and Indigenous populations) [43], stigma and taboo [44], lack of mental health service integration [45], and cost of services not covered by private insurance plans

[46]. According to Statistics Canada (2018) [47], out of the 2.3 million Canadians reporting unmet or partially met mental healthcare needs, the most frequently reported barriers were related to personal circumstances (78.2%) that included a knowledge gap on where to get help, echoing the informants' perspectives.

One of the limitations of a qualitative enquiry is not being able to generalise the results to other settings with different cultural and socio-economic characteristics. Our results obtained from a convenience sample of ESHC staff would only apply to their subjective perspectives of the patient population they serve. We did not collect opinions of health professionals, institutionalized patients or caregivers of the psychiatric patients attending ER to stay true to the objective of the study and the characteristics of the recruitment. We declare the lack of inclusiveness of the informants as a limitation of this enquiry.

Conclusion

The experiences and needs revealed in this qualitative enquiry prompted the hospital's Inter-professional Practice and Research department to create a one pager describing the available community resources to find crisis and mental health supports in 2023 (https://www.erieshoreshealthcare.ca/communityresources). However, the usefulness of this one pager in reducing wait time has not been evaluated. The cross-cutting factors impacting the psychiatric patient wait time demands a holistic approach of different multidisciplinary solutions to manage emergencies that may promote rational use of healthcare resources and better healthcare outcomes. Echoing the informants' perspectives, the authors believe that a better access to mental health services outside the ER would not only benefit people with mental health conditions but the healthcare system at large. Future research studying the impact of education resources available to frontline workers on psychiatric patient wait times in ER, how to improve emotional support for caregivers or how to improve self-care of this population are needed.

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