SBAR TAILORED FOR MENTAL HEALTH INTAKE TO IMPROVE MENTAL HEALTH
CRISIS TRIAGE FOR OLDER ADULTS

A Doctor of Nursing Practice Project Report

by

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This Doctor of Nursing Practice Project Report meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

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Chair   Co-Chair

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ACKNOWLEDGEMENTS

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ABSTRACT

Mental illness is a global crisis. Unfavorable economic, social, and environmental circumstances contribute to lack of quality care in those affected by mental illness. The purpose of this quality improvement (QI) project was to determine if the addition of the Situation Background Assessment Recommendation (SBAR) tool tailored to mental health pre-screening assessment of older adults presenting to the emergency room in mental health crisis improved self-efficacy and communication between the mental health intake professionals and the psychiatrist, and increased accuracy of the preadmission assessments in the geropsychiatric unit at Matagorda Regional Medical Center. The design for this project was a non-randomized, one-group, pre-test/post-test guided design using Plan-Do-Study-Act (PDSA) cycle to improve handoff reporting from the mental health intake professional to the psychiatrist. geropsychiatric admission rate was 50% (n=24) pre-intervention and increased by 13% to 63% post-intervention (n=30). Mental health crisis triage for older adults was improved through the implementation of the SBAR tool tailored to mental health screening and the assessment.

Keywords: mental illness, SBAR, crisis triage, older adults, and behavioral health.

SBAR TAILORED FOR MENTAL HEALTH INTAKE TO IMPROVE MENTAL HEALTH CRISIS TRIAGE FOR OLDER ADULTS

Introduction

According to Horizon Health Behavioral Health Service (2016), there are 49.2 million Americans over the age of 65 living with a mental illness. By 2030, this number is expected to grow by 19% (Horizon Health, 2016). Mental illness within the older adult population is overlooked and challenging to diagnose (Rowen, McAlpine, & Blewett, 2013). Drastic cuts of over $5 billion in mental health services between 2009 to 2012 and the elimination of 4500 public psychiatric hospital beds in the United States (U.S.) contribute to inappropriate and unsafe discharges home from emergency rooms (ER) instead of admissions into an inpatient psychiatric facility (Weiss, Barrett, Heslm, & Stocks, 2016). According to Rowan, McAlpine, and Blewett, (2013), 20 million Americans are affected by a mental illness and report not being able to get the access they need to mental health care in the outpatient setting. Barriers to getting appropriate mental health care include: lack of mental health insurance, qualified providers and treatment centers; finances, access to medication, and lack provider and patient mental health education, negative social stigma gender, and racial barriers. The effects of mental illness on the older-adult population can diminish the health and well-being of an individual.

According to Centers for Disease Control (2017), 20% of the adults aged 60 and older suffer from a mental disorder and many who enter the ER in mental health crisis are misdiagnosed and sent home instead of being referred for mental health inpatient services (World Health Organization, 2017). Misdiagnosis and early discharge are related to a myriad of complex issues including inadequate exchange of information and poor communication between interprofessional health care professionals.

Thus, older adults in a mental health crisis presenting to the ER may benefit from thorough and consistent use of structured triage by mental health intake personal using the Situation Background Assessment Recommendation (SBAR) method as a part of the preadmission intake assessment. Use of SBAR could improve the self-efficacy of the mental health professional, accuracy and efficiency in assessment, and communication between the mental health worker and psychiatrist.

The Matagorda Regional Medical Center (MRMC) geropsychiatric unit is a single bed twelve-room unit located on the second floor of a rural county owned hospital in south Texas. The unit employs three mental health intake professionals (usually individuals with a bachelor's or master's degree in social work or psychology) and other staff that include psychiatrist, registered nurses, certified nurse aides, and an activity director.

A review of records from this unit revealed 48 referrals from the ER to the geropsychiatry unit between January and March of 2018, of those 48 referrals only 24 patients (50%) were admitted to the unit. The other 50% (n=24), were either discharged home, refused inpatient service, or needed further medical care. When a patient, aged 55 years or older presents to the ER at Matagorda Regional Medical Center he/she is first medically screened. If cleared medically, and mental health crisis is suspected, the ER initiates a referral to the geropsychiatric unit. A mental health intake professional from the geropsychiatric unit presents to the ER to screen the patient for possible geropsychiatric admission. The mental health professional collects information about the patient, places a phone call to the psychiatrist, and hand-off of patient information is exchanged. The type of patient information collected and the manner in which it is communicated to the psychiatrist is critical to obtain an accurate determination decision by the psychiatrist. However, hand-off of patient information and communication between the mental

health intake professional and psychiatrist has not traditionally been structured and has led to patients being misdiagnosed and sent home instead of being referred for mental health inpatient services

The purpose of this quality improvement project is to determine if addition of the SBAR to the pre-admission intake assessment of adults aged 55 and older presenting to the ER with symptoms of mental health crisis improved the mental health intake professional's self-efficacy and communication with the psychiatrist, increased accuracy of pre-admission assessments, and appropriate admissions to the geropsychiatric unit at MRMC. The practice question that guided this quality improvement project was: In adults aged 55 and older experiencing symptoms of a mental health crisis, does the addition of a mental health focused SBAR reporting tool, improve the mental health intake professional's self-efficacy, assessment, and communication with the psychiatrist, resulting in an increased number of appropriate admissions to the geropsychiatric unit? The current assessment uses generic assessment tools which are not tailored toward the needs of a person in crisis and has not been revised since 2012.

According to the American Association of Colleges of Nursing (2006), this initiative exemplifies AACN DNP Essentials #1,2,3,6, and 8. DNP essentials #1 and #2 are demonstrated through the development and evaluation of new, evidenced based practice approaches and the use of advanced communications skills and processes that lead quality improvement and patient safety. Essential #3 was accomplished with the design and implementation of a process to evaluate outcomes of practice and the application of relevant findings to develop practice guidelines. The Project Director (PD) led the interprofessional team to create change within the practice to use the SBAR tool between the mental health intake professional to the psychiatrist leading to improved communication and change within the unit and organization. Essential #8 which focuses on interprofessional collaboration for improving patient and population health

outcome was accomplished through the SBAR implementation resulting in enhanced communication across health care professions and improved patient outcomes resulting from more appropriate admissions to the geropsychiatric unit at MRMC.

Review of Literature

Poorly managed transitions among care settings for those affected by a mental illness are a serious problem affecting continuity of care, quality of care, and cost efficiency and can ultimately increase symptom exacerbation (Viggiano, Pincus, & Crystal, 2012). Patients discharged from the ER with a mental health illness who did not receive hospitalization, had a higher probability of returning within thirty days related to their mental illness and other factors such as increased age, comorbidity burden, diagnosed personality disorders, schizophrenia, prior acute care utilization, and mood disorders (Viggiano, Pincus, & Crystal, 2012).

Communication between providers and disciplines must include accurate and detailed information. A hand-off is when a patient and all information is transferred to the care of another provider. Thus, information that is given must be accurate as this is critical to the continuity of patient-centered care, safety, and care coordination (Frisen, White, & Byers; 2008). Therefore, communication methods must be provided, critical patient information must be detailed, and transfer of care accepted by the receiver. The effectiveness and efficiency of care planning and patient safety revolve around the importance of proper hand-off procedures. (Frisen, White, & Byers; 2008)

One of the risk factors leading to communication breakdowns during transition of care is a lack of standardized procedures in conducting successful handoffs (Joint Commission; 2012). Studies indicate that use of structured handoff tools such as SBAR (Situation-

Background-Assessment-Recommendation) will improve the quality of patient handover (Clark, et al.; 2009; Velii, 2008; Wayne, et al., 2008).

The SBAR tool is an effective simple way to create system change in communication between health care providers leading to improvement in systems, safety, and culture to create a safer patient care environment (Blom, Peterson, Hagell & Westergran 2015). According to Stewart & Hand (2017), utilization of SBAR establishes a common zone for communication regarding patient care and outcomes specifically when used to guide information exchange in hand-offs. When used consistently by any health care professional SBAR eliminates any perceived superiority of those exchanging information preserving effective communication between two health care professionals. Performing hand off information the same way every time facilitates improved self-efficacy and proficiency for the mental health intake professions (Stewart & Hand, 2017). According to Panesar, Albert, Messina, and Parker (2016), SBAR provides a clear, concise and consistent framework of communication that improves patient safety, outcome, and builds interprofessional relationships. Utilization of the SBAR combines the communication styles of health care providers to establish a handoff report to promote effective patient information exchange between the two health care professionals (Panesar, Albert, Messina, & Parker 2016). Use of a SBAR tailored to mental health can improve patient outcomes, increase self-efficacy of the mental health providers utilizing the tool, improve quality of intake, and report/handoff (Richards, 2016).

Early intervention and advanced screenings are focuses of House of Representatives Bill 2646 which is *The Helping Families in Mental Health Crisis Act of 2016* (GovTrack, 2016). Early interventions and training of those that attend to those in mental health crisis is a focus of this house bill. Educating those mental health professionals with a tool such as the SBAR that

increases their self-efficacy, knowledge and communication is a source of mental health reform with improvement in the assessment of those in mental health crisis.

Between 1995-2006, breakdown in communication was the leading cause of sentinel events reported to the Joint Commission in the United States (World Health Organization, 2007). Currently the pre-admission screening form used at MRMC provides minimal psychiatric terminology to assist the mental health intake professional in collecting patient mental health crisis information. According to Stewart and Hand, (2017), SBAR tool bridges the gap between health care professionals such as a mental health intake professional and a psychiatrist who may have different communication styles. According to Panesar, Albert, Messina, and Parker (2016), SBAR utilization electronically was associated with increased in frequency of documentation which correlated with improved multidisciplinary communication. Use of a SBAR tool tailored to mental health can improve patient outcomes, increase self-efficacy of the mental health providers, improve quality of intake, and result in a more accurate report/handoff (Richards, 2016). The SBAR tool is an effective and simple tool to create system change in communication between health care providers leading to improvement in systems, safety, and culture to create a safer patient care environment (Blom, Peterson, Hagell & Westergran 2015).

Conceptual Framework

The Tidal Model middle rant theory guided this quality improvement project. It was developed by Phil Barker and Poppy Buchanan-Barker in the 1990's. The Tidal Model provides a practice framework for exploration of the patient's need for nursing and the provision of individually tailored cared the main focus of the model is to help individual patients create their own voyage of discovery and help reclaim the personal story of mental distress by recovering their voice (Brooks, Murata, & Tansey, 2006). Nurses who coordinate care in interprofessional

teams with mental health professionals and psychiatrists are aware of the common barriers to effective communication will be able to anticipate and properly react to roadblocks. With this focus, nurses can help ensure optimal communication and patient care. The mental health professional that is responsible for pre-assessing the patient will gain improved self-efficacy with the implementation of the Situation-Background-Assessment-Recommendation (SBAR) tailored to mental health. The mental health professional will have improved self-efficacy and accuracy of their pre-assessment admission with the knowledge gained from the implementation of the SBAR. With this improved self-efficacy, the knowledge learned with the implementation of the SBAR will allow the mental health professional to successfully follow the ten commandments of the Tidal Model and value the voice of the patient and respect the language the patient is speaking. The Tidal Model helps those reclaim their story of their mental health crisis. Factors include cumulation and diverse understanding of the water metaphor to gain a better understanding of a patient's immediate situation and inevitable changes. Integrating this model into evidence base practice entails collecting information from each patient about their mental health with the use of the ten commandments (See *Appendix A*). The mental health professional must develop a curiosity to the patient's crisis and become the apprentice to allow the patient to express how they are feeling. Then the mental health professional can reveal their own personal wisdom but remain transparent. The mental health professional should allow the individual time to express their crisis and encourage the patient that change is constant (Fletcher and Stevenson, 2001).

When the mental health professional properly utilizing the SBAR tool with the patient information gained through the implementation of the Tidal Model and SBAR the communication with the psychiatrist will improve and the individual will more than likely admit

to the geropsychiatric unit to assist with resolution of their mental health crisis. Understanding

and valuing this person's wisdom of their own story allows for better evaluation, treatment, and

positive patient outcomes (Brookes, Murata, and Tansey, 2006).

Project Aims

Project Aim #1: To determine if addition of the SBAR to the mental health triage

assessment will increase the self-efficacy of the mental health intake professional by:

(a) Determining if the post intervention self-efficacy scale score of the mental health

intake professional has improved as evidenced by a self-efficacy score at least 10%

higher than the pre-intervention self-efficacy score. The scale is adapted from

Schwarzer and Jerusalem (1995). (See general self-efficacy scale *Appendix B).*

Project Aim #2: Determining if the quality of the pre-admission assessment of those in a

mental health crisis presenting to the emergency room has improved by:

(a) Determining if the quality of triage assessment has improved as evidenced by a

10% increase in intake quality score pre versus post data collected using the 5-point

Likert Scale adapted from Likert (1932). (See mental health pre-admission intake

quality tool *Appendix C*). This scale according to Sullivan and Artino (2013), was

developed by Rensis Likert to measure attitude and opinions of the respondents. The

mental health professionals will respond to pre and post 5-point Likert surveys to

determine if the addition of SBAR to the pre-admission triage assessment improved

the intake quality of the information obtained by the mental health professional.

Methods

Project Design

This Quality Improvement project used the Plan-Do-Study-Act (PDSA) cycle. This cycle

uses a non-randomized, one-group, pre-test/post-test guided design (See *Appendix D*).

Protection of Human Subjects and Confidentiality

This project is focused on introducing SBAR into the pre-admission assessment mental health screening for adults 55 and older that present to the project site, Matagorda Regional Medical Center Emergency room, in mental health crisis. A Determination of Non-Human Subjects from the Institutional Review Board (IRB) has been obtained for this project (See *Appendix E*). Protected health information (PHI) such as age, gender, ethnicity, diagnosis and symptoms will be collected from the geropsychiatric unit at Matagorda Reginal Medical Center using only codes as patient identifiers. The director of the geropsychiatric unit will store codebooks and all other protected information in a locked file in her office. Rhonda Brown, QI Project Director, has received permission to access this information through a letter of support from Mike Lee the Chief Nursing Officer at Matagorda Regional Medical Center (See letter of support *Appendix F).*

Participants

Convenience sampling will be used to identify participants. Inclusion criteria for this study was as followed: patients aged 55 and older presenting to the project site emergency room for a mental crisis between January 1, 2019 through March 31, 2019. Inclusion criteria for mental health workers with all levels of education were all mental health professionals employed at Matagorda Regional Medical Center geropsychiatric unit. Each received an email invite for participation in the project. Any staff that became an employee during the implementation of the project were included. Posters were located on the geropsychiatric unit related to SBAR, in servicing was provided prior to implementation, during weekly staff meetings for new and current employees, and daily one on one in-servicing occurred for the mental health professionals participating in the project. Any patient that meets criteria was included if they present to the ER in a mental health crisis during the project's implementation time frame.

Setting

Information for the SBAR was collected in the emergency room and geropsychiatric unit at the project site. The emergency room is a fourteen-bed unit and the geropsychiatric unit is a 12-bed behavioral health unit located on the second floor of Matagorda Regional Medical Center in Bay City, Texas, a not for profit, county hospital. This unit admits those aged 55 and older presenting to the emergency room in a mental health crisis. The letter of support has been received from the pilot site.

Intervention

The main focus was to enhance the delivery system design by implementation of the tailored SBAR to allow a change concept to better facilitate treatment (See *Appendix G*). The current assessment process for adults over 55 in mental health crisis presenting to the project site involves a mental health intake professional using a pre-admission screening form. This form lacks information specific to mental health. The addition of the SBAR to the preadmission screening assessment is needed to identify a patient in mental health crisis, assist in the collection of pertinent information, and to assist in the communication with the psychiatrist when presenting the patient for possible admission into the geropsychiatric unit (Cash, 2013). Validity of the SBAR has been established through its utilization combined with the communication styles of health care providers to establish a handoff report to promote effective patient information exchange between the two health care professionals (Panesar, Albert, Messina, & Parker, 2016); (Raymond & Harrison, 2014). This rationale to include the SBAR was explained to staff utilizing the form prior to implementation and during use of the updated pre-admission form. In-servicing was provided to all the employees of the geropsychiatric unit and the psychiatrist so that all understand the rationale of the new tool. The QI Project Director also assisted in any extra educational in services needed for the implementation. Pocket sized SBAR tools, posters, handouts, and a power point were available as teaching tools and used by those

participating in the project. The mental health intake professionals received their SBAR

education through the use of posters, handouts, group, one on one, and role playing in-servicing.

All preadmission forms currently used were pulled and the new forms that include the SBAR

were put into circulation for use January 2019.

Data Collection

The collection of the data needed for this project was done by the QI project director. The

DNP project team consists of the project director, a content expert which is a psychiatrist, mental

health professionals, and geropsychiatric unit manager who was the facilitator. The Project

Director presented training to the psychiatrist, unit manager, and mental health professionals.

The psychiatrist made recommendations to the SBAR tool as the content expert. The

geropsychiatric unit manager was the facilitator and assisted with all data collection, participants,

and implementation of the updated form. *Appendix H* is a time line that reflects the time points at

which the data was collected.

The mental health intake professionals and psychiatrist were recruited at their weekly

geropsychiatric group meeting and through email. The geropsychiatric unit's team that includes

mental health intake professionals and psychiatrist along with unit staff and managers meet every

Tuesday evening for staffing meetings. This was an opportunity to discuss the QI project and

expectations of those participating. The self-efficacy of each mental health intake professional

was evaluated through a 10-point self-efficacy scale adapted from Schwarzer and Jerusalem

(1995). The project leader with the assistance of the unit manager of the geropsychiatric unit

assessed the accuracy of triage assessment January through March 2018 using a 5-point Likert

Scale to determine accuracy of intake as interpreted by the mental health professionals.

Incorporating SBAR into the pre-admission assessment showed improved accuracy post

implementation. The communication difference between the mental health intake professionals

and the psychiatrist after the implementation of the SBAR was assessed with a pre and post

survey questionnaire with opened ended questions, yes or no questions and with qualitative,

descriptive data gathering. The self-efficacy scale was also used post SBAR implementation to

evaluate change in self-efficacy of the mental health workers. All questionnaires were

administered through survey monkey.

SBAR Tool

The proposed process change of the SBAR was to improve communication between

the mental health intake professionals and the psychiatrist. According to the Institute for

Healthcare Improvement (2019), the SBAR was originated by the U.S. Navy specifically for

nuclear submarines and was introduced into nursing in 2002 by Michael Leonard, MD, a

physician leader for patient safety, along with colleagues Doug Bonacum and Suzanne Graham

from Kaiser Permanete of Colorado. According to Achrekar, Murthy, Kanan, Shetty, Nair and

Khathry (2016), SBAR showed to be a reliable tool after conclusion of a prospective study

showed a 4% increase in the amount of information provided during patient handoff of patient

information when the SBAR was used routinely when communication occurred between two

healthcare professionals. According to Randmaa, Martensson, Sweene, and Engstrom (2014),

improved safety, a 20% decrease in negative effects, and an improved significance of (P= 0.001),

occurred with the consistent use of SBAR.

General Self Efficacy Scale

A general self-efficacy scale from Schwarzer and Jerusalem (1995), was used to measure

the mental health intake professional's self-efficacy pre and post implementation of the SBAR.

The tool chosen to audit the results of the self-efficacy exam as well as the pre-post assessment

screening form was the original Likert scale. According to Likert (1932), the Likert scale is a

psychometric scale the rates responses in a survey. When responding to a Likert item the

respondents specify their level of agreement or disagreement on a symmetric agree-disagree scale for a series of statements.

Intake Assessment Tool

Proficiency of the pre-admission intake assessments was measured with quantitative data using the 5-point Likert Scale to determine accuracy and the quality of intake. These results were examined pre and post implementation of the SBAR communication tool. Both samples consisted of three mental health intake professionals. Each respondent answered all questions on pre and post surveys. Interval consistency of the 5-Point Likert scale used to show accuracy of form completion and enhancing communication was demonstrated by Cronbach's Alpha which was 0.83 for both pre and post pre admission assessment screening tool with the implementation of SBAR. The sum of the answers to this Likert scale was fifty-eight pre implementation and sixty-five post implementation. Validity was demonstrated via correlation of confidence level of 95%. A paired t-test had a two-tailed P value less than 0.0001. By conventional criteria, the difference is considered to be extremely statistically significant. The mean of group one (pre) minus group two (post) equals -1.73. This was a 95% confidence interval of the difference from 1.99 to -1.46. —T=14.6660 the degrees of freedom=14 and the standard error of difference =0.118.

The Cronbach's Alpha for the interval consistency of the self-efficacy survey pre implementation was 0.74 and post implementation 0.74. The sum of the answers to the self-efficacy survey pre implementation was 72 and post implementation 100. The paired t-test for the self-efficacy pre and post also had a two tailed p value less than 0.0001. by conventional criteria the difference is considered to be extremely statistically significant. The mean of group one minus group two equals -1.07 There was a 95% confidence interval of the difference from 1.42 to -0.71. T= 6.186 the degrees of freedom was 29 and the standard error of difference equals

0.172.

Data management

All data was collected by the QI Project Director and stored using a digital identifier only. Data will be destroyed within three years after the project is complete. Anti-malware and firewalls will be used to protect all electronic data, which will be kept on the PD's password protected computers, kept in office only accessible to the QI Project Director (Human Research Protection Office, 2018).

Data analysis

The first step in the analysis of data in this project began with the dissemination of the pre and post surveys given to the mental health professionals ninety days apart. The two female and one male mental health intake professionals that participated in the survey ranged in age from 25-65 years of age, two were Caucasian and the other African American. All three participants hold a master's level degree. The two surveys were adapted from a Likert-type ordinal measurement scale designed to measure attitude and opinions. The general self-efficacy scale was used to evaluate the self-efficacy of the mental health professionals on the geropsychiatric unit at Matagorda Regional Medical Center when communicating patient information to the psychiatrist. Each mental health professional completed both pre and post surveys completely. This self-efficacy survey was a 10-point scale which 60% (n=18), of their answers pre-implementation of the SBAR were "hardly true" and 40% (n=12), of their answers were "moderately true" when asked about how to manage and solve difficult problems, confidence in communicating, unexpected events, resourcefulness and effort at solving problems. After the implementation of the SBAR 44.4% (n=16) of their answers were "moderately true" and 43.3% (n=13) answered "exactly true", which showed an increase in the self-efficacy of the mental health professionals related to the implementation of the SBAR based off the answers to the self-efficacy scale questions.

Figure 1. Likert Scale Results

	Not True	Hardly true	Moderately true	Exactly True
Post/SBAR	0	0	16	14
Pre/SBAR	0	18	12	0
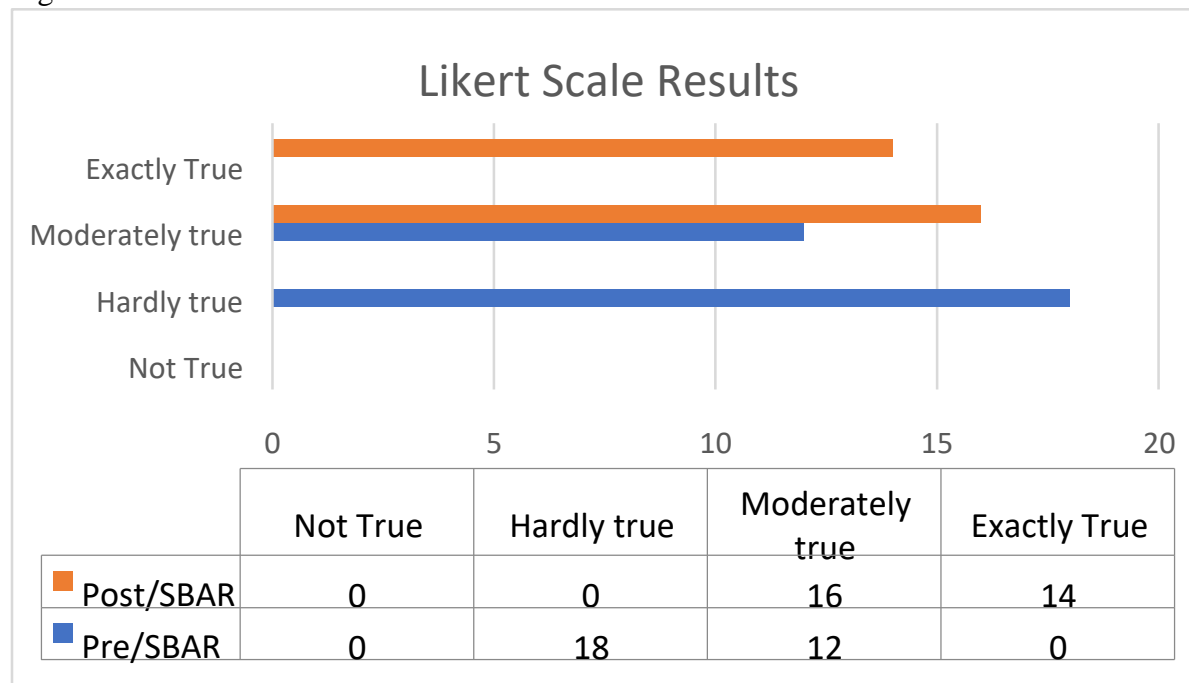
The mental health pre-admission intake quality tool collected quantitative data related to how the mental health workers felt about the patient information they were collecting when performing an assessment on a patient that would potentially be admitted to their geropsychiatric unit. This is the mental health pre-admission intake quality tool that is a 5-point Likert scale to test the data collection self-efficacy and communication skills of the mental health professional pre and post addition of the SBAR to the pre-admission assessment. The questionnaire included questions about accuracy of completing the form, full identification of the patient's mental health status, and information exchanged about the patient with the psychiatrist during handoff. Prior to the implementation of SBAR, the respondents replied with 66% (n=10) disagreeing with the questions asked, 26.6% (n=4) were neutral, and 6.6% (n=4) agreed. Post implementation, 13% (n=2) of the answers were neutral, 60% (n=9) agreed and 26.6% (n=4) strongly agreed.

Implementation of the SBAR to the pre-admission assessment increased the confidence level,

knowledge, and accuracy of the form evidenced by their improved responses to the post survey.

Figure 2. Mental Health Pre-Admission Intake Quality Tool with SBAR

Mental Health Pre-admission Intake Quality Tool with SBAR

	Strongly disagree	Disagree	Neutral	Agree
Post-SBAR	0	0	2	9
Pre-SBAR	0	10	4	1
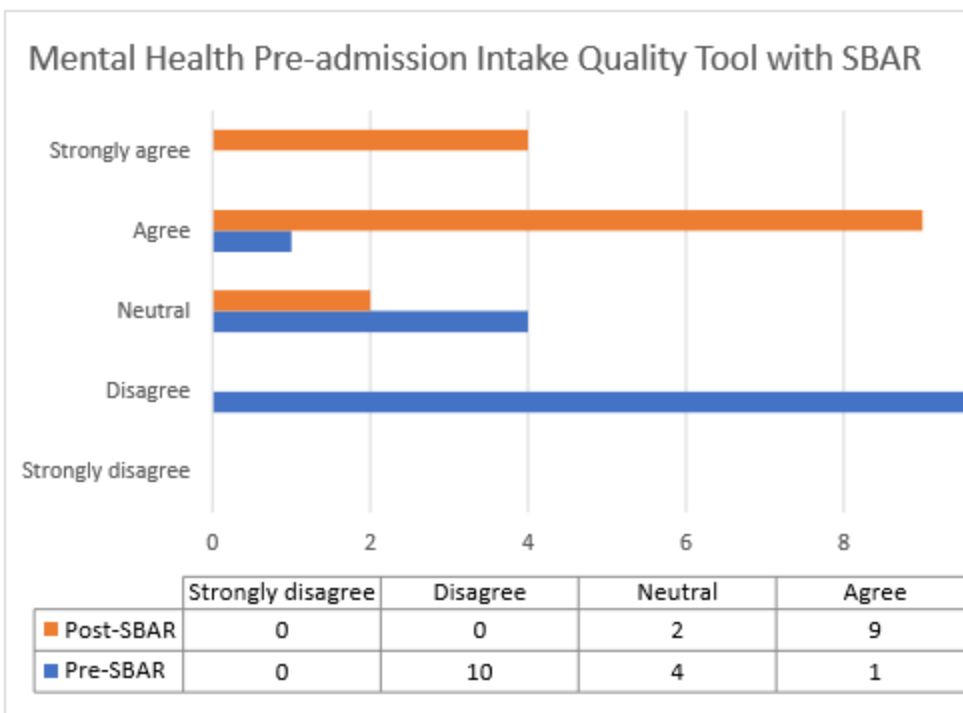
The pre-implementation data and post implementation data were collected from January

through March of 2018 and 2019. The total number of patients were ninety-six. The mean age of

the patients pre SBAR was 68 years of age (SD=12). The mean age post SBAR was 74 years of

age (SD=9). The frequency of male patients pre SBAR was 43.75% (n=21); and post was 41.6%

(n=20). The frequency of female patients pre SBAR was 56.25% (n=27) and post SBAR 58.3%

(n=28). The mean for the female gender was 24 and (SD=4.24 pre; and SD=5.65 post). Age

ranges pre SBAR implementation were ages 55-65 33.3% (n=16), 66-75 16.6% (n=8), 76-85

27% (n=13), and 86-95 23% (n=11). Post implementation ages 55-65 years of age 27% (n=13),

ages 66-75 43.7% (n=21) ages 76-85 14.5% (n=7), and ages 86-95 14.5% (n=7). Ethnicity had a

mean of 12 for pre and post SBAR and a (SD=13.36 pre and SD=16.02 post). Frequency of

ethnicity pre SBAR was Caucasian 66%; (n=32), Hispanic 12.5%:(n=6) African Americans 8.3%: (n=4), and other was 12.5%; (n=6). Post implementation of SBAR ethnicity was Caucasian 75%; (n=36), Hispanic 10.4%; (n=5), African American 8.3%: (n=4), and other 6.25%; (n=3).
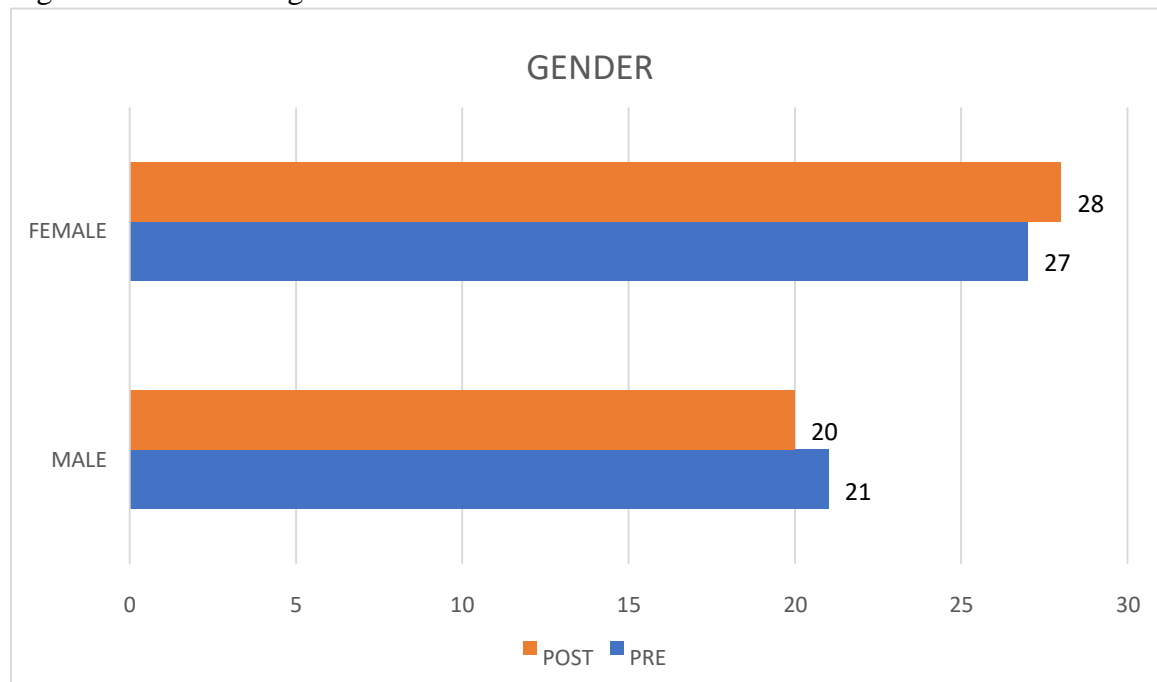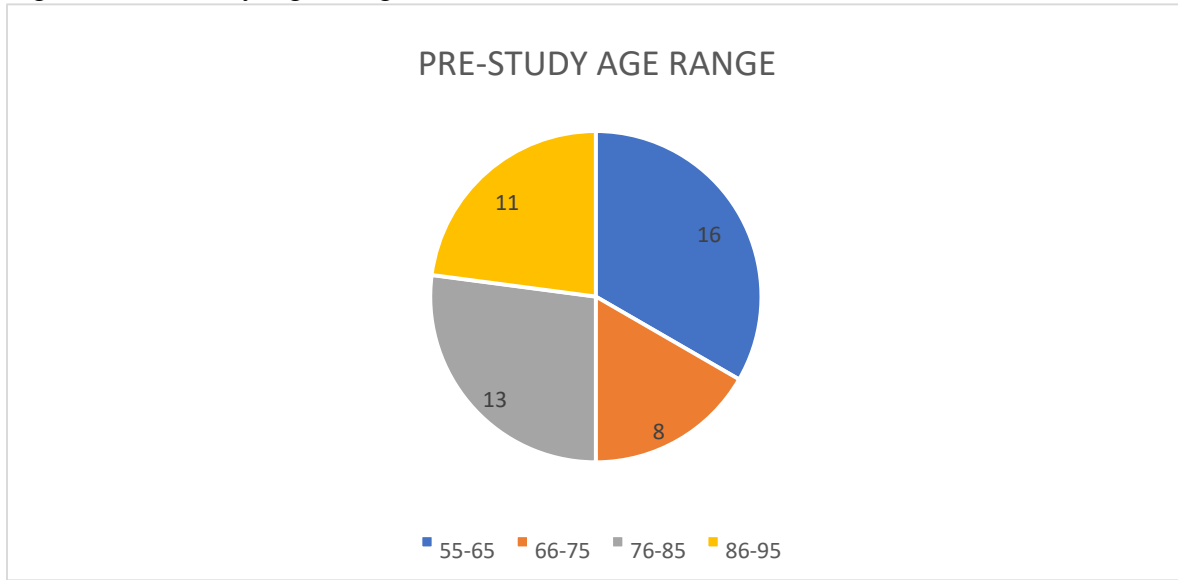
Figure 3. Gender Range

Figure 4. Pre-Study Age Range

Figure 5. Post-Study Age Range
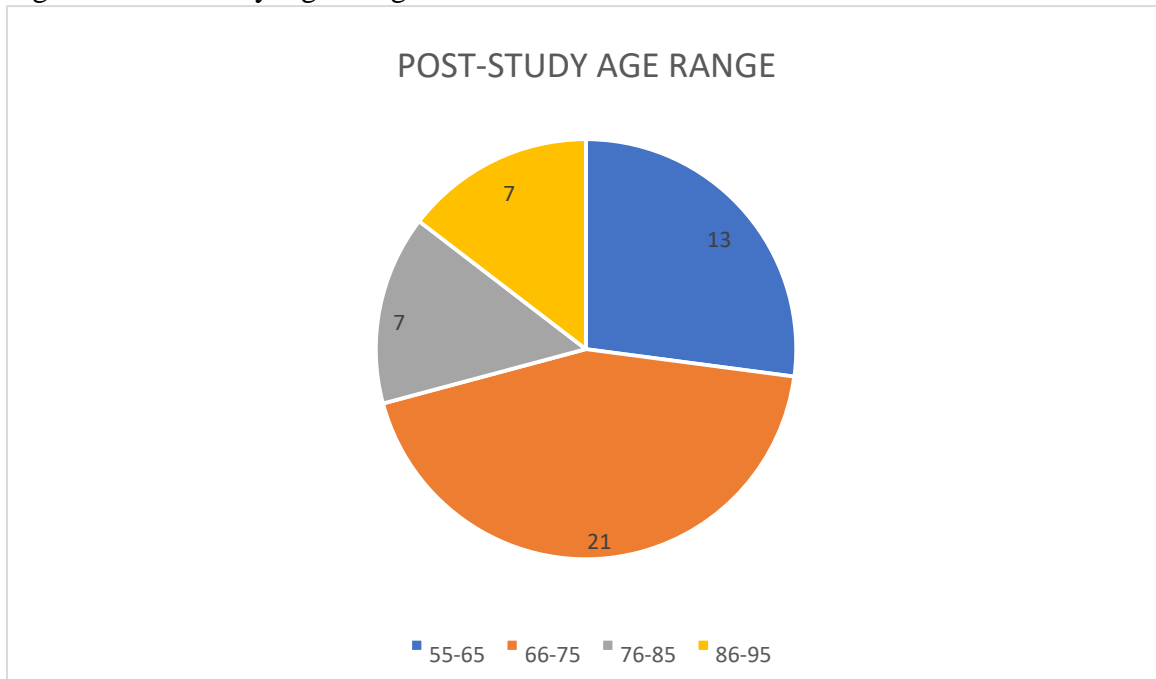
Figure 6. Ethnicity
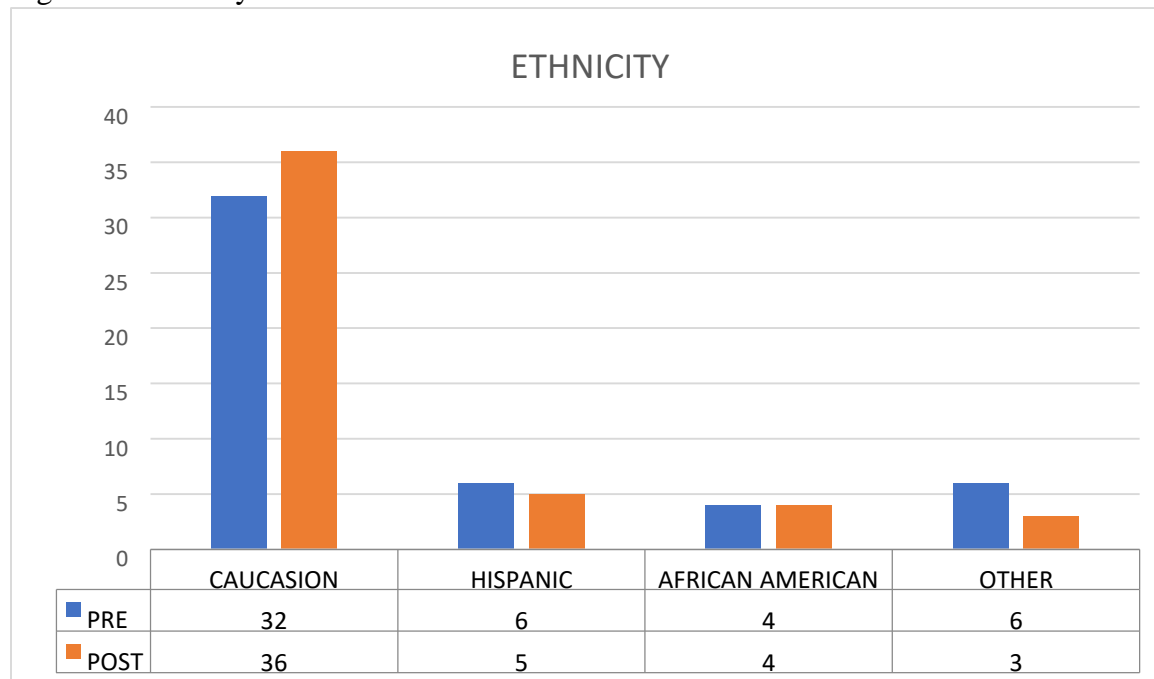
The following categories were compared pre and post implementation of SBAR: admissions, discharges, admission refusals, and needed medical clearance. The P value of the relationship between pre and post admissions into the geropsychiatric unit was p=0.05. Statistical findings of the 48 participants pre implementation revealed 24 admissions, 12 discharges, 9 refusals, and 3 needing medical clearance from a medical surgical unit. Post implementation of SBAR there were 30 admissions, 13 discharges, 3 refusals, and 2 needing medical clearance from a medical surgical floor. There was a 50% (n=24), admission rate pre implementation and a 63% (n=30), admission rate post implementation of the SBAR.

Figure 7. Patient Assessment Outcomes

PATIENT ASSESSMENT OUTCOME

	ADMISSIONS	DISCHARGE	MEDICAL CLEARANCE NEEDED	REFUSALS
POST	30	13	2	3
PRE	24	12	3	9
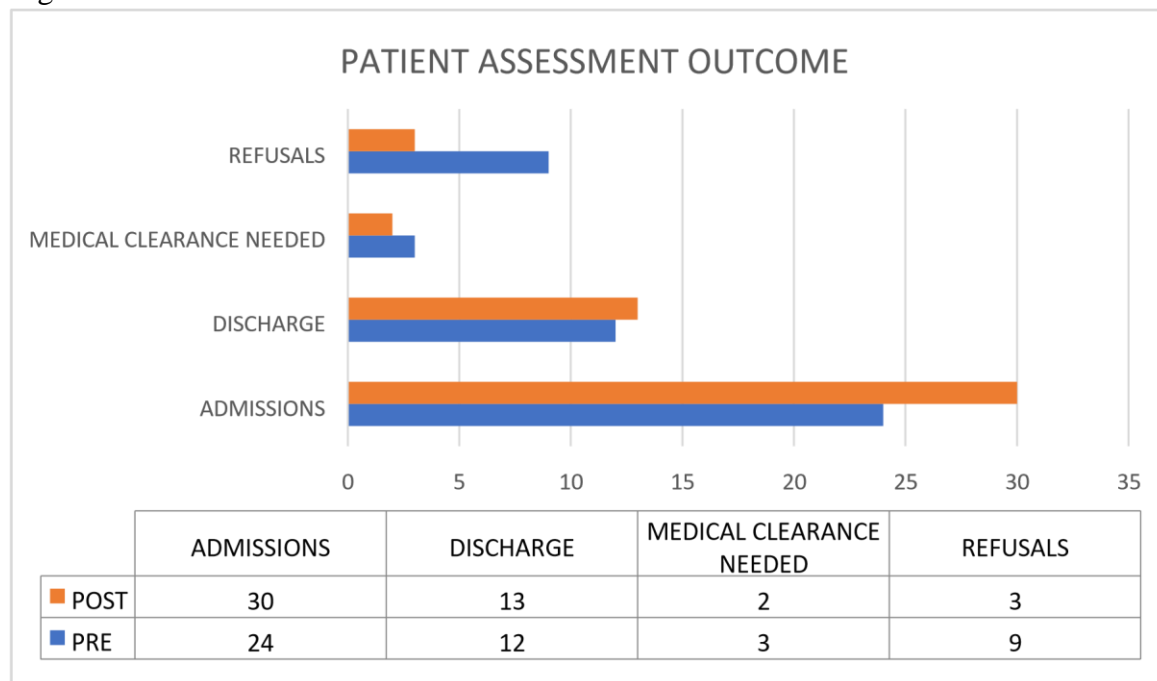
Data was also collected related to the diagnosis of those admitted to the geropsychiatric unit.

Figure 8. Diagnosis

DIAGNOSIS

	Psychosis	Major Depression with Behavioral Disturbance	Dementia with Behavioral Disturbance	Suicidal Ideation
PRE	4	11	26	7
POST	5	13	24	6
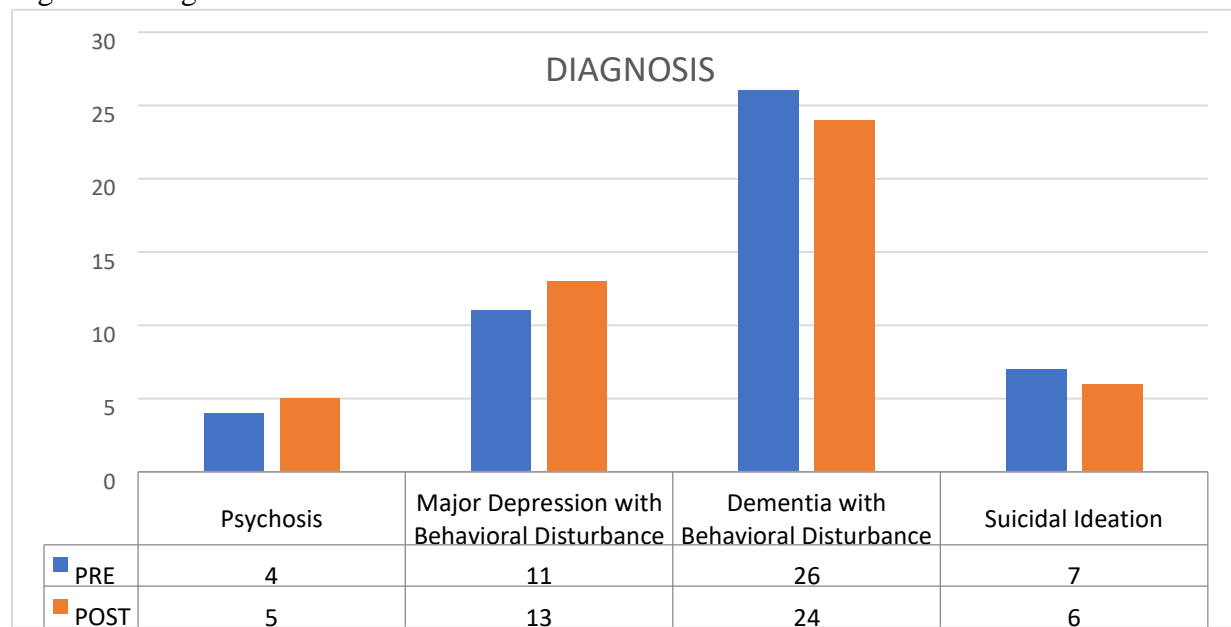
Context and Risk Assessment

Possible risks to the implementation of the SBAR tool included resistance of mental health professionals (participants) to change behavior (way of collecting data). Staff may not want to change the way they collect information. Another risk may be failure of leadership to require implementation of intervention. Lack of knowledge and education about the intervention may also be a risk because staff will hesitate to fully implement change due to not fully understanding how and why. Please (see *Appendix I)* for a complete risk assessment

Feasibility and Preliminary Budget

The projected costs for this project are low. It is possible that the addition of the SBAR tool will increase proficiency of the mental health workers which will allow them to better communicate with the psychiatrist which could increase the number of appropriate admissions to the geropsychiatric unit increasing revenue by $1400.00 a day/patient for each admission. (See *Appendix J)* for projected budget.

Evaluation Plan and Framework

The Plan-Do-Study Act model created by W. Edwards Demming, the father of modern quality control, is a four-step management method to control and improve processes (Six Sigma, 2018). Plan to test a change, do something by carrying out the change, observe and learn through studying results of the change, and act by making modifications to the change are the major steps of the process (Six Sigma, 2018). Implementation of PDSA will guide this project in improving the handoff reporting from the mental health worker to the psychiatrist with the implementation of the SBAR tailored to mental health.

Planning is the first phase of the model this involves an assessment of a current process or new process proposed for change or improvement. Addition of the SBAR to the pre-admission assessment for the geropsychiatric unit at Matagorda Regional Medical Center was the identified change. It is in this phase that educating and training of all stakeholders and staff that would be

utilizing the tool are informed of the tool and purpose for its use. The Do phase allows for the

plan to be enacted. In-services were given to all staff on how to use the SBAR that was added to

the pre-admission assessment and utilization of the tool began. Data was gathered to determine if

the SBAR implementation resulted in improvement. Results are then evaluated in the Study

phase. Data is compared to the expected outcome for similarities and differences. The last phase,

Act allows for continuation of the change if there was an improvement with the addition of

SBAR to the pre-admission assessment form for the mental health workers self-efficacy

knowledge. This phase also determines if the addition of the SBAR improved the process and the

change should be made or it did not improve the process and adjustments need to be made and a

subsequent cycle begins. Implementation of this model will assist in improving mental health

workers' self-efficacy, quality of intake assessment and support appropriate inpatient admissions

for those suffering from a mental health crisis for a figure depicting the PDSA process.

Results
Outcomes

All three mental health intake professionals completed the pre and post surveys.

PreSurveys were administered prior to the implemenation of SBAR in January 2019. Post

surveys were administered 90 days later at the completion of the QI project March 2019. All

three also completed an SBAR of every adult patient 55 years of age and older presenting to the

ER in a mental health crisis between January 2019 through March 2019 when a pre-admission

assessement was completed. This was a 100% compliance to the pre and post surveys and SBAR

tool. During the time frame of the project daily and weekly inservicing were done, posters,

pocket-sized handouts, power points, one on one, and group discussions were also done to

improve knowledge and use of the SBAR tool. The pre and post surveys were analyzed to

determine if the self -efficacy of the mental health intake professional improved with the implemenation of SBAR to the pre-admission assessment.

Each survey was answered completely by the mental health intake professionals who participated in this project. Confidence levels of the respondents increased from pre versus post implementation of the SBAR as evidenced by results of the 10 point Likert scale. The mental health intake professionals identified that they had an increase in their confidence, ability to solve problems, increased comfort level when communicating with the psychiatrist, an increase in the mental health knowledge about a patient when communicating patient handoff with the psychiatrist.

The 5 point Likert scale was the second scale used to test the self efficacy of the mental health intake professionals when collecting participants information upon entry in the emergency room when in a mental health crisis. The respondents showed a significant increase in their ability to accurately complete the pre-admission assessment with the addition of the SBAR. An SBAR tool was used and completed on all 48 patient evaluations as evidenced by a binder kept on all SBAR tools and each participant had a completed SBAR in the binder for the period of January 2019 through March 2019. The mental health intake professionals also identified that they had improved communication with the psychiatrist with the utilization of the SBAR that is specifically tailored towards mental health.

The information provided in this QI project has demonstrated that appropriateness of admissions could be supported with the implementation of the tailored SBAR tool. Prior to implementation, the admission rate was 50% (n=24). After education and implementation, admissions were shown to be 63% (n=30)., a 13% (n=6) increased after the use of the SBAR tool. There was no other correlating data such as age, gender or ethnicity that could be identified

with the increased admissions only with the use of SBAR was there a correlation with increased

admission into the geropsychiatric unit at Matagorda Regional Medical Center.

Discussion
Summary

 According to Shahid and Thomas (2018), the SBAR tool is a structured communication tool

that has been proven beneficial in reducing adverse events, effectively communicating patient

information, improving quality of care, promoting patient safety, and increasing health care

professional's satisfaction.

The expected outcome for this project was to improve the mental health intake

professional's proficiency of the pre-admission intake and self-efficacy with the implementation

of SBAR tailored to mental health for the mental health professionals when communicating with

the psychiatrist. As evidenced by the statistical data and outcomes both aims of this project were

met. There was an increase in the self-efficacy of the mental health intake professionals and

improvement of the pre-admission's assessment tool. With both of these improvements an

increase of appropriate admissions by 13% (n=6) into the geropsychiatric unit at Matagorda

Regional Medical Center was also identified. With the implementation of the SBAR the mental

health intake professionals improved their self-efficacy which allowed them to improve their

communication with the psychiatrist which correlated with increased admissions into the unit.

Strengths and Limitations

Strengths of the study included the project facility being very supportive of the project.

The three mental health intake professionals that were the focus of the project were open to

utilization of the SBAR tool no resistance to change was made evident. Each participant attended

all education in-services, the psychiatrist attended weekly meetings, and the unit manager and

stakeholders gave no resistance to implementation of SBAR. Limitations in this study included a

small sample size, time constraints, and the scope of discussions. Future work is needed to assess

the impact of the SBAR communication tool on patient outcomes, cost-effectiveness, minimization of communication errors, comparison with other communication tools, and the validation of the tool in other subspecialties and or other departments of healthcare (Shahid & Thomas, 2018).

Interpretations

This project was focused on using a tailored SBAR to improve self-efficacy of the mental health intake professional, accuracy of the pre-admission assessment, admission and communication with the psychiatrist. The statistical data collected supports the aims of this project being met with the improvement of self-efficacy, accuracy of the pre-admission assessment and admission into the unit. The expectations of the project were met with the implementation of SBAR improving self-efficacy of the mental health intake professional thereby improving communication with the psychiatrist. In the psychiatric setting there is concern about patient and staff safety due to potentially unpredictable behaviors of the psychiatric patient in crisis. The importance of the mental health intake professional gaining knowledge of the mental health crisis and patient information through the use of SBAR allows important information to be passed on that is patient focused and goal oriented to ensure continuity of care. Developing a process to communicate such as the SBAR is an important component of appropriate admission assessments.

Conclusion

According to Shahid and Thomas (2018), improving communication of patient information with the utilization of the SBAR communication tool in all spheres of medical practice will improve satisfaction among all health care professionals, improve quality of care,

patient safety and outcomes. Educational training and culture changed will be require to sustain its clinical use (Shahid & Thomas, 2018).

Through this quality improvement project, it has been determined that the addition of the SBAR during the pre-admission assessment increased the self-efficacy of the mental health intake professional and enhanced communication to the accepting psychiatrist. This intervention was successful and resulted in increase in appropriate admissions to the geropsychiatric unit at Matagorda Regional Medical Center. Through pre and post surveys statistical data showed an increase in the mental health intake professionals' self-efficacy and the improved accuracy of the pre admission assessment. With improvement in both of these areas a correlation was found with increase of appropriate admissions into the geropsychiatric unit. The SBAR has been a great addition to the pre admission assessment and the mental health professional will continue to learn how to improve communication because of this intervention. Successful implementation requires the will to change and improve communication. This and other studies have shown that the SBAR is considered a good structure for effective communication between caregivers.

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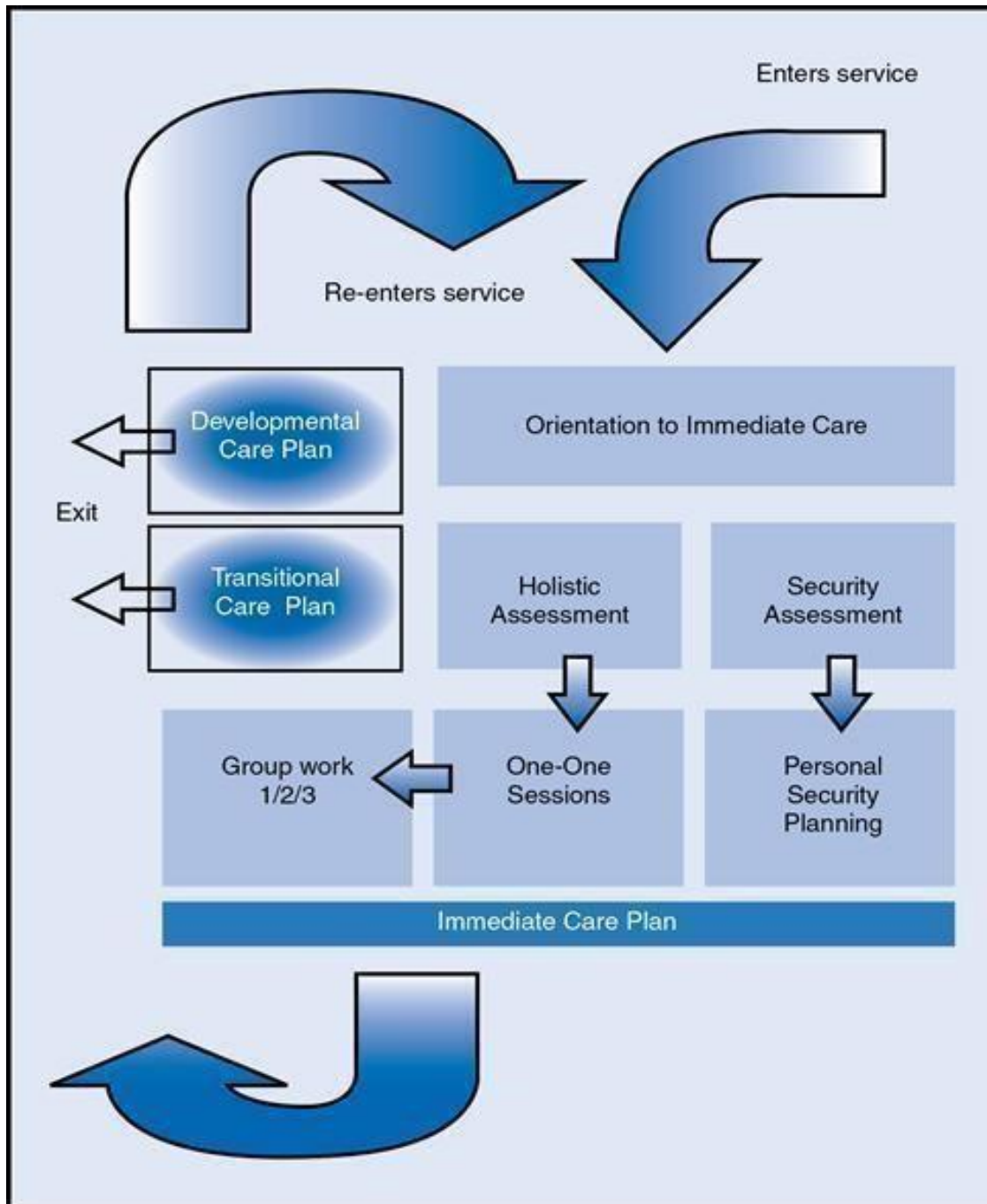
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LIST OF APPENDICES

Appendix A:

The Ten Commitments of the Tidal Model middle range theory

The values of the Tidal Model can be distilled into Ten Commitments.

1. **Value the voice** – the person's story is paramount
2. **Respect the language** – allow people to use their own language
3. **Develop genuine curiosity** – show interest in the person's story
4. **Become the apprentice** – learn from the person you are helping
5. **Reveal personal wisdom** – people are experts in their own story
6. **Be transparent** – both the person and the helper, Professionals are in a privileged position and should model confidence, by at all times being transparent and helping to ensure the person understand exactly what is being done
7. **Use the available toolkit** – the person's story contains valuable information as to what works and what doesn't
8. **Craft the step beyond** – the helper and the person work together to construct an appreciation of what needs to be done "now"
9. **Give the gift of time** – time is the midwife of change. The question that should be asked is, "How do we use this time?"
10. **Know that change is constant** – this is a common experience for all people

Enters service

Re-enters service

Exit

Developmental Care Plan

Transitional Care Plan

Orientation to Immediate Care

Holistic Assessment

Security Assessment

Group work 1/2/3

One-One Sessions

Personal Security Planning

Immediate Care Plan

Appendix B

The General Self-Efficacy Scale

The following scale was developed to evaluate the self-efficacy and knowledge level comfort of mental health workers at Matagorda Regional Medical Center in the Geropsychiatric Unit

Response format

1=not at all true
2=hardly true
3=moderately true
4=exactly true

1. I can always manage to solve difficult problems if I try hard enough: _____

2. I am confident about the information I am communicating to the psychiatrist about the patient

   I am screening: _____

3. I am confident that I could deal efficiently with unexpected events: _____

4. Thanks to me resourcefulness, I know I can handle unforeseen situations: _____

5. I can solve most problems if I invest the necessary effort: _____

6. I can remain calm when facing difficulties because I can rely on my coping abilities:

   _____

7. When I am confronted with a problem, I can usually find several solutions: _____

8. I can usually handle whatever comes my way: _____

9. I am knowledgeable about the information I communicate: _____

10. If someone opposes me, I can find means and ways to get what I want: _____

Total: _____

Appendix C
                    Mental Health Pre-admission Intake Quality Tool

Survey Scale:

 1: Strongly disagree
2. Disagree
3. Neutral
4. Agree
5. Strongly agree

1. The pre-admission assessment form has been accurately and completely filled out

2. The pre-admission assessment form fully identifies/describes the patient's current mental health crisis

3. Information exchanged with this form is accurate and detailed

4. Important patient care information is exchanged during handoff

5. I communicate complete patient information during handout

Total _____

Appendix D: Evaluation Plan
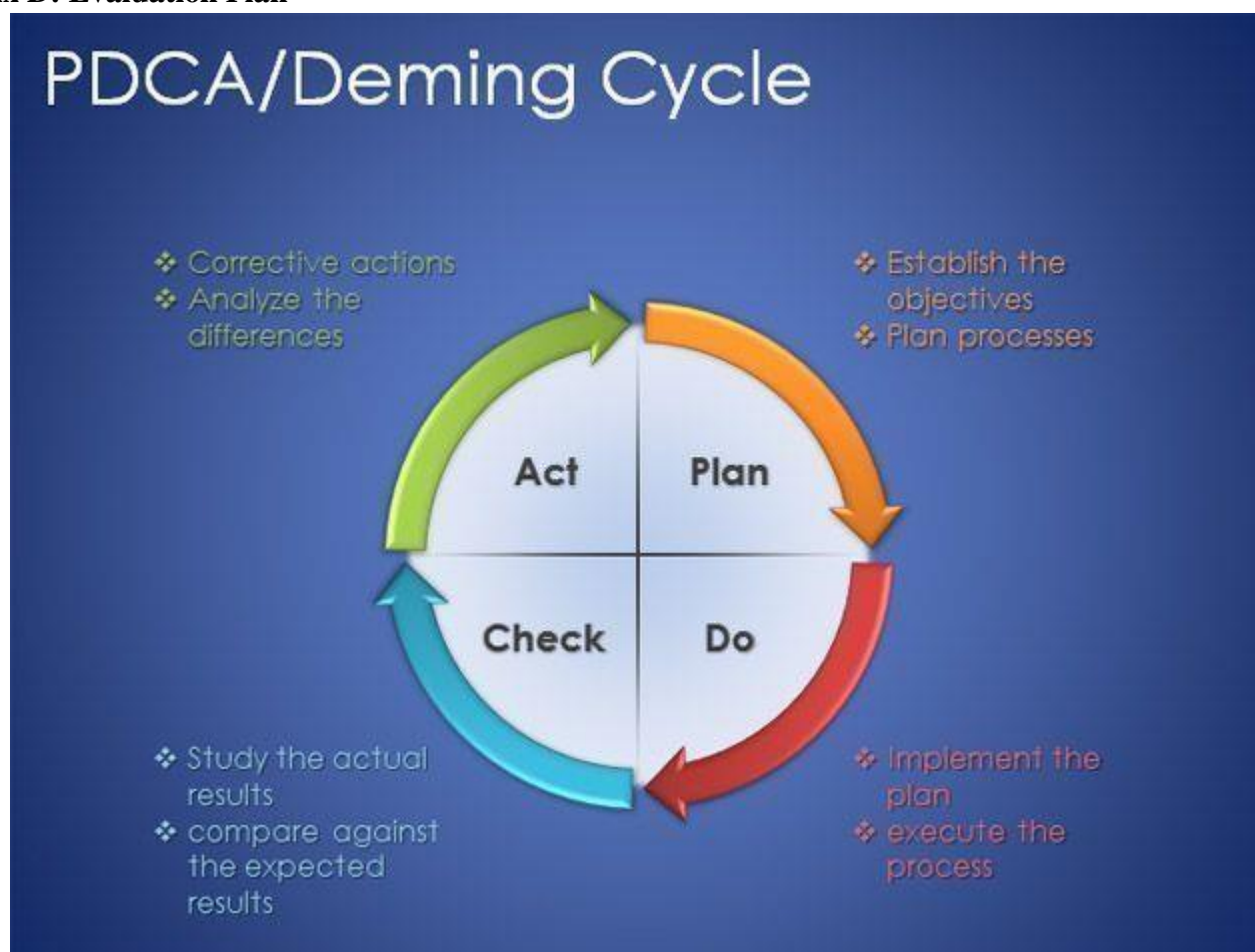
Plan: Systemic review of literature. Assessment of current screening and the addition of the SBAR to current practices

Do: In servicing of staffing and setting plan into motion with implementation of the SBAR into current practice. Gather data for determination of improvement.

Study: Evaluate pre and post results to compare outcome for similarities and differences

Act: Determine if addition of SBAR shows improvement to implement the proposed changed.

Appendix E:

Human Subjects Protection Program	Institutional Review Board

Activities meeting the DHHS definition of research or the FDA definition of clinical investigation and involves one or more human subjects are subject to IRB review and approval.

DATE: January 2, 2019

On January 2, 2019, the Texas A&M University-Corpus Christi Institutional Review Board reviewed the following submission:

TO: Christina Murphey, Nursing and Health Sciences

CC: Rhonda Brown, Student

FROM: Office of Research Compliance

SUBJECT: Not Human Subjects Determination

TEXAS A&M UNIVERSITY CORPUS CHRISTI

Type of Review:	Not Human Subjects Determination
Title:	SBAR Tailored for Mental Intake to Improve Mental Health Crisis Triage for Older-Aged Adults
Project Lead:	Christina Murphey
IRB ID:	NHS 54-18
Funding Source:	None

Documents Reviewed:	IRB Completed 600.02 Form, Not Human Subjects Research Request (1)
	REVISED IRB Completed 600.02 Form, Not Human Subjects Research Request
	Information Sheet for submittal to IRB Finalized
	IRB self-efficacy scale for submittal
	IRB Mental Health Pre-Assessment Quality tool SBAR template for IRB

Texas A&M University-Corpus Christi Office of Research Compliance determined that the proposed activity does not meet the DHHS definition of research or the FDA definition of a clinical investigation.

Therefore, **this project does not require IRB approval**. You may proceed with this project.

This determination applies only to the activities described in the documents reviewed. **Any planned changes require submission to the IRB to ensure that the research continues to meet criteria for a non-human subject research determination.**

Please do not hesitate to contact me with any questions at irb@tamucc.edu or 361-825-2497.

Respectfully,

Rebecca Ballard, JD, MA, CIP
Director, Research Compliance
Division of Research, Commercialization and Outreach

Appendix F:

MATAGORDA REGIONAL
M E D I C A L C E N T E R Your
Health. Your Hospital.

October 19. 2018

Dr. Yolanda Keys
Associate Dean for Academic Programs College of
Nursing and Health Sciences Texas A&M University
— Corpus Christi
6300 Ocean Drive
Corpus Christi, TX 78412

Dear Dr. Keys, The purpose of this letter is to provide Rhonda Brown, a Doctor of Nursing Practice student

at Texas A & M

University College of Nursing and Health Sciences, support in conducting a quality improvement project at Matagorda Regional Medical Center. The project,
Implementation of SBAR tailored to mental health, entails <u>improving self-efficacy, knowledge, and communication of the mental health worker with the psychiatrist.</u>

The purpose of this project is to determine if implementation of SBAR tailored to mental health improves selfefficacy and knowledge of the mental health worker, and the communication between the mental health worker and psychiatrist to improve inpatient admissions of those aged 55 and older presenting to the emergency room with a mental health crisis. Matagorda Regional Medical Center was selected for this project because a geriatric inpatient psychiatric unit is located on the second floor of the hospital. Rhonda Brown is employed at this institution, and has an interest in improving care at this facility.

I, Mike Lee, RN, BSN, MBA, Chief Nursing Officer at Matagorda Regional Medical Center, do hereby fully support Rhonda Brown in the conduct of this quality improvement project, Implementation of SBAR tailored towards mental health within the Senior Care Unit at Matagorda Regional Medical Center.

Sincerely,

Appendix G:

	SBAR Template Tailored to Mental Health
S	**Situation**: State your name and name age date of birth of individual you are calling about *****Below circle all the apply prior to exchanging handoff of patient information*** **Give overall description of patient**: **hygiene** (good, fair, poor, neglected, unkempt), gait (normal, unsteady, shuffled, weakness, other) **Posture** (normal, rigid, slouched, relaxed, other) **Motor** (normal, tics, restless, slow, agitated, tremors, continuous movement, other) **Mood** (normal, angry, anxious, depressed, guilty, agitated, other) **Affect** (normal, congruent, blunted, flat, other) **Speech** (normal, talkative, pressured, minimal, loud, mumbled, whispered, other) **Orientation** (Person, place, time current situation) **Current symptoms (circle all that apply)**: depressed mood, unable to enjoy activities, sleep pattern disturbance, loss of interest, concentration forgetfulness, change in appetite, excessive guilt, fatigue, depressed libido, racing thoughts, impulsivity, increase risky behaviour, increased libido, decrease need for sleep excessive energy, increase irritability, crying spells, excessive worry, anxiety attacks, avoidance, hallucinations, suspiciousness, suicidal
B	**Background:** Give patient history of: **Allergies**: **Current weight and height**: **Medications**: Current and any past related to mental illness Medical Problems **Surgeries** **Past Psychiatric History**: (outpatient or inpatient treatment and when and why) **Family psychiatric history** **Family background and childhood history** **Substance abuse** (drugs, alcohol) **Trauma history** (hx of sexual, emotional, physical abuse or neglect) **Relationship history and current family situation** **Legal** (ever arrested or any pending legal problems) **Spiritual life** (belong to a particular religion spiritual group)

A	**Assessment:** Explain the situation in further detail: **Reason for presentation identify and explain the mental health crisis:** **This patient presents** with: anxiety, depression, schizophrenia, bipolar, suicide attempt, assaultive behaviour, self-mutilative behaviour, hallucinations, delusions, illusions **Medical condition** that may be cause of mental crisis **Perception**: appropriate, hallucinations, auditory, visual, olfactory, tactile, delusions, paranoid, grandiose erotic other **Thought process**: goal directed, flight of ideas, blocking, evasive, obsessive, confused, disoriented, suicidal, homicidal, somatic, phobic, pre-occupied with I**ntelligence**: average above average, below average unable to ascertain **Sensorium**: alert, aware, lethargic stupor, other **Insight**: good aware poor denial intellectual insight emotional insight
R	**Recommendation:** Explain what you recommend for this patient inpatient services/outpatient services explain your rationale.

Appendix H: Timeline

Milestones	Description	Estimated Completion Date
IT/DNP project leader to produce pre and post surveys for project	Establish knowledge base of mental health professionals pre and post implementation of SBAR and to increase quality of intake	Dec 2018 and March 2019
Education of mental health professional/psychiatrist to SBAR	In-servicing/posters to educate staff to SBAR	October- December 2018
Obtain psychiatrist as expert for content of SBAR	Established content expert of mental health to improve outcome of implementation of SBAR	October 2018
Establish Facilitator and clinical site for project implementation	Need site to conduct implementation of intervention and need for facilitator to assist with collection of data	October 1, 2018
HEOC with letter of Support	Must be completed to proceed	November 13,2018

Appendix I: Risk/Impact/Barriers

Risk	Impact	Countermeasure	Facilitators	Barriers
Resistance of participants to change behavior (ways of collecting data)	Intervention/communication not improved no change	Education licensed mental health professionals to full confidence in change	Clinical directors, chief nursing officer, administrator, nursing staff, psychiatrist	Training time, cost of implementation, lack of participation with inservices, personal differences, cultural differences
Failure of leadership to require implementation of intervention	Intervention cannot be fully assessed for improvement	Provide evidencebased practice about intervention to push change	Licensed mental health workers, nursing staff, clinical directors, chief nursing officer, administrator, psychiatrist	Lack of resources, leadership defensive or skeptical of change resistant, varying levels of preparation, qualification or status, clinical responsibility
Lack of knowledge on understanding of how to improve system	Intervention not used to its full potential. Lack of knowledge	Provide online or in person in services about intervention	Psychiatrists, providers, licensed mental health workers, nursing staff, administration	Staffing shortage, lack of in-service attendance, failure to comply or participate with implementation due to lack

Appendix J: Budget Table

Task	Labor		Materials		Fixed Cost	Budget	Actual	Under/Over
	Hours	Rate	Units	$/Unit				
Survey Pre/Post knowledge								
IT to create survey (survey monkey)	4	$15.00	5 employees	Fixed rate/hourly		$100.00		
Inservice for SBAR tool	4	$12.00	5 employees	240.00		$200.00		
Use of copier/SBAR (for those that do not complete online survey	2					$50.00		
ink for copier		$20.00				$50.00		
Task								
Survey for Quality								
IT to create survey	4	$15.00				$100.00		
Inservice to discuss quality of tool	4	$12.00	5 employees	240.00		$200.00		
use of copier /sbar	2							
ink for copier		$20.00				$50.00		
Task								
Electronic Health Record Data								
pre- implementation SBAR	8		10-20 admissions monthly JanJune	Data to be collected by DNP student				
post implementation SBAR	8			Data to be collected by DNP student				
admission to inpatient psych					1400.00 day for inpatient			
Room to train								
Training Material								

In servicing of new employees	4	$40.00						
Total		$134.00		$480.00		$750.00		

Appendix K: List of Figures

1. Likert Scale Results
2. Mental Health Pre-Admission Intake Quality Tool Results
3. Gender Sample
4. Pre-SBAR Age Range
5. Post-SBAR Age Range
6. Ethnicity
7. Patient Assessment Outcome
8. Diagnosis