Rachel Myers

Quality Improvement Activity: ER Patients Being Sent Home Too Early

A 23-year-old woman was brought to the emergency room by her mother for fatigue, weakness, nausea, and abdominal pain. The triage nurse drew labs and sent the patient back to the waiting room without asking many questions. Once the provider was able to see the patient, the provider asked the patient if she had vomited or if she just had nausea and did not ask the patient about her diet, medication, history, or mental health history. The patient reluctantly told the provider that she had not vomited. The patient spoke quietly and would not offer information unless the provider asked specifically. The provider determined that the patient probably had a stomach virus and told the patient to go home and rest, drink plenty of hydrating fluids, and gave her a prescription for ondansetron to help with the nausea. The patient's mother dropped her off at her house and left to allow her to rest and said she would return in a few hours to check on her. When the patient's mother returned to the patient's house to check on her as promised, she found the patient unconscious on the bathroom floor with an empty bottle of Ibuprofen. The patient's mother immediately called the ambulance and the patient was rushed back to the emergency room.

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

In the scenario above, the patient was brought into the emergency room by her mother for fatigue, weakness, nausea, and abdominal pain. The triage nurse only asked the patient when the symptoms started and since the patient did not volunteer any information, the triage nurse did not know that the patient had a history of suicidal ideation and had stopped taking her prescribed antidepressants approximately 6 weeks ago. The provider relied on the triage nurse to ask all of the questions and because of this, the provider also did not ask about the patient's mental health history. Situations such as this should not be as common as they, unfortunately, are. Many emergency room employees will not ask about mental health or suicidal ideation unless it is obvious that the patient is struggling with mental health.

What circumstances led to the occurrence?

The circumstances that led to this situation was the triage nurse not asking the patient questions about mental health or medication history and the provider discharging the patient after only a few hours in the emergency room without running the proper tests or asking all of the questions that may be relevant.

In what way could you measure the frequency of the occurrence? (interview nurses, examining charts, patient surveys, observation, etc.)

The frequency of patients committing suicide within a month of discharge from the emergency room is constantly an issue that needs to be addressed in many emergency rooms. Due to the severity of this issue, the majority of hospitals do their best to prevent it by implementing protocols and mental health surveys in order to attempt to prevent patient suicides after discharge. One way to measure the frequency of the occurrence is audit patient charts and determine if emergency room staff asked every patient about their mental health history and assessed their risk for suicide in order to determine if patients need help with a mental health issue along with whatever symptoms brought them to the emergency room.

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What evidence-based ideas do you have for implementing interventions to address the problem?

Having protocols for mental health and suicidal ideation assessments should be implemented in every emergency room along with protocols for what to do if a patient shows mental health issues upon assessment. Having staff meetings to determine what went wrong and chart audits when a suicide after discharge occurs should also be implemented in emergency rooms. Reinforcing the protocols and having a mandatory refresher class every year can also help emergency room staff to ensure patient safety while in the emergency room as well as after discharge. After each occurrence, the staff involved should have to take the refresher class again and discuss if protocol was broken. Patient suicides after discharge can not always be prevented but assesing each patient for suicide risk and mental health history can go a long way in lessening the frequency of these occurrences.

How will you measure the efficacy of the interventions?

The efficacy of these interventions can be measured by having yearly evaluations regarding these occurrences and continuing to have chart audits to keep track of the number on incidents each quarter and each year. Any change in the frequency of these occurrences can be documented and brought to the attention of the staff. This will help the unit to reflect on why these incidents happen and what part of the protocols needs to be reviewed or possibly changed.