

EXPERIENCE EXCHANGE

When mental health and medicine collide: Maintaining safety in the emergency department

Caroline Cusick Vierheller, Mike Denton

Nursing Administration of Nash Health Care Systems, Rocky Mount, the United States.

Correspondence: Caroline Cusick Vierheller, MSN MHA-I RN. Address: Nursing Administration of Nash Health Care Systems, 2460 Curtis Ellis Drive, Rocky Mount, the United States. Email: cvierheller@nhcs.org or ccusickrn@aol.com

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Abstract

Mental health patients seeking care through emergency departments (ED) create different challenges for nurses than their medical counterparts. Understanding the special needs of psychiatric populations requires nurses to identify recurring characteristics, subgroups, and demographics. Psychiatric patients share similar traits that hinder their access to health care despite the distribution of mental illness across age, race, gender, and ethnic barriers. Similarities among psychiatric patients include impaired thought processes, tendency to withdraw from social interaction, and shame related to the stigma of mental illness. Psychiatric patients using emergency departments for primary care compound their vulnerable status by circumventing patient-provider relationships that develop when establishing routine practice and familiarity with a primary care physician. This article illustrates how nurses in the American health care system, specifically those in emergency specialties, can respond to environmental challenges while caring for mental health patients. Strategic planning allows ED teams to prepare for an influx of mental health patients and maintain safety as they serve this vulnerable population.

Key words

Emergency, Nursing, Mental, Psychiatric, Health, Hospital, Medicine, Nurse, Behavior, Outpatient, Safety

Introduction

One fourth of Americans experience mental health challenges and 21 percent of hospital admissions result from mental illness ^[1,2]. “Mental illness accounts for approximately 12 percent of all disease worldwide and half of all measurable disabilities.” ^[1]. Emergency nurses must remain vigilant for a variety of patient presentations and understand that any patient’s care can include treatment of mental health conditions. Emergency departments (ED) nurses must constantly monitor their clinical environments and prepare responses for behavioral emergencies. Familiarity with space, occupancy, equipment, protocols, and procedures empowers ED nurses to react swiftly and without hesitation as physical or psychiatric emergencies arise.

Patient scenario

This example shows how an emergency department nurse responded to an unforeseeable event with confidence and finesse by combining instinct and ingenuity. Emergency medical services (EMS) brought an unresponsive 58-year-old

man to a community hospital ED for evaluation. The registered nurse (RN) intervened according to protocol. Evaluation followed a standard algorithm by addressing airway, breathing, circulation, and neurologic factors for patients experiencing stroke, myocardial infarction, overdose, sepsis, or a myriad of possible conditions that contribute to decreased level of consciousness. The patient's condition changed and the RN found himself as a hostage rather than a caregiver.

Most emergency department patients and visitors enter through the lobby and pass through metal detectors. Metal detectors and security teams protect the safety of patients, visitors, and staff. Patients arriving by EMS circumvent this security checkpoint. Stretchers and their metal-buckled safety straps interfere with the effectiveness of metal detectors so these mechanical barriers are avoided when patients arrive by EMS.

The gentleman in this scenario arrived by ambulance; he wore pajamas and a bulky, green bathrobe. No special cues prompted a search for weapons because nurses believed the patient's condition stemmed from medical rather than psychiatric illness. "Upon my initial assessment the patient was extremely rigid, had clenched teeth, clenched eyes, felt mildly febrile, and was completely unresponsive to verbal or painful stimuli," the RN reported. Information indicating history of mental illness emerged after review of the patient's background.

Identifying risk

Psychiatric patients lack the reasoning abilities possessed by healthy individuals. These patients exhibit more risk for violence or self-harm than general populations. Their unique characteristics require emergency intervention, medication, and de-escalation ^[3]. Psychiatric patients exhaust their entire repertoire of coping skills before turning to emergency departments for assistance. This patient's unresponsive behavior persisted until physical interventions began that triggered his change.

Attempting to obtain a rectal temperature ended the patient's stupor instantly. "Hey man, what cha doing?" the patient asked clearly, speaking for the first time since his arrival. The patient gradually improved. He allowed caregivers to start an IV, insert a Foley catheter, and deliver all the ordered care. He "showed rapid signs of progression physically and mentally" according to the nurse. The RN described this patient's affect as "pleasantly confused, polite, and cooperative."

Preparing for the unknown

The need to remain in constant attendance with this one patient diminished as the patient improved. The nurse ensured the stretcher's side rails were raised and that the patient could reach a call-button. The patient was left unattended briefly and "without any warning, I noticed a green figure staggering down the hall," the nurse recalled. "I looked up and my patient was walking towards the waiting room." The nurse moved into action. He approached the patient and placed a gentle hand on the patient's shoulder. "Hey bud, what's up?" the nurse asked softly. Wrapped in his bathrobe, the patient staggered and stared. "Come with me and let's get you back in your bed," the nurse prompted as he led the patient back toward his room.

The patient's room showed bloody evidence of a hasty escape. "His Foley was ripped out along with his IV. Blood and saline were pooling on the floor. His Foley bag was still attached to the bed but his catheter, with the balloon still inflated, was on the bed leaking urine on the sheets."

The patient faced his nurse and said "I'm late. I gotta go." Noting the patient's confusion, the nurse suggested "Let's sit down for a second because I don't want you to fall." Stepping around the patient, the nurse lowered the side rail to assist the patient into bed. This movement placed the patient between the RN and the doorway. "In an instant he swung around, closed the door, and locked it." The nurse was trapped. "He snarled at me," the nurse recalled. "Now my patient stood between me and a locked door."

“As if I was pre-programmed, I instantly yanked my sharps off my side, took off my stethoscope, and threw them into the far corner behind me. The tools I use daily to save lives could be the same tools used against me. The patient didn’t seem to notice what I had done as he proceeded to ask me ‘What you doing in my house?’” the nurse narrated. The nurse explained that the patient was in the hospital. “You’re lying!” the patient yelled. “You’ve always been a good liar.” The nurse raised his ID badge and stepped toward the patient but the patient raised his fists and declared “I’ll hit you in the face if you come any closer. I swear I’ll kill you. Get out of my house before I shoot you!” The patient reached into the pocket of his bulky green robe and the RN realized that the patient’s claim to have a gun could be true. No one searched the patient’s robe or checked for weapons.

The patient’s tone and posture convinced this nurse that he meant every word. “For this situation, I could either physically get out or I could manipulate a delusional patient and resolve this peacefully.” The RN understood that this 58-year-old man had no idea what was happening around him. “I knew I had to distract him from the door,” the RN explained. “If I could signal someone from outside and distract him simultaneously, I could manage to unlock the door and staff would come into the room to help.”

Understanding how to manage psychiatric patients before violence erupts decreases risk to both patients and health care workers. Both the nurse trapped in the patient’s room and the team responding to signals for help benefited from their previous experience and training caring for confused patients. The American College of Emergency Physicians reports that emergency departments experience more physical assaults than any other health care environment ^[6]. Increasing rates of community violence have spilled into hospitals and clinics across the country ^[7]. Traditional barriers to protect health care workers often fail. Nursing leaders realize that additional safety measures must be constructed to compensate for potential violence.

Applying experience and training

Well trained nurses know how to react when patients’ conditions change. Priority shifts during these critical moments. Attention turns to employee and patient safety. Treatment of physical conditions becomes secondary. Standard ED treatment rooms contain monitoring wires, suction tubing, sharp disposal containers, oxygen access, electrical outlets, and mobile furniture. Patients predisposed to self-harm or aggressive behavior rapidly transform lifesaving equipment into weapons. Not all behaviorally challenged patients receive treatment in these hazard-free rooms designated for treating psychiatric patients. Medical patients with underlying psychiatric conditions can receive treatment in any room of the emergency department.

Appropriate staffing ratios

ED leaders design departments and organize staffing patterns based on multiple factors including census, volume, acuity, and staff expertise. Different patient-to-staff ratios exist for medical patients than for psychiatric patients requiring constant observation. The California Nurses Association sets the gold standard for emergency nursing by recommending 4:1 nursing ratios in most ED environments ^[4]. More lenient federal regulations only require staffing to be “adequate” to provide care as needed, according to the Code of Federal Regulations ^[5].

Safety measures

Protective measures in this emergency department include physical barriers, human security measures, and social standards of conduct. Physical measures equip the emergency department with panic buttons, call systems, intercoms, cameras, mirrors, metal detectors, bullet-proof glass, badge-access doorways, and multiple egresses for escape. Human factors supplement physical barriers by incorporating a multidisciplinary team of security officers, patient care techni-

cians, nurses, and physicians. This strategy adjusts staffing ratios for patients with mental health disorders. The organization provides crisis intervention training for staff and provides psychiatric evaluations for ED patients. On-site behavioral health specialists respond to patient outbursts immediately and help nursing teams protect the visitors who pass through high-risk areas. Organizational leaders support and enforce standards of conduct expected from patients and visitors. This stance against assaulting health care workers corresponds with “no tolerance policies” for workplace violence being adopted across the country ^[8].

Constructing safe work areas

ED leaders know that well designed treatment areas support efficient work-flow, provide safe work environments, allow confidential discussions, and monitor treatment to support safety ^[9]. Safe psychiatric units require two passageways for employees to access patients. This design differs from medically-based treatment areas which only require one access in and out of patients’ rooms. Creating a safe physical space for behavioral health patients protects both staff members and patients. Maintaining specially designed areas decreases risk of harm and prevents nurses from finding themselves in danger ^[10]. Designing and constructing psychiatric emergency facilities requires dramatic financial investment, planning, and the dedication of leaders to support the needs of mental health communities. These actions serve a patient population that generates little revenue ^[11].

Growth of this patient group continues. Cost and regulatory complications have lead to the closing of mental health hospitals across the nation because administrators find it impossible to balance operational expense with flagging reimbursement. Quantities of psychiatric care providers are diminishing, leaving mental health patients with little recourse other than seeking care in overcrowded emergency departments.

Patterns and trends

A variety of demographic groups contribute to the increasing psychiatric populations. Greater than half of mental health patients presenting to emergency departments are male, young, adult, intoxicated, or have a history of mental illness with noncompliance ^[12]. In contrast, other research cites populations over age 65 as the fastest growing segment of society with mental illness because geriatric patients often seek care for depression, anxiety, isolation, and cognitive decline ^[3].

Research suggests that African Americans, Asians, and Latinos in the United States experience higher incidence of mental illness than white Americans but statistics substantiate no link between mental illness and nationality, culture, or gender ^[2]. African Americans report 22.2% of the United States’ psychiatric conditions. Asians experience 21.2% of mental illness. Latinos provide 24.2% of the nation’s psychiatric population. These measured outcomes surpass the contribution of white Americans who make up 14.4% of this country’s mental disorders ^[12]. Disparity between these numbers may stem from patients’ willingness to report symptoms. Mental health patients can be burdened by shame, confusion, or debilitated thought processes. Many patients who present to emergency departments with physical complaints or situational crises cannot articulate how their symptoms correspond with underlying mental illness.

Education level, language skills, and financial capacity of mental health patients can hinder access to care or contribute to the disparities between demographic groups. “Research has found that non-English speaking minorities living in the United States were less likely to have access to mental health care than those who spoke English well” ^[2]. This analysis suggesting that reported volumes of mental illness would climb higher if education levels across demographic categories equalized.

Recognizing crisis

ED nurses predict impending psychiatric crises by recognizing escalating behavior. Statements that convey confusion, anger or threats provide risk indicators. Behavioral clues include loud voice, pacing, fidgeting, changes in eye contact,

blood pressure increase, heart rate changes, posture, restlessness, and verbalized threats ^[6]. The American College of Emergency Physicians sites high risk for violent outbursts during evenings and nights. Planners should recognize that the times of day when staffing tapers down can correspond with influx of behavioral health patients.

A retrospective analysis of the ED population in this rural emergency department confirmed the prediction that psychiatric patients tend to arrive during evening and night shifts. The review also revealed this rural community facility cared for 2,348 psychiatric patients in 2011, followed by 2155 in 2012. This number includes both the patients who arrived seeking psychiatric care and those who arrived with medical symptoms but received psychiatric diagnoses. Pediatric patients accounted for 9.4% of these psychiatric cases. Patients between 18 and 60 years old comprised 82.3% of psychiatric patients; 8.3% of these patients were 61 or older.

Length of stay

The greatest source of frustration for psychiatric patients in the ED comes from the length of time required to receive placement at inpatient care facilities. Keeping patients calm and encouraging ongoing cooperation presents obvious challenges. Even patients and family members who seek care voluntarily may struggle to maintain the patience required when wait-times extend longer than eight hours. Unfortunately, the average length of stay for psychiatric patients requiring placement exceeds 24 hours; some psychiatric patients have resided in the ED up to seven days before achieving placement in a facility ^[12]. ED teams strive to decrease length of stay, improve patient outcomes, increase patient satisfaction, and promote environmental safety.

Action plan

Containing violence is essential to providing a safe workplace. Nurses willing to work in emergency specialties accept some risk of danger but do not deserve to suffer abuse while delivering patient care. *ED Management* reports that “between 8% and 13% of ED nurses experience some type of physical violence in the course of doing their jobs” ^[13]. Including verbal abuse escalates that number; 78% of nurses reported either physical or verbal abuse within the past 12 months ^[13].

Not all hospital ED’s offer the luxury of designated space for psychiatric patients. Facilities that intermingle medical and psychiatric patients can implement a series of solutions. First, clear the patient’s immediate environment of unessential items. Remove clutter, extra furniture, cords, cables, wires, and equipment. Lock cabinets and drawers. Open doors; increase visibility. Assign team members to maximize patient observation.

Maintaining safety requires preparing for crisis with practice drills, annual education, crisis intervention training, and safe equipment. Sufficient numbers of employees, quick response of security teams, and the continual presence of security members in the ED contribute to safety while deterring outbursts. Mnemonic learning tools can serve as reminders for employees. One checklist reminds employees to be: courteous, calm, confident, control the space, clutter removal, and clearly visualize the patients. Requiring all ED employees to attend annual education reinforces the importance of recognizing behaviors that precipitate escalations. Clues to impending crisis include postural, vocal, and physical cues.

Interdisciplinary approach

The community ED in this scenario implemented daily interdisciplinary meetings to review the progress, treatments, and care plans of psychiatric patients in the ED. Daily meetings allow nurses, physicians, counselors, and regional psychiatric facilities to discuss care for patients awaiting placement. Psychiatric teams direct the care for mental health patients and contribute insight when patients present with concurrent medical and mental health conditions.

ED physicians join with psychiatrists and psychiatric pharmacy experts to initiate medication routines that promote therapeutic care while patients are still in the ED. This multidisciplinary approach decreases the time required for stabilization. The daily meetings promote collaboration, decrease the length of time required for assigning placements, unite staff from multiple facilities, and develop a cohesive team with common goals of improving patient outcomes. Including specialized teams of psychiatric nurses, intake counselors, and physicians allows health organizations to practice multidisciplinary care and solve problems specific to mental illness in emergency departments.

Conclusion

Mental health populations represent a vulnerable segment within the United States' health care system. The trend can be expected to increase as state facilities close and patients are discharged back into community environments for long-term care management. Acute care facilities are ill-equipped to provide psychiatric services without planning to accommodate the special needs of mental health patients. Twenty five percent of people receiving health care in America have a current or previous psychiatric diagnosis ^[1]. Increasing awareness, maintaining vigilance for safety, and preventing danger are important to future success. Health providers remain unwilling to sacrifice either staff or patient safety. Therefore, deliberate measures must be taken to care for psychiatric patients who present with or without underlying medical conditions.

The patient in the scenario described was cleared of medical conditions. The care team initiated involuntary commitment papers. The patient received admission for continuation of care and no one suffered injuries. No weapons were found in his pockets. Crisis intervention classes continue to be an integral part of annual nursing education.

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