

# Issues up close

## Care, not chaos

By Susan Trossman, RN



### Framework focuses on improving emergency care for patients with psychiatric and substance abuse disorders.

**THE PACE, SOUNDS,** and sheer volume of people in a busy emergency department (ED) hardly create the most conducive environment for a patient in the midst of an acute psychiatric episode. Yet emergency nurses report their departments increasingly have become the portal of care for people with psychiatric and substance abuse disorders who need a range of services.

Given that trend, the Emergency Nurses Association (ENA) worked with ANA, other healthcare organizations, and advocacy groups to determine how these patients can receive effective treatment in an environment that is safe for all. The ultimate result of their collaboration is a document called *Emergency Care Psychiatric Clinical Framework*, which contains principles of care for this patient population as well as clinical evaluation guidelines.

“Overcrowding and boarding of patients because of a lack of inpatient beds are a realistic part of our world,” says Patricia Kunz Howard, PhD, RN, CEN, FAEN, an emergency nurse for 26 years, Kentucky Nurses Association member, and ENA’s representative on the ANA Congress on Practice and Economics (CNPE). “And for about the last decade, and decidedly the last 5 years, the number of patients with behavioral health emergencies coming to the ED has increased as fewer and fewer care options have been available for them.”

ENA President Bill Briggs, MSN, RN, CEN, FAEN, agrees, saying the deinstitutionalization of people with mental illnesses followed by ongoing budget cuts to community-based and inpatient mental health services have contributed to this influx to the ED. The large number of homeless people with mental health issues is also a factor. “The ED has become the safety net for the entire healthcare system,” Briggs says. And that has led to concerns among staff that may lack the resources, training, or even adequate space to provide care to patients who may be a danger to themselves or others.

The total number of visits to EDs nationwide in

2006 was 119.2 million, according to the *National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary*. Of that total, 4.3 million patients were given a primary diagnosis of “mental disorders.”

Howard points to reports that show psychiatric patients are boarded in EDs more frequently and for longer periods of time than other types of patients.

### The quest for consensus

The ANA board of directors recently endorsed the emergency care psychiatric framework at the recommendation of the CNPE, which develops policies on nursing and healthcare trends. But ENA’s desire to build consensus on standardized guidelines for care goes back a couple of years.

When ENA members were discussing priorities for the association in 2007, Briggs says three issues “bubbled to the top”: boarding, care of patients with mental health issues, and violence in the ED. ENA decided to address these often-interrelated issues head on by bringing in representatives from a wide range of organizations, including nurse, physician, and regulatory groups, for a June 2008 meeting. Representing ANA at that meeting was former CNPE member and current Louisiana State Nurses Association President Patricia La Brosse, APRN, BC, an expert in psychiatric-mental health nursing with a background in emergency nursing.

“The ED is a fast-paced service, and it’s intended to be that way,” La Brosse says. “It’s also a very stimulating environment. Bells and whistles are going off. Ambulances are bringing in patients who may have been involved in a three-car pileup. Then you have folks coming in whose behavior indicates that they may be a danger to themselves or others. They may be paranoid and angry that they were taken out of their home, and suddenly a nurse is sticking a needle in their arm. They already are fragile, and the stimulating environment can enhance their fragility and escalate their symptoms.”

At University Medical Center in Lafayette, Louisiana, where La Brosse works, the ED has a separate area, the Mental Health Emergency Room Extension, where patients with mental illness or substance abuse disorders can be moved to a less stimulating, safer environment. La Brosse also is available to consult with ED nurses and other staff to help manage immediate care

and determine options for patients' next level of care.

Howard also works in an ED that has a four-bed behaviorally safe area, which has metal garage door-like coverings over hospital supplies and equipment. ED staff can watch patients on the closed-circuit TV or directly through the room's windows, which have blinds controlled from outside the area.

But looking at the national picture, Howard says that EDs with specialized psychiatric units and staff are in a "small minority." "We can manage ICU and general medical patients really well in the ED, but we don't have the expertise or provide the care that an inpatient psychiatric care unit does," Howard says. "And that can really contribute to [psychiatric] patients' symptoms and compromise their outcomes."

The clinical framework, which was completed in December 2008, helps guide ED staff who lack adequate resources and experience, as well as lays the foundation for nationwide change. Howard emphasizes that patients with mental illness and substance abuse disorders deserve to get the care they need no matter where they live.

### Framing care

The framework outlined in the document contains six principles, which nurses say are all equally important. One principle addresses the importance of ensuring that ED staff implement evidence-based practice when providing care to patients with mental illness, a substance abuse disorder, or both. Other principles call for ED staff to possess core competencies to accurately assess these patient populations and to follow a standardized ED triage scale to ensure timely and appropriate evaluation and treatment.

The document also states that patients who need inpatient care should not be boarded in the ED. La Brosse says that while boarding is not a good practice, she fears that it will continue until communities around the nation have thoughtful discussions about the range of resources they need for persons with mental illness and substance abuse disorders and then fund those services. "We want all our patients and staff to be safe," La Brosse says. "But to not board, you've got to have places for patients to go."

The document also lays out three major clinical evaluation guidelines. The first guideline requires that ED professionals perform a psychiatrically relevant and focused medical assessment on patients presenting with signs and symptoms associated with mental illness to exclude other reasons for their behavior.

"Part of our assessment with all patients is to determine if they are alert and oriented to person, place, and time, as well as the appropriateness of their responses and interactions," says Linda Riazi-Kermani, RN, an emergency nurse at a Level 1 trauma center,

Ohio Nurses Association member, and a CNPE member. It is common practice to keep patients whose behavior is suspect in the ED for a period of time to rule out medical causes, such as infections or drug interactions.

"If the primary complaint is of a psychiatric nature, we complete a more thorough assessment to identify suicidal or homicidal risk, as well as a previous history of suicidal or homicidal attempts," Riazi-Kermani says. Her ED also employs two psychiatric nurses who help manage patients with mental illness and expedite their care, although they are not available around the clock 7 days a week.

Again, emergency nurses contend that standardized triage and in-depth assessments are not consistently performed in every ED throughout the country—particularly when staff lacks sufficient training. "Sometimes ED professionals have perceptions of people that are not correct, so it's important to sort out symptoms and address comorbidities that can interfere with determining a diagnosis and treatment," Briggs says.

The second guideline calls for ED staff to perform a psychiatric assessment of every patient, beginning with a mental status exam that includes checking the person's mood, speech, appearance, and judgment.

The third, and final, guideline details objectives that should be part of an emergency psychiatric evaluation. Those objectives include:

- ensuring there are processes in place to keep the patient and others safe
- establishing a provisional diagnosis of the most likely mental disorder causing the current emergency
- reviewing current medications, relevant laboratory tests, and radiologic reports
- identifying family members or others who can provide accurate information, especially if the patient is cognitively impaired, agitated, or unable to communicate effectively
- determining whether the patient is willing to participate in further assessment and therapeutic treatment.

"These guidelines are the result of all of us working together to solve a problem that impacts patients and staff," Howard says. "Everyone realized this is not strictly an 'ED issue,' because access to care, overcrowding, and boarding are healthcare system issues." Howard hopes more resources will be developed that address the many issues that came out of the consensus meetings, including more specific guidelines for patients with substance abuse disorders.

The clinical framework can be found at <http://ena.org/about/position/positions/default.asp>. ★

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