INSTITUTE FOR QUALITY, SAFETY & INJURY PREVENTION

# ENA Topic Brief

### Key Information

- Factors that lower the quality of behavioral health care include lack of consistent guidelines, inadequate education and training of ED staff, a stressful and crowded ED environment, and a lack of in-patient and outpatient resources.
- Training in de-escalation techniques is essential for recognition, avoidance, prevention, or mitigation of aggressive and violent behavior in agitated patients.
- The role of an advance practice psychiatric emergency nurse in the care of behavioral health patients is cited as a positive influence on quality of patient care and staff satisfaction.
- Prolonged lengths of stay have been shown to have detrimental effects on behavioral health patients, particularly those from the most vulnerable populations (pediatric, active psychosis).
- The lack of a common language to describe behavioral health symptoms, assessments, and findings contributes to inconsistency in treatment and disposition recommendations, including increased lengths of stay.
- Further research is needed to identify and improve triage prioritization tools for patients with behavioral health emergencies.

# Care of Behavioral Health Patients in the Emergency Department

## Purpose

Emergency department (ED) care providers are challenged daily with caring for behavioral health (BH) patients across the lifespan. In 2010, The Agency for Healthcare Research and Quality (AHRQ) reported that mental disorders and/or substance abuse accounted for one out of every eight ED visits in the United States. In 2013, the Emergency Nurses Association (ENA) published a white paper authored by Anne Manton, PhD, APRN, FAEN, FAAN, entitled *Care of the Psychiatric Patient in the Emergency Department*[1] that identified best practices and gaps in the care of the behavioral health patient in the ED. The purpose of this topic brief is to summarize the findings of that ENA white paper.

## Overview

The term behavioral health (BH) encompasses various conditions characterized by impairment of an individual's normal cognitive, emotional, or behavioral functioning. Impairments include those caused by misuse and abuse of legal and illegal substances (e.g., alcohol, illegal drugs, inhalants, prescription narcotics, tobacco) and/or mental health conditions resulting from social, psychological, biochemical, genetic, or other factors such as infection or head trauma.

Caregivers across all levels of emergency care have described experiencing varying degrees of discomfort in caring for behavioral health patients. Contributing factors include inadequate educational preparation, lack of confidence in their expertise, shortage of services and treatment options (e.g., inpatient beds), ED crowding and boarding of patients, and lack of clear guidelines for the care of the BH patient.[2–5]

The above-noted ENA white paper presents a review of current research literature and summarizes the findings into the following categories:

- Staff and patient attitudes and concerns
- Triage of psychiatric patients in the ED
- ED management of psychiatric patients
    - Medical clearance
    - Safety concerns related to violence, agitation, and restraints
    - Ongoing care and assessments
    - Length of stay (LOS)

- o Disposition, hand off and follow up care
- o Pediatric and adolescent emergency patients

The white paper concludes by summarizing its findings and practice and research recommendations.

## *Staff and Patient Attitudes*

In addition to gaps in educational preparation for the care of BH patients, other identified variables include the stigma associated with behavioral health issues, negative staff attitudes toward this population, lack of definitive, evidence-based practice guidelines, and the widespread lack of hospital and community resources for BH patients.

## *Triage of Psychiatric Patients in the Emergency Department*

A variety of assessment scales exist for the triage of patients presenting to the ED. Although the ESI scale (Emergency Severity Index, Version 4)[6] allows the emergency nurse to triage most ED patients appropriately, it does not fully address nuances in the symptoms of patients presenting with BH issues. In addition to ESI, other triage systems have been developed but not validated for use in EDs. No comparative studies of these tools have been conducted. Acuity systems specific to the triage of patients with mental health issues have been developed in both Canada and Australia.[7–8] Although screening and triage tools have been developed for the specific assessment of suicide risk,[9] there is currently no externally validated suicide assessment or risk stratification method for use during the patient's ED visit; nor are there evidence-based tools to assess ongoing risk and safety for the broader scope of behavioral health presentations to the ED (e.g. psychosis, agitation, mania, etc.).[10] Safe discharge of BH patients poses an additional risk as no reliable tools exist to make this determination.

## *Emergency Department Management of Psychiatric Patients*

Issues related to the actual emergency care provided to BH patients were divided into the following categories:

- Medical clearance
- Safety concerns related to violence, agitation, and restraints
- Ongoing care and assessments
- Length of stay
- Disposition, hand off, and follow up care

### *Medical Clearance*

It is essential to rule out medical etiologies as causes for acute psychiatric symptoms. In 2009, the American College of Emergency Physicians defined guidelines for medical clearance for BH patients. Now widely accepted by the emergency medicine community, the guidelines state that "*within reasonable certainty, there is no known contributory cause for the patient's presenting psychiatric complaints that requires acute intervention in a medical setting.*" [11]

### *Safety Concerns in Care of BH Patients: Violence/Agitation/Restraints*

Alcohol intoxication, drugs, and psychiatric diagnoses are contributory factors in violence against emergency nurses. Verbal de-escalation facilitates a positive clinician-patient relationship, decreases the necessity for

hospital admission and use of more restrictive measures (e.g., medications, restraints, seclusion), and prevents longer hospital stays.[12-13] The Centers for Medicare and Medicaid Services (CMS) provides clear guidelines for the use of alternative methods (e.g., de-escalation techniques) prior to the use of restraints and seclusion.[14]

### *Ongoing Care after Triage*

The role of a dedicated psychiatric emergency nurse is consistently cited as a positive influence, improving both patient care and staff satisfaction. This specialist is able to provide direct, timely assessment and care of the BH patient as well as ongoing support and education for the emergency nursing and other ED staff.

### *Length of Stay*

Crowding is a critical issue with BH patients, and several studies have documented longer lengths of stay for these patients compared with those being treated in the ED for medical issues.[15-17] The lack of both outpatient and inpatient resources (availability of specialty consultants, need for ongoing patient evaluation, inconsistency in provider decisions regarding disposition, shortage of services, long waits for treatment) can have potentially deleterious effects on this population, particularly the most vulnerable patients (e.g., children, patients with active psychosis or dementia). Various models of care have been proposed to help address ED crowding and LOS issues, including investigating the feasibility of transferring drug- or psychologically-impaired patients to holding units outside of the ED.

### *Hand-off, Disposition, and Follow-up Care*

In the case of the BH patient, accurate hand-off is essential. Communication between ED providers and other caregivers, particularly primary and psychiatric care providers, has been shown to be inadequate.[18] The lack of a common language to describe behavioral health symptoms, assessments, and findings may lead to inconsistencies between providers caring for this patient population. Data and assessments may be interpreted differently from provider-to-provider, resulting in differences in treatment as well as disposition recommendations.[19] It has been suggested that, with additional specialty education, ED providers would be able to make appropriate discharge dispositions for these patients, thus shortening overall lengths of stay.

### *Pediatric and Adolescent Psychiatric Emergency Patients*

Studies have indicated that behavioral health issues in children and adolescents are frequently not identified or thoroughly addressed. In 2007, the Institute of Medicine noted inadequacies in the evaluation of children presenting to the ED with mental health issues. Reasons for this inadequate assessment and subsequent care included lack of education and training of ED staff, a stressful ED environment, lack of inpatient resources (beds), and lack of best practice guidelines.

## *Conclusion*

Behavioral health patients pose a challenge to emergency nurses. Inadequate educational preparation and skills, lack of clinical care guidelines, and lack of validated assessment tools are but a few of the obstacles to providing consistent, safe, and effective care to this patient population. The ENA white paper, *Care of the Psychiatric Patient in*

*the Emergency Department*[1], offers many insights into opportunities for research and the development of improved assessment and practice guidelines. The complete version is available in the research section of ENA's website.

## *Definitions of Terms*

| Term | Definition |
|---|---|
| **Behavioral Health (BH) Patient:** | Behavioral health patients may present with a wide range of conditions that affect mood, thinking and behavior. Normal cognitive, emotional and/or behavioral functioning is impaired. Examples include depression, anxiety disorders, eating disorders, and addictive behaviors due to misuse/abuse of legal and illegal substances. |
| **De-escalation:** | A set of specific skills that consists of teachable, non-coercive techniques (e.g., concise verbal communication, active listening, calm demeanor) that clinicians use to help agitated patients manage emotions and distress, and maintain or regain control of their behaviors. |
| **Emergency Severity Index (ESI):** | The Emergency Severity Index is a five-level emergency department triage algorithm that provides clinically relevant stratification of patients into groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. |
| **Stigma:** | A sign of disgrace or discredit, which sets a person apart from others and can lead to discrimination by individuals, institutions, or society at large. |

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