

EFFECT OF CONCENTRATED PSYCHIATRIC EDUCATION ON PERCEIVED COMPETENCE TO CARE FOR BEHAVIORAL HEALTH PATIENTS

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Introduction: Increasing numbers of behavioral patients are presenting to emergency departments, where competency of staff to care for this group is unknown.

Methods: This pre-post study measured the effects of a 7-hour conference on perceived competency of nurses and allied health professionals to care for behavioral health (BH) patients, as measured by the 23-item Behavioral Health Care Competency (BHCC) survey.

Results: Of 102 participants, most were emergency nurses (72%), acute care nurses and case managers (20%), and allied health personnel (trauma technicians and paramedics) (8%). Before the conference, participants had moderate average perceived competency in caring for BH patients. BHCC scores differed significantly by job category, with emergency nurses scoring higher than did nonemergency nurses and allied health personnel. Overall competence of participants increased

significantly after the conference. The effect size, as reflected by partial eta squared, was 0.265. Significant increases in scores from before to after the conference occurred for the total BHCC and 2 competencies: practice/intervention and resource adequacy.

Discussion: This study provides needed research demonstrating improved perceived competency of nurses and allied health professionals to care for BH patients in emergency departments after brief concentrated education. Improvements occurred despite the fact that participants had initial baseline competencies that were higher than those of general hospital nurses from a historical sample.

Key words: Emergency nursing; Psychiatric patients; Staff education; Behavioral health care competency; Conference

Contribution to Emergency Nursing Practice

This study documented that concentrated psychiatric education can improve perceived competency of nurses and allied health professionals to care for BH patients in EDs.

- Essential competencies to care for BH patients can be improved in emergency nurses with education; specifically, as little as 7-hours of education.

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- Emergency departments can use the BHCC survey as a needs assessment with content developed to address identified staff competency deficits.

Behavioral health (BH) disorders, which include psychiatric complaints and substance abuse, affect 22.5% of persons in the United States.¹ With the advent of newer atypical antipsychotic medications and treatment changes, many persons who previously might have been cared for in long-term psychiatric facilities are now living in the community. Persons living with mental illness may experience severe symptoms that necessitate ED visits. Emergency departments have seen an increase in BH patient volume, with 1 in 8 ED patient visits for BH diagnoses.^{2,3} This increase has had an impact on safety, patient throughput, and staff satisfaction. Medically based complaints among ED BH patients add complexity to care delivery because of probable late presentation, chronic under management, and resulting increases in acuity.^{4–6}

Effects of ED Context

Emergency departments are experiencing overcrowding, decreases in bed turnover, and losses of revenue.⁷ Further complicating this situation is the presence of BH patients, who are routinely boarded in emergency departments because of difficulty in arranging transfer to inpatient units or community sites. Reported lengths of ED stays for BH patients range from 18 to 24 hours,⁸ with average boarding costs estimated at \$2264/stay.^{7,9} Adding to costs incurred by ED boarding are the use of security personnel and sitters.⁷

For BH patients, prolonged ED lengths of stay could increase the likelihood of symptom exacerbation, elopement, and restraint usage.⁹ A single restraint episode can add 4 to 6 hours to an ED stay.⁷ Disruptive behaviors displayed by BH patients could negatively affect their treatment. Additionally, one patient's agitation might incite disruptive behaviors in other BH patients; in addition, medical/trauma patients or visitors in close proximity to disorderly BH patients may experience distress or fear, and patients could experience disruption in treatment. These factors can lead to declines in patient satisfaction scores.¹⁰

Effects of BH Patients on Emergency Departments

The ED environment is not ideal for BH patients. Traditional emergency departments have been constructed to provide care for medical/trauma patients, not for the unique needs of BH patients. Putting BH patients on gurneys or in beds in examination rooms might be problematic because these patients may have difficulty lying still, especially for prolonged periods. Restricting movement could lead to anxiety and ultimately agitation, contributing to an increased risk for violence.¹¹ Severe agitation and the potential to harm themselves or others might lead to use of restraints. Further, staff inattention and reduced vigilance could lead to increased episodes of violence requiring use of restraint.¹²

Staff attitudes might come across as demeaning and judgmental, thereby increasing the stigma sometimes experienced by BH patients.^{8,13} The environmental isolation, restrictions, coercion, or use of force by staff⁶ could lead to agitation or acting out.¹⁴ Some reports indicate inequitable care related partly to staff perceptions that BH patients are "less ill" and less deserving of care than are medical patients.^{8,15,16}

Effects of BH Patients on Emergency Nurses and Staff

Patient agitation and violence can contribute to workforce disruption, staff injuries, and decreased staff morale and

satisfaction.^{17,18} Particular behaviors (eg, agitation, yelling, and spitting) contribute to negative perceptions of BH patients and resulting staff unwillingness to care for these patients.⁸ Within the hospital, ED staff is at the greatest risk for violence from patients.^{19,20} Despite evidence to the contrary, emergency nurses often perceive BH patients as those most responsible for perpetrating violence, thus adding to their fears.^{21,22}

Most patients seeking emergency care accept the care offered to them. However, some BH patients seen in emergency departments might not have sought care or may have been brought in against their will. Other BH patients seen in the emergency department may not disclose a chief complaint associated with a psychiatric or substance abuse disorder.²³ These patients may be unwilling to accept care or to participate in care, thus creating moral distress for nurses.²¹

Lack of Preparation Among ED Nurses

Nursing schools provide limited education and clinical experiences in managing acutely ill BH patients. Practicing nurses report varying perceptions of competency in caring for BH patients.²⁴ Among 844 nonpsychiatric nurses from one health system who completed the Behavioral Health Care Competency (BHCC) instrument, emergency nurses had the highest perceived competence in providing care to BH patients.²⁵ However, their average scores on care provision (3.66/5; 1 = strongly disagree, 5 = strongly agree) and recommendation of psychotropic medications (3.39/5) competencies showed room for improvement. No evidence was found showing the impact of focused education on ED staff perceived competence to provide care to this population.

Research Questions

This study focused on the effects of a 7-hour concentrated education experience on perceived competency of nurses and other allied health professionals to care for BH patients. Two research questions were examined.

1. Does the perceived competence of nurses and allied health professionals to care for BH patients improve after concentrated psychiatric education?
2. For nurse participants before the conference, what associations existed between perceived competencies to care for BH patients and initial nursing education, years in nursing and emergency nursing, time since their last Management of Assaultive Behavior (MAB) class, prior experience in psychiatric nursing, and the psychiatric

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