

**CARING FOR PEOPLE WITH MENTAL HEALTH PROBLEMS WHO
PRESENT AT THE EMERGENCY DEPARTMENT: A NURSE
EDUCATOR'S JOURNEY**

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ABSTRACT

The New Zealand Emergency Department (ED) nurse is faced daily with the challenge of caring for patients of all ages with a wide variety of presenting complaints. Courses are available for ED specialty work such as trauma and paediatric assessment. However, as this thesis argues, it is difficult to access updated and ongoing education in relation to caring for people with mental health problems who present to the Emergency Department. In addition to this education deficit are the challenges of providing care in an overcrowded ED environment. Such factors contribute to a perceived lack of confidence and sometimes ambivalence or frustration on the part of nursing staff in caring for this group. This may result in an inconsistent standard of care for the the person with a mental health problem unless such issues are addressed.

The aim of this research paper was to explore the education needs of ED nurses when caring for people with mental health problems. A literature review was undertaken to investigate the broad education strategies available to overcome these challenges. Diverse approaches were identified such as workshops, clinical guidelines, and mental health consultation-liaison roles. Research was also identified that examined ED nursing attitudes and their learning needs in relation to mental health.

This paper concludes with a discussion of recommendations for the New Zealand setting with the intention of developing a more confident and competent nursing workforce, who are better prepared to care for the person with a mental health problem.

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SECTION ONE

Introduction to the research inquiry

Introduction

This thesis argues that the person with a mental health¹ problem presenting at the Emergency Department (ED) will receive an inconsistent standard of care until nurses and other ED staff are given effective training and resources. The theme of consistency is emphasised as I see many examples of confident and excellent care being delivered to this group of people. However, as a nurse educator in the ED setting, I am aware of the lack of education opportunities about mental health in comparison to other topics. This education deficit can lead to a lack of confidence on the part of the ED nurse assessing and managing people with mental health problems.

Compounding this lack of education are resource constraints that ED nurses face, such as overcrowding, which is recognised internationally as the most significant problem facing EDs over the past decade. All patients are directly affected as they wait longer for triage, and nursing assessment and management is reduced in frequency or delayed (Ardagh & Richardson, 2004). This problem has been renamed from emergency to hospital overcrowding as it reflects system problems throughout the organisation (Howard, 2005).

In addition to the influences of hospital overcrowding and education deficits, there are the unique features that characterise working in the ED that may impact on the care a person with a mental health problem receives. Wears, Croskerry, Shapiro, Beach, and Perry (2002) describe these features which include the lack of control over the influx of patients and the complete variation of presentations. This 'ED culture' with its frequent interruptions, rapid interventions, and focus on physical

¹ The World Health Organisation defines mental health as “a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (Mental Health Foundation of New Zealand, 2005, p.1).

illness and injury appears incompatible with what is required for the person with a mental health problem. In contrast, this group often has “complex mental, medical, and social needs” that require time for discussion (McArthur & Montgomery, 2004, p. 488). Waiting in such a crowded and noisy environment for assessment may add to the distress of the person with a mental health problem. For ED staff, while attempting to build rapport with this person, may find it disrupted by the sudden request to “escort your patient in Cubicle 3 to radiology *now*”.

It is this challenging emergency setting that I have worked in as a staff nurse and as a nurse educator for the past eight years. As a registered general and obstetric nurse who graduated twenty one years ago , I have minimal pre registration and no postgraduate mental health experience. During this time I have developed my mental health knowledge and skills in a somewhat haphazard manner. As a result I have lacked the confidence to speak with any authority or teach about this group. This creates an over reliance on busy mental health emergency teams and senior ED medical staff to provide education. Every year I start with the fresh objective to create effective ongoing mental health education for staff, however, every year there seems to be other unexpected priorities. This thesis gives me the opportunity to explore this objective rather than let it slip down my list of “things to do”.

The first aim of this paper is to identify and discuss the challenges of providing effective mental health education to ED nurses within the constraints of the current ED environment. The second aim is to explore education options used as a way of finding possible solutions. Critiquing the interface between mental health policy and practice in the ED is the third aim, with fictionalised scenarios included to illustrate this interface. Whelan (2003) argues that the failure in ED to adequately assess people with a mental health problem “is a missed opportunity to positively affect the quality of life for both them and their families” (p. 91). Therefore the final aim is to present recommendations designed to improve the quality of care the person with a mental health problem receives in the emergency setting.

The inclusion of practice stories

From my literature review it was apparent that the British and Australian perspective on mental health education for ED nurses was well researched and published. Because the New Zealand perspective was missing in the literature, I have included vignettes based on my personal practice. These are used to illustrate the influences on my role as a clinician and a nurse educator in relation to mental health. The vignettes have been fictionalised to ensure patient confidentiality. Their use relates to the role of narrative as outlined by Benner, Tanner and Chesla (1996). As opposed to objective accounts of case studies or conditions in textbooks, narrative stories allow the writer to include the emotions and contextual factors that influenced their decision making. Stories potentially help to bridge the gap between what is described as ideal in education models such as clinical guidelines with the realities of the individual workplace.

My professional experience and background to this thesis

This section commences with one fictionalised vignette from my professional practice.

Late one night I assessed a man who was a “frequent attender”² who had taken an anti-depressant drug overdose. I can remember the response I received when I attempted to bring this patient from the waiting room in to the treatment area. An experienced ED nurse stopped me and declared that the patient could wait because “he was always here attention seeking”. Following this statement she turned away from me. There was no room for negotiation. I felt very uncomfortable because the man was sleepy, and so I monitored his level of consciousness and heart rate frequently. I was also stunned that a colleague could feel so frustrated towards this person. Then I felt annoyed with myself that I didn’t feel strong enough to challenge the situation, or how to articulate to my colleague about why I was concerned.

² A frequent attender has a pattern of multiple attendances at the ED. Their presenting problems are inclined to be complex “including physical and psychiatric illness, cognitive impairment, psychosocial difficulties, and alcohol and substance abuse” (Royal College of Psychiatrists., & British Association for Accident and Emergency Medicine, 2004, p. 48).

Finally, the situation was resolved unexpectedly by the appearance of the medical registrar who had been expecting this man. He reprimanded me for leaving such a patient in the waiting room and gave me a concise and curt lecture on the risks to the patient of this specific drug overdose. The patient was rapidly transferred to a room for assessment. I recall the sense of relief that the man was being taken seriously, yet frustrated at the injustice that I had been perceived by this registrar as having inadequate knowledge.

As an experienced ED nurse, when I recall this story I can now reflect on the environmental factors that contributed to such a response. At that stage there was no training about how to deal with people with mental health problems. Consequently I didn't ask the patient about suicide because no one had taught me how to do this as part of the assessment. No poisons database was available to access drug overdose information via the computer as occurs today. Case management plans for frequent attenders were not in existence, but are now routine. The nursing structure consisted of one charge nurse, thus he/she was not available after hours to discuss the above dilemma when it occurred. There were no ED consultants available for support. Thus the knowledge and resources were not there to manage the patient effectively, and I felt at a loss to confidently challenge the experienced ED nurse.

Coupled with this poor knowledge and lack of resources, the ED physical environment was very old and cramped at that time. I recall that the interview room used by the mental health emergency team was situated in a windowless cupboard that had holes in the wall.

While the environment and resources were problematic, the focus of the NZ Ministry of Health (MOH) policy at this time was primarily related to trauma, medical and surgical emergency management within the ED setting. Although mental health was mentioned, it was noted that it was not a primary focus of this policy. It was the expectation that "psychiatric triage can be achieved through the use of psychiatric liaison services and the development of common standards and protocols" (MOH, 1999, p. 11).

As a result of this MOH focus, a postgraduate certificate in clinical nursing (trauma and emergency³) was developed. I became the ED clinical nurse educator and embarked on a new journey. New technologies were being introduced such as non-invasive ventilation⁴. These technologies are mentioned because they signalled a change in direction for EDs to high acuity patient care that was traditionally the domain of intensive care units. What has this to do with mental health? The organization and maintenance of such technology has been delegated to nursing staff, along with provision of training in its use. As a result significant time is spent on such activities, creating “a challenge when nurses feel that the technical demands of their job seem to override the simple care that their patients may need” (Knaggs, 2003, p.1). This serves as a consistent distraction from building a mental health education strategy for staff.

As part of the postgraduate certificate curriculum I invited guest speakers such as the mental health emergency team and ED medical consultants. All were valuable, but had time constraints. Apart from lectures at university the participants on this postgraduate certificate had local tutorials where mental health speakers could be accessed at times, but once again this was subject to availability. These tutorials also revealed the participants experiences in working with people with mental health problems. These reactions centred around areas of concern such as communication skills, medicolegal issues and the management of complex presentations. It became evident to me as the programme facilitator that the occasional speaker was not enough to meet their needs.

Mental health education had already commenced for the ED nursing staff including triage and general principles of management, a session running approximately two hours with the very supportive mental health emergency team. Triage is a senior

³ This certificate contributes towards a masters level qualification. It is funded by the Clinical Training Agency, and is available for nurses who work in publicly funded EDs.

⁴ Noninvasive ventilation is the delivery of ventilatory support to a patient who is spontaneously breathing without endotracheal intubation (Hotchkiss & Marini, 1998).

nursing role in the ED, and is defined as the purpose of ensuring “patients are treated in the order of their clinical urgency ...It also allows for allocation of the patient to the most appropriate assessment and treatment area” (ACEM, 2000, p. 1). National triage standards for mental health were revised by the Australasian College of Emergency Medicine⁵ (ACEM) document (ACEM, 2000). With the move to a new purpose built ED, separate interview rooms were allocated for people with mental health problems away from the hustle and bustle of the main treatment area. All these steps felt such a major improvement for both staff and patients.

As part of my educator role, I also became involved in the revision and redesign of the national triage course over a two year timeframe. This course is facilitated by the College of Emergency Nurses New Zealand⁶, and is available to ED nurses nationally. This review coincided with the release of a NZ Ministry of Health guideline focusing on the assessment and management of people at risk of suicide in the emergency department setting (NZ Guidelines Group[NZGG] & Ministry of Health, 2003). The guideline included a mental health triage code framework. The implementation of this framework created some debate among ED nurses which will be discussed in section three.

Attempting to research an emergency nursing perspective in relation to mental health was difficult in the redesign of this course as emergency nursing textbooks and journals had limited information regarding mental health emergencies. There was

⁵ ACEM is an educational institution with a primary aim of the education and examination of emergency physicians within Australasia. Its other aims include ED accreditation, policies and standards, research, publishing and “those aspects of the medico political framework that have a direct impact on health outcomes for emergency patients” (ACEM, 1999, p.1)

⁶ The College of Emergency Nurses NZ has aims that include professional development activities, the development of nursing standards, and “expert nursing knowledge and advice at Government and Ministry level” (New Zealand Nurses Organisation, 2005, p.1).

also no published literature related to the use of section 111⁷ of the NZ 1992 Mental Health (Compulsory Assessment and Treatment) Act (MHCAT) from an ED nursing perspective. Liaison with mental health colleagues was very valuable during this time, leading to a better understanding of how to use the MHCAT in the emergency department setting. I can remember wishing that I could have more of their time.

During my role with the national triage course redesign, I commenced a new position as an ED nurse educator in a different location. New technologies are being introduced that continue the trend towards more complex patient management in the emergency setting. The international trend of overcrowding exists with a ten percent increase in presentations over the past twelve months (D. Jones, personal communication, 1 September, 2005). I have a very supportive mental health emergency team to network with, but I can find it challenging to find time to catch up with them.

In partnership with the senior nursing and medical team, I am responsible for ensuring the 41 registered nurses have appropriate learning support⁸ and training opportunities. Currently their mental health education consists of triage principles, and they have access to reading the document entitled *Assessment and Management of People at risk of Suicide* (NZGG & MOH, 2003). Approximately three nurses attend the postgraduate certificate in clinical nursing (trauma and emergency) each year which will have some mental health component in the curriculum. Apart from these resources, there is no other formalised mental health education.

⁷ Section 111 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 enables a nurse “to detain, for the purpose of an assessment examination, a person who has been admitted to hospital (or who has been brought to a hospital) who is believed to be mentally disordered. This detention cannot be for more than six hours from the time the nurse first calls for a medical practitioner to examine the person (section 111(3))” (Ministry of Health, 2000, p.49).

⁸ Learning support includes the concepts of preceptorship, mentorship and clinical supervision (Morton-Cooper & Palmer, 2000).

Gaps such as the care of people with mental health problems in current postgraduate education are recognised by the College of Emergency Nurses NZ (CENNZ) (CENNZ, 2004). It has acknowledged that currently there are education deficits for ED nurses between entering the emergency nursing speciality, and accessing postgraduate tertiary education. A working party of ED nurses has been established by the CENNZ with the aim of developing a national education framework, and this continues to be work in progress.

Looking back at this journey, it is evident how much progress has been made since my experiences as a novice emergency nurse. There are now better working environments and more education. However, there are continuing challenges which face the ED nurse responding to the needs of the person with a mental health problem. Eight years later I still have experiences that expose my own knowledge deficits, as the following fictionalised vignette outlines.

I attended a meeting to discuss the role of restraint in the ED setting. During the course of discussion I asked innocently about where I would find information about chemical restraint in the local restraint guideline being discussed. The look of horror on peoples faces matched the sinking feeling in my stomach as it was explained to me that this was not an appropriate term to use any more. Feeling suitably embarrassed I returned to the ED to ask my colleagues whether they knew about this change in terminology. Some did know and some didn't. I looked up the literature on this theme to discover that this term has been redundant for several years.

When I recollect this experience, I feel a sense of frustration that once again the acquisition of relevant mental health knowledge was gained in a haphazard route. Emergency Department nurses and doctors can attend national courses on topics such as trauma management and paediatric emergencies, and thus recent changes or innovations filter back to the workplace. However, there is no such formal education available for mental health.

This concept of demonstrating ongoing competency is of critical importance for registered nurses as a legislated requirement under the Health Practitioners Competence Assurance Act 2003. This year the Nursing Council of New Zealand (NCNZ) released the revised document entitled *Competencies for the registered nurse scope of practice* which includes specific competencies that nurses engaged in education must demonstrate⁹ (NCNZ, 2005). If I am to achieve and maintain these education related competencies in the area of mental health, the following literature review will assist this goal.

Themes from worldwide literature

The literature review for this paper was sourced from New Zealand, Australia, United States of America (USA), Canada, and the United Kingdom. It revealed six broad themes related to emergency nursing and mental health. The first theme focuses on identified knowledge and skills deficits for ED nurses about mental health. The second theme relates to education strategies used internationally to improve ED nurses competence. Potential solutions are diverse, including workshops, training manuals, and internet resources. The publication of guidelines for ED health professionals caring for people with mental health problems is the third theme. Mental health triage frameworks as a type of guideline are the fourth theme. The fifth theme identifies mental health consultation/ liaison nursing as a potential solution to ED challenges. Finally, the sixth theme of ED health professional attitudes was recurrent throughout the areas of writing mentioned above.

⁹ “Promotes an environment that contributes to ongoing demonstration and evaluation of competencies

Integrates evidence – based theory and best practice into education activities

Participates in professional activities to keep abreast of current trends and issues in nursing” (NCNZ, 2005,p.8).

Overview of sections

There are five sections in this thesis. Section one has outlined the source of my interest regarding the challenges of providing effective care to the patient with a mental health problem in the ED. This has been achieved by recollections of my personal journey as both a staff nurse and a nurse educator in this setting. The aims of the thesis and the literature themes have also been presented.

Section two has examined the concept of competence in relation to mental health in the ED setting. A literature review highlighted two main themes. The first theme is negative attitudes towards the person with a mental health problem, how these manifest, what their potential causes are, and an examination of strategies that are available to address these. The second theme explores identified training deficits in ED, and also looks at strategies for possible solutions.

The third section has presented an overview of the guidelines available for EDs in relation to assessment and management of the person with a mental health problem. The main themes discussed are the mental health triage code frameworks used in NZ, followed by a brief discussion about other common themes that arise such as clinical supervision. It also presents a summary of various strategies used to provide clinical supervision for non mental health trained staff in the emergency setting.

Section four focuses on the role of mental health consultation liaison services within the ED setting. Finally an argument for supporting education costs in the healthcare system have been discussed.

Section five draws the thesis to a close by outlining conclusions. Recommendations have been presented as a plan to providing ED nurses with the appropriate training and resources for care of the person with a mental health problem in the emergency setting. A short reflection on my experiences of writing this thesis is also included.