Australasian Emergency Nursing Journal (2015) 18, 138—148

Available online at www.sciencedirect.com

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journal homepage: www.elsevier.com/locate/aenj

RESEARCH PAPER

US emergency nurses' perceptions of challenges and facilitators in the management of behavioural health patients in the emergency department: A mixed-methods study

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Received 3 October 2014; received in revised form 25 March 2015; accepted 25 March 2015

KEYWORDS
Behavioural health;
Nursing care;
Lengths of stay;
Emergency service;
Attitude;
Crowding

Summary
Background: Behavioural health patients often have longer lengths of stay in the emergency department compared with general medical patients, and their modalities of care are not well documented. This study's purpose is to describe US emergency nurses' estimates of lengths of stay for behavioural health patients, explore factors affecting length of stay, and assess nurses' perceptions of their skills, beliefs/attitudes, and confidence in caring for this population.
Methods: Using a mixed-methods design with demographically-diverse samples of emergency nurses, survey data ($N = 1229$) were analysed using descriptive statistics, correlation coefficients, and linear regression. Focus group participant data ($N = 20$) were analysed for themes using constant comparison.
Results: Findings suggest that shorter lengths of stay are associated with higher levels of perceived nursing confidence/preparation to care for this population, along with the availability of appropriate resources and protocols/standards of care ($p = 0.01$). Longer lengths of stay are associated with an absence of dedicated inpatient space for managing the care of these patients.
Conclusions: Participants note a lack of education, resources, and treatment options tailored to the delivery of safe, effective care for behavioural health patients. The use of trained specialists

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http://dx.doi.org/10.1016/j.aenj.2015.03.004

and additional guidelines/protocols may help move patients through the emergency department faster and with greater surety.

What is known?

- Behavioural health patients often have longer length of stays in the emergency department compared to general medical patients.
- Increased lengths of stay have been associated with delays in care.
- The lengths of stay and modalities of care are not well-described.

What this paper adds?

- The identification of an estimated, average length of stay in the emergency department of 18.5 h (median = 10.0 h) suggests a dearth of resources available to both behavioural health patients and the emergency providers who care for them.
- Specifically, emergency nurses voice frustration with the lack of tailored education, resources, and treatment options.
- The presence of a trained behavioural health nurse appears to be associated with a shortened estimated, average length of stay; emergency nurses might benefit from advanced training in behavioural health care.
- Both survey and focus group findings suggest that additional practice guidelines and protocols may improve feelings of competence and confidence, and again, potentially move patients through the assessment and disposition process with more surety.

Introduction

In the United States (US), the term behavioural health (BH) is used to encompass various conditions characterised by impairment of an individual's normal cognitive, emotional, or behavioural functioning. This includes impairment 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. Thus, the spectrum of BH care includes comprehensive services that encompass preventive, diagnostic and treatment options for patients with BH conditions.[1] This population accounts for approximately 12.5 per cent of all US emergency department (ED) visits and these visits are two and a half times more likely to result in a hospital admission.[2] Yet, numerous studies have suggested that ED healthcare providers do not feel prepared to care for patients with BH issues (BHPs) and have posited the following aetiologies for this phenomenon: societal attitudes and personal biases, inadequate educational preparation, organisational climate, safety concerns on the part of emergency nurses and other ED staff, ED crowding, insufficient hospital and community resources, healthcare provider lack of confidence in skills and/or negative attitudes towards patients with BH issues, and lack of treatment guidelines.[3–16]

The American College of Emergency Physicians (ACEP) and others suggest that an extended length of stay (LOS) for BHPs is a significant contributor to ED crowding (from initial triage to leaving the ED).[17–20] Several studies have reported increased LOS for emergency patients with BH complaints compared with those with medical problems.[21–25] Weiss et al. suggest that the average length of stay (ALOS) of BHPs in US EDs is 11.5 h, significantly longer than the 4 h and 7 min for general ED patients as reported by a national company focused on healthcare performance improvement.[26,27] Weiss and colleagues found that the greatest influence on LOS was boarding (a ''boarded patient'' is defined as a patient who remains in the ED after a decision to admit has been made, but the patient has not yet been transferred to either an inpatient unit or offsite facility).[28] The effects of the longer stays on individual patient outcomes are unclear; but there is evidence that boarding of BHPs can contribute to delays in care and disposition of all emergency patients.[17–27,29,30]

The purpose of this study is to describe US emergency nurses' perceptions of the current state of emergency care for the BHP and to report identified facilitators and challenges. We address the following questions:

1. What types of care models, including providers and protocols, are being used in EDs in the U.S.?
2. What is the estimated ALOS for BHPs in the ED?
3. Is there a relationship between the presence of a psychiatric provider (i.e. Medical Doctor [MD], Doctor of Osteopathy [DO], Licensed Independent Clinical Social Worker [LICSW], or Advance Practice Registered Nurse [APRN]) in the ED and the estimated ALOS for BHPs?
4. Does the presence or absence of resources (dedicated BH staff and space for delivery of care to BHPs in the ED; availability of treatment services in the hospital and community) affect estimated ALOS?
5. Is there a relationship between the education and/or experience of the nurse and the estimated ALOS for BHPs in the ED?
6. How do emergency nurses identify the challenges and facilitators to effective, safe care of BHPs in the ED?

Methods

We conducted an exploratory mixed-methods study incorporating a self-report survey and focus group interviews for