Letters to the Editor

that these cause. It may mean getting someone in the facility to train the ED staff on behavioral disorders, signs and symptoms, and interventions that are evidence based. There are myriad ways to minimize conflicts in any health care setting, the first being in the “client’s corner,” listening, empathizing, and being consistent and trustworthy in your responses.

3. The use of restraint to contain individuals with mental conditions in EDs when they try to leave that setting. Your third issue is easier. First and foremost, the above interventions must be put in place, as the use of restraint should be viewed as a safety measure of last resort only in the event of imminent danger to self or others. That is the federal law that governs restraint use.

However, if a patient is court-ordered or involuntarily committed to the ED until being transferred to an inpatient bed, the hospital will most likely be liable if the patient leaves. You should ask for a legal opinion on this from the Protection and Advocacy staff in North Carolina. If you or the other staff have done everything you can think of to meet the individual’s needs and have documented this carefully and the patient still tries to leave, you may need to contain the patient. Most of the time, most EDs have security or police presence, and this responsibility does not fall on ED nursing staff. If you do not have these security staff present then you will need to potentially restrain someone. What needs to occur, if this does happen, is that you or your peers will need to immediately try to find out why the person is leaving and if you can relieve his or her distress by simply meeting the patient’s needs, whatever those are. If you need to use restraint, then this intervention must be used as a practice that follows the federal Centers for Medicare & Medicaid Services (2006) and Joint Commission (2009) standards, if relevant. These are clearly described by both of these agencies, and if you need training on this, you need to at least ask for this training in writing.

Finally, I would also suggest reviewing Susan Stefan’s (2006) book, Emergency Department of the Psychiatric Patient: Policy Issues and Legal Requirements. Thanks for writing. The issue you face is probably shared by many of your colleagues in other states and counties across the country.

REFERENCES


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The author discloses consultant work regarding seclusion and restraint with the following organizations: Caldwell Associates, Canada National Health Service, Finland National Health Service, Massachusetts Department of Mental Health, Substance Abuse and Mental Health Services Administration (SAMHSA), and National Association of State Mental Health Program Directors (NASMHPD); employment at the Delaware division of SAMHSA; grant funding from SAMHSA and NASMHPD; and serving on the speakers bureau for the National Council for Community Behavioral Healthcare.

BELIEVING IN THE BASICS

To the Editor:

I read with great interest the guest editorial entitled “Psychiatric Nursing: Back to Basics” in the December 2011 issue of JPN (Cullen-Drill & Prendergast, 2011). The editorial indicated it is imperative that psychiatric nurses do not limit their role—as psychiatrists have found themselves doing—to primarily medicating patients, and that the nursing profession needs to initiate steps to prevent this from occurring.

One approach I found helpful in my practice to keep in touch with a “holistic” approach to caring is to support best-practice interventions involving each individual with a psychiatric diagnosis by thinking of the following four areas: medication options, treatment/rehabilitation interventions, family education and support, and client self-care skills/abilities.

Psychiatric nurses need to be conscious that our society is almost exclusively being convinced by big Pharma that for “every ill there is a pill” to a point that citizens are now being referred to as “Generation Rx.” We as RNs should not resort to being reduced to “pill pushers.”

REFERENCE


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