Letters to the Editor

RN SEeks Advice for Psychiatric Patients in EDs
To the Editor:

I am a licensed RN who works in an emergency department (ED) in North Carolina. I have been there several years, and surely like most other EDs in North Carolina, we keep psychiatric patients for long periods of time in our department awaiting placement to a mental facility, sometimes for weeks without any security outside their doors. The staff there are frequently called on to pursue fleeing psychiatric patients and sometimes get into physical altercations to ensure they do not escape. These patients are awaiting placement with custody orders.

My question is, having received no training in apprehension of these patients, do we as untrained staff have the legal authority or obligation to effect this type of restraint when security is not available (which is always the case)? Frankly, I get the vibes this is very big gray area that the hospital administration would rather avoid discussing and continue to leave us guessing. But I fear for my job and do not wish to be labeled a troublemaker for forcing the issue. But at the same time, I need to be able to see something in writing that justifies those actions should I ever end up in court for something related to this type of incident, so I will know with confidence I have not neglected my duty or overstpped my authority.

I believe this would be an interesting topic for an article, and thanks for any help in this matter.

Name withheld
North Carolina

The author has disclosed no potential conflicts of interest, financial or otherwise.

Response:

Thanks for writing. The Editor of JPN asked me to respond to you based on my experience with seclusion and restraint interventions with people with mental health conditions. You have identified several issues that are common to many other EDs, depending on the state or local service system, and I will attempt to address these by first listing these issues as follows:

1. People with mental conditions who are left in EDs for more than 24 hours. It seems, from your letter, that the primary issue here is the fact that people with mental conditions are just abandoned by the mental health system to be left in your ED. An ED is perhaps one of the most inappropriate, uncomfortable, stressful, and unsafe places for people with mental health issues, other than prison. I am sorry to hear that your local mental health agencies have not addressed this issue with some urgency. It is very poor care to leave people who need mental health treatment in EDs, not only because most EDs do not have credentialed mental health staff but also because they are not generally set up to manage these clients in a safe and respectful manner that meets their basic needs. Can you imagine having to live in an ED for more than a day, let alone a week? Any one of us would try to leave.

I would venture to note that it is close to neglect to leave such people in your ED for these long periods of time, as they will, of course, try to leave and will often require a lot of staff attention based on their illnesses. People with mental conditions are people first; they will know they are not welcome, and most will quickly realize that their basic needs are not being met in that environment (basic needs defined as safety, security, belonging, comfort, and quiet). As nurses, we all know these as facts.

This is a political and economic issue. I would strongly suggest that you contact the state Protection and Advocacy Division which is in Raleigh, and report this. They will keep your statement confidential, and they are funded to intervene on these kinds of system-wide practice and policy gaps. If you do not know how to do that, you should call the National Disability Rights Network in Washington, DC and ask to speak to the Director so you can get their North Carolina affiliate engaged. Again, it is completely unacceptable to leave people with mental conditions in an ED for more than 24 to 48 hours.

2. Challenges ED staff face when people with mental conditions are housed in their service area. Your second and third concerns are completely preventable if the state of North Carolina acts to put policy in place than disallows leaving individuals in EDs. However, since this is a reality for you, I will address these, starting with your second issue.

The first and most basic issue regarding people with mental health conditions is that, again, they are people first. They are not going to appreciate being confined in a small area or being ignored. They will not know how or whom to ask to get their basic needs met. An ED is a scary place for most people, and many with mental health conditions will have past experiences in EDs that were traumatizing. You can put in place a number of prevention-based interventions here if you and your colleagues want to. You can ask for one area of the ED to be used for clients with these illnesses. You can make that area safer by removing obvious environmental risk factors. You can request/demand a psychiatric nurse consultant to come in to assist you in setting up this area and revising your policies. You can make sure that every client who meets this definition knows whom and how to ask for help or to get his or her needs met, whether for food, the bathroom, or to use the telephone.

Prevention here means avoiding unmet needs and the resultant conflicts...
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 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 is the “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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