REGISTERED NURSES' EXPERIENCES OF CARE
FOR INDIVIDUALS WITH MENTAL HEALTH ISSUES
IN THE EMERGENCY DEPARTMENT

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Abstract

Purpose
The main purpose of this study was to explore ED nurses' experiences in caring for individuals with mental health concerns and their thoughts of what contributes to or inhibits their ability to care for this patient population.

Methodology
A qualitative study using a descriptive phenomenological tradition was guided by the following research questions:

a) What are the participants' experiences of the care that is provided to the individual experiencing mental health issues in the ED?

b) What are the participants’ descriptions of elements that contribute to or inhibit their ability to effectively care for individuals with mental health issues in the ED?

c) What are the participants’ educational experiences related to mental health issues?

d) What are the participants’ recommendations for the enhancement of mental health nursing care in the ED?

Conclusion
Nurses practicing in the ED stated they lack psychiatric knowledge related to theory, and skills in assessment and least restraint interventions which are often utilized when providing care to mental health patients in the ED. Mental health education at the undergraduate and practical level relevant for practice in non-psychiatric settings needs to be enhanced and supported at an organizational level. The use of control interventions such as restraints and seclusion pose
significant ethical issues for nurses. Interventions are often chosen based on the need to ensure the perceived safety for the patient and those within the ED and not necessarily on least restraint practices. Further barriers include a lack of time, role and responsibility confusion and a fast-paced environment that was not conducive to provide quality care for those with mental health issues. These factors detracted from care practices, and ED nurses thought their care did not meet the needs of the mental health patient. These findings will provide a platform for education and organizational efforts that support the ED nurse and optimize care of individuals with mental health issues seeking care in the ED.
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Chapter 1
INTRODUCTION

Statement of Problem

Emergency departments (ED) have changed dramatically over the past decades with increased demands on time, space, wait times, and accountability for staff. In Canada and internationally, the rising demands in Emergency Department services have become a concern to the health care delivery system (Crouch & Williams, 2006). Although care provided by nurses should address both psychiatric and physical acute health issues of the patient receiving care, emergency department staff have historically provided acute care in an environment that is primarily equipped to meet the needs of the medical patient (Crowley, 2000). Increasingly, ED nurses are caring for individuals with mental health issues and the expansion of health care practice must now incorporate psychiatric care. Canadian statistics related to mental health presentations to ED's is limited but it has been reported to range from 5-10% (Clarke, Brown, Hughes, & Motluk, 2006; Kerrison & Chapman, 2007) and these rates have the potential to increase. In fact, psychiatric emergency visits in the United States have increased from 5.4% of all visits in 2000 to 12.5% in 2007 (Chang et al., 2011).

A significant shift in the delivery of mental health care has occurred since the de-institutionalization of mental health services. With the trend in transitioning individuals with psychiatric health issues being shifted out of institutionalized care and into more community settings, there has been an increased focus on the use of community treatment options. The ED is now a point of entry for those in acute mental health crisis (Kirby & Keon, 2006). Compounding this issue is the lack of available inpatient psychiatric beds which has resulted in the increased need for mental health related treatment in the ED (Chang, et al., 2011; Broadbent,
Moxham, & Dwyer, 2010; Summers & Happell, 2003). As the ED is a key contributor within the mental health continuum of care, providing care to the increasing population of individuals experiencing mental health issues involves a significant portion of the ED nurse's workload.

Mental illness involves any combination of alterations in thinking, mood, affect, and behaviour that can be associated with significant distress or impaired functioning (Government of Canada, 2006). One in five people in Canada experience a mental health issue(s) or illness in every given year, with an economic cost in excess of $50 billion (Smetanin, Stiff, Biante, Adair, Ahmad, & Khan, 2011). To facilitate appropriate care and treatment, the continuum of care for mental health services was designed to support those with mental illness through the phases of crisis, stabilization and recovery where the individual is at the centre of care (Figure 1).

The continuum of care of mental health services is an interactional and intermeshed set of mental health services. The Canadian Council on Health Services Accreditation (CCHSA) defines a continuum of care as "an integrated and seamless system of settings, services, service providers, and service levels to meet the needs of clients or defined populations" (Alberta Health Care Services, 2010). The process that drives this continuum emphasizes coordination and smooth, efficient transition of services for the mental health care recipient along the levels of care. Typically, the continuum of care includes hospitals, emergency rooms, crisis intervention services, an array of outpatient alternatives services, and supportive and integrated services, such as case management and assertive treatment teams. As such, it is imperative that ongoing assessment and appraisal of the mental health care provided through the continuum of mental health services is evaluated and supported by research. In response, this study will focus on the ED nurses’ perceptions of care provided to individuals with mental health issues.
Individuals will move through the continuum of care from one service setting to the next, as their clinical condition dictates. The matching of clients with the appropriate resources is a critical component for the mental health services system (Tyerman, 2012). To guide the development of psychiatric services within the continuum, Canada adopted the Psychosocial Recovery Model of Care (Anthony, 1993) that promotes personal recovery and optimal quality of life for those with mental illness. This is facilitated through engagement in a wide continuum of mental health services where the ED is often the point of entry into the healthcare system. Within this model,
the patient’s recovery is placed at the centre of health care. Recovery requires a variety of patient
supports and resources along with interventions that work with the patient, not to solve their
problems but to reduce their symptoms (Kirby, 2008). Nurses understand the challenges of
health care delivery and embrace the opportunity to use their skills to assist the individual to
promote health and optimize wellness (McMurray, 2001).

An exemplar of a successful continuum of mental health services within the Canadian
custom is in Brandon, Manitoba. With the closure of the Brandon Mental Health Centre,
services were planned for transition to a community model between 1994 and 1999. Kirby and
Keon (2006) the Canadian Standing Senate Committee on Social Affairs, Science and
Technology identified the ‘Brandon experience’ as an example of successful integration of
community based mental health services and supports. Evaluation of their program revealed that
advanced planning played a key role in the successful transition of the deinstitutionalization of
mental health care. Preparation began years before the actual closure of the Brandon Mental
Health Centre to ease clients into this transitioned care delivery. Key principles included
recruitment and education of mental health service providers to ensure close and frequent contact
with clients to assist with their independent living. This included the establishment of a full
spectrum of services needed to support clients within the community setting. Continued fiscal
support for programs and services was set as a priority within all levels of government.
Additionally, strong partnerships with other health and social service agencies, hospital services,
physicians, police services and housing authorities are needed.

As the ED plays a key role within the continuum of care, the evaluation of users and
services provided is important. Recurrent use of the hospital ED among people with mental
illness is a concern, with 15% to 20% of people returning to the ED within 30 days of an initial
visit/admission (Durbin, Lin, Rush, Thibault, & Smith, 2007). According to the Kirby and Keon report (2006) *Out of the shadows at last: Transforming mental illness and addiction services in Canada*, the ED is the most common site for the individual in mental health crisis to seek care. Within the continuum of care, ED's are often a point of entry for people in psychiatric crisis. However, many utilize the ED due to a lack of other available options. A lack of access to community mental health services, no family physician and decreased community based psychiatric care are key reasons for emergency room visits (Moskop, Sklar, Geiderman, Schears, & Bookman, 2009).

Crisis response, such as that provided in the ED, is a key component within the continuum of mental health services and provides support for individuals during the acute phases of their illness. The goal is to maintain the dignity of the patient while providing relief of symptoms, prevent further symptom exacerbation and resolve crises as quickly as possible (Purcell, et al. 2011).

Many individuals are embarrassed about and face discrimination because of their mental illness (Statistics Canada, 2004). According to the 2002 Mental Health and Well-being Survey, 54% of individuals with mental health issues reported facing discrimination due to their illness such as mental health stigma. This stigma is expressed by individuals feeling exposed, judged and ignored. Unfortunately, those seeking ED services do not always perceive care to be empathetic and non-judgemental (Gordon, Sheppard, & Anaf, 2010). A significant number of individuals who present for emergency psychiatric care do not stay for treatment and/or psychosocial assessment and follow-up (Bennewith, Peters, Hawton, House, & Gunnell, 2005; Mojitabai, et al., 2011). Individuals presenting to the ER with mental illness routinely experience stigma, regardless of whether they are seeking medical or psychiatric care. This
stigma often translates into delays in receiving services and increased wait times in the ED (Schizophrenia Society of Canada, 2008; Schulze, 2007).

The nature of nursing differs in the ED from other nursing units and settings. The rapid assessment and treatment of patients, the typically short disposition time, and the diverse range of patient behaviours and their associated presenting symptomology make nursing care particularly challenging. Patients who present with vague symptoms characteristic of some psychiatric illnesses (e.g. depressed mood, suicidal thoughts, anxiety) and who require prolonged assessment, disrupt the fast paced normal flow of the ED and can lead to frustration and feelings of inadequacy among ED staff (Broadbent et al. 2010; Marynowski-Traczyk, Broadbent, 2011).

Additional intensive care interventions implemented to maintain patient and staff safety, such as de-escalation, are required when the patient is psychotic, aggressive or self-harming. To effectively implement these focused interventions, the nurse needs to maintain ED psychiatric competencies (CNA, 2008a). It is therefore essential that treatment and care provided by ED nurses be comprehensive and supported by specialized education in an environment conducive to psychiatric care.

Expertise in assessing and caring for psychiatric patients is a central competency of the ED nurse (Dunnion & Griffin, 2010). The symptoms or maladaptive behaviour associated with psychiatric crisis can include disruptive or dangerous actions directed towards themselves or the general public (Allen & Tynan, 2000; Clarke et al. 2006). This requires the ED nurse to provide appropriate, optimal, safe, and ethical care in a challenging environment to a unique population. The ED has also become a site for identifying many mental health problems and where the initiation of crisis interventions occurs.
As with chronic illnesses, the trajectory of serious mental illness is complex involving periods of stability interspersed with episodes of exacerbation of clinical symptoms or behaviours. When in the crisis phase of illness, the individual often requires ED psychiatric assessment, immediate intervention, and hospital admission for stabilization. In the 2002 Mental Health and Well-being Survey, 4.9% of the Canadian population (4.3% of men and 5.4% of women) required ED assessment with subsequent admission to an inpatient psychiatric unit for mental health related issues. Relapse and re-hospitalization was identified as a significant concern due to the cycling between crisis and stabilization. After discharge from a psychiatric hospital, one in three individuals present to the ED within 30 days for crisis care (Bruffaerts, Sabbe, & Demyttenaere, 2004).

When in crisis, the maladaptive behaviours associated with mental health crisis may pose a serious risk to self and others and can extend into the ED itself. This has the potential to pose a risk to ED nurses. The International Council of Nurses (ICN) identified healthcare workers were more prone to experience violence in the workplace than prison guards and police officers (International Council of Nurses, 2009). The risk for workplace violence is highest in EDs and psychiatric units. The Emergency Nurses Association (2008) identified reasons for this increased violence in the ED that included environmental factors such as working with potentially dangerous people - some of whom may be experiencing symptoms of mental illness, poor security, uncontrolled access to rooms, and crowded and uncomfortable environment. Unfortunately, the individual experiencing a psychiatric emergency and the treatment received may be mismatched (Broadbent, Moxham & Dwyer, 2010; Marynowski-Traczyk & Broadbent, 2011).
The aim of this study was to articulate the experience of ED nurses caring for individuals with mental health issues in the ED. Understanding what occurs in the ED is an indication of how other services within the continuum of mental health services are functioning (Dawe, 2004; Hillard, 1994, Spurrell, Hatfield, & Perry, 2003). Increasing trends in the utilization of the ED for mental health assessment and treatment may indicate a breakdown in service delivery within the community setting. Similar to mental health care systems, emergency services for people with psychiatric disabilities are under-discussed, underfunded, fragmented and isolated (Stefan, 2006).

**Thesis Organization**

The second chapter of this thesis is the literature review chapter which focuses on the current understanding of nursing care of the mental health patient within non-psychiatric settings, as well as challenges in providing psychiatric care in the ED. The third chapter provides a detailed overview of the methodological considerations utilized in this research study. Chapter four contains a summary of emergent themes identified from participant transcript analysis. Chapter five is the discussion of study themes, along with the implications for practice and future research.

**Purpose of the Study**

The main purpose of this study was to conduct exploratory qualitative research examining the experiences of ED nurses' caring for individuals with mental health concerns. To meet this purpose, a qualitative study using a descriptive phenomenological tradition was guided by the following research questions: a) What are the nurses' experiences of the care that is provided to the individual experiencing mental health issues in the ED? b) What are the participants’ description of elements that contribute to or inhibit their ability to effectively care
for individuals with mental health issues in the ED? c) What are the participants’ educational experiences related to mental health issues? and, d) What are the participants’ recommendations for the enhancement of mental health nursing care in the ED?

The key research question guiding the inquiry was: What are the ED registered nurses’ experiences of care for individuals with mental health issues in the ED?

**Significance of the Study**

The aim of this study was to contribute to an understanding of ED nurses’ experiences of care provided to individuals with mental health issues. It will also enhance our understanding of the factors that contribute to or detract from the nurse’s ability to effectively care for the mental health patient in the ED. The bulk of research on ED nursing care of the psychiatric patient has focused on triage assessments (Broadbent et al. 2010; Clarke et al. 2006) and issues with the high risk mental health patient (Allen & Tynan, 2000; Arnetz & Arnetz, 2001; Carlsson, Dahlberg, Lützen, & Nystrom, 2004; Cowin, Daview, Estall, Berlilne, Fitzgerald, & Hoot, 2003; Nicholls, Brink, Greaves, Lussier & Verdun-Jones, 2009) but little is known about what nurses’ experiences are in caring for individuals with mental health issues in the ED setting, thus leading to the need for a qualitative study exploring this phenomenon.
Chapter 2
LITERATURE REVIEW

In this chapter, background literature related to the care of individuals with mental health issues within the ED by nurses is examined in order to provide grounding related to the research question in this study. The review of literature was conducted using four electronic databases; ProQuest, Ovid/Medline, PsychINFO, and Cumulative Index to Nursing and Allied Health Literature (CINAHL). Limits applied included publication between 2000-2013 and English language. Keywords included nursing, mental health, psychiatric assessment, confidence, education, emergency service and emergency department. For the purposes of this study, the terms psychiatric and mental illness will be used interchangeably.

This literature review evaluates the limited research on nursing care provided to mental health patients outside of psychiatric settings and highlights the known challenges to providing care to individuals with mental health issues. Literature was limited and tended to focus on challenges and barriers to providing quality care in the ED. The literature was categorized into mental health care within a) mental health and the ED, b) emergency nurse psychiatric competencies, c) nursing educational preparation, d) continuing education to provide safe and quality ED care, e) clinical confidence, and f) stigma. In total, 24 articles (Appendix A) were identified as relevant to the research topic. Only 2 studies were identified addressing ED nurses experiences in providing mental health care. In addition a conceptual framework relevant to patients with mental health issues and ED nurses is presented.

The purpose of this literature review was to address what is currently known, identify gaps, and establish the rationale for this qualitative study.
**Mental Health and the Emergency Department**

Canadian statistics reveal that 1 in 10 people with mental illness will receive some form of treatment in hospitals during their lifetime (CIHI, 2006). Emergency departments (ED) are often a point of entry for people in mental health crisis. The Canadian Institute for Health Information’s (2012a) Canadian Mental Health Database reported that 76.9% of psychiatric admissions are admitted after psychiatric evaluation in the ED. Recurrent use of the hospital ED of those in mental health crisis is a concern, with 15% to 20% of people returning to the ED for mental health services within 30 days of an initial visit/admission (Durbin et al. 2007). However, many utilize the ED due to a lack of other available options. A lack of access to community mental health services, no family physician and decreased community based mental health care are key reasons for emergency room visits. The Ministry of Health and Long Term Care (2010) have stated that too many individuals living in Ontario who are coping with mental illness require hospital ED care because of an inability to access the community supports they require.

Although, the majority of mental illness treatment occurs in community settings, in certain situations, treatment may occur in the hospital environment. Interventions and policies associated with deinstitutionalization of mental health services have replaced previous long-term hospitalizations with short term admissions during mental illness cycles of de-compensation and remission. Despite changes in mental health laws and policies, as well as improved treatments for mental disorders, the persistent course of many chronic mental disorders will remain constant and require periods of intensive psychiatric care. The decision to treat in hospital is strongly influenced by the availability of alternative treatment services and the availability of designated
psychiatric beds within the region (Chang, et al., 2011). The ED often is the entrance point when individuals require hospital admission.

Crowley (2000) suggested that the ED environment is not conducive to the needs of mental health patients. A therapeutic environment is paramount when providing mental health treatment. A high stimuli environment, lack of privacy, inadequate nursing time available and an open environment which makes disturbed behaviour difficult to contain, were identified as barriers to care within this environment (Zun, 2012). Environmental setup within the ED is often organized with the division of patients via curtained partitions without discreet rooms. Seclusion rooms are often placed in central locations to allow for close observation. Plant and White (2013) suggest the need for a specialized area within or near the ED designated for mental health care. Within this segregated or specialized area, patients would be triaged, assessed, and treated away from the general population of the ED thus allowing for increased privacy/confidentiality, maintenance of a low stimuli environment, and the opportunity to engage in close observation of high risk behaviours. There are alternative ED models for providing psychiatric care such as those staffed by skilled mental health ED nurses who work collaboratively with social workers, crisis clinicians, staff psychiatrists and support teams (Sharrock & Happell, 2002; Nicholls, Gaynor, Shafiei, Bosanac, & Farrell, 2011). Mental health evaluation and treatment would take place in a therapeutic environment that respects and validates the person.

Emergency medical staff, including triage and staff nurses, play a role in crisis stabilization, the determination of care needs, and the decision to provide inpatient care. Due to the lack of available inpatient beds, patients could potentially spend longer periods of time within the ED. As such, maintaining emergency nurse competencies related to psychiatric care is essential for safe and effective care.
Emergency Nurse Psychiatric Competencies

There are multiple pressures on the ED nurse to rapidly assess and act during crisis situations. The professional culture demands being decisive and in control with performance measurement based on the ability to multi-task the needs of multiple patients. With regard to caring for individuals with mental health issues, Canadian EDs lack standards in basic elements of evaluation and treatment for individuals with problems. The Canadian Nurses Association (2008b) Emergency Nurse Certification lists eight core competencies in psychiatric care which amounts to only 8 (4.5%) of 180 competencies suggested for ED care. These competencies include subjective assessment, objective analysis utilizing specialized skills of mental status exams and risk evaluations, and appropriate nursing interventions based on assessments. The International Council of Nurses maintains that nursing regulatory bodies are responsible for the basic competence of nurses. Additionally, they have a vested interest in continuing competence to ensure consumer safety and awareness (Bryant, 2005). Moreover, the Canadian Nurses Association (CNA) - ED certification is not required for nurses to work in the ED, therefore, proficiency in competencies is not monitored or evaluated. The importance of meeting and maintaining competencies may not be a priority to the nurse or organization and may have an effect on the work setting.

Psychiatric assessments and evaluation of risk are core competencies as they are routinely performed by both triage and staff nurses in the ED. Wand and Happel (2001) asked ED nurses to rate their perceived skill, confidence, and knowledge of mental health assessments and interventions to validate the need for a mental health liaison nurse position in the ED. Nurses identified a generalized uncertainty in providing care to the mental health patient, challenges in conducting mental health assessment and reported that they had difficulty caring for the patient
who resists treatment. Focus group discussion revealed ED nurses perceived a lack of clear, comprehensive standards defining what constitutes an adequate assessment of a client presenting with mental health problems.

The stress associated with making prompt evaluations and decisions may have negative effects on the attitudes of ED staff towards patients, particularly patients presenting with deliberate self-harm (Rao, Mahadevappa, Pillay, Sessay, Abraham, & Luty, 2009). In turn, the patient with mental illness may negatively react to the pressures felt by ED staff. The rapid assessment that occurs in this environment is counter to the needs of many mental health patients in crisis who need time. Emergency psychiatry and crisis resolution advocates that the best mental health care involves communication and developing a therapeutic relationship with the patient (Hickey, Hawton, Fagg, & Weitzel, 2001). The time commitment required for mental health nursing care disrupts the flow of the ED that functions through rapid evaluations and treatment. With ministry dictated four hour triage to disposition benchmarks, the time needed to engage in the psychiatric ED care/competencies of accurate psychiatric assessments, implementation of least restrictive practices such as verbal de-escalation, and the establishment of the therapeutic nurse-patient relationship becomes hindered by the ED environment. Improved patient outcomes and higher quality of care are linked with ED’s that increased nurse staffing levels (Spetz, Harless, Herrera, & Mark, 2013). Increasing the nurse-patient ratio is recommended to improve patient safety (Kane, Shamliyan, Mueller, Duval, & Wilt, 2007). This supports the nurse perception that providing care to the individual with mental health issues requires time to adequately assess, develop the therapeutic nurse- patient relationship and evaluate the effectiveness of applied treatments.
The Kerrison and Chapman qualitative study (2007) explored the educational needs of ED nurses related to psychiatric care. Focus group discussions with nurses suggested that non-psychiatric trained nurses lack adequate knowledge, assessment and communication skills to adequately provide care to individuals with complex mental health issues. Skills in de-escalation of the aggressive patient are hindered by fear and concern for safety of self and others. Key learning areas identified included workplace aggression and violence, mental health assessments, and chemical dependence. These learning needs are all reflected in the core emergency nursing competencies (CNA, 2008b).

Emergency room mental health competencies include skills of assessment of risk factors for violence and self-harm and the de-escalation of violent behaviour (Canadian Nurses Association, 2008b). Violence in the clinical setting is a serious occupational risk for the emergency nurse and many hospitals provide workplace violence prevention programs to staff to enhance proficiency in handling aggressive behaviours. These initiatives include safety and education for staff, in an effort to take preventative measures, thus ensuring the safety of all healthcare workers, their patients, and visitors (Emergency Nurses Association, 2010).

Although the College of Nurses of Ontario (CNA, 2008b) competencies outline the knowledge, skill and judgements necessary for safe and ethical quality practice for an RN in Ontario, no research was found to indicate the frequency with which these competencies are met and maintained by the ED nurses. The opportunity to achieve and maintain these competencies influence both quality of care and the nurse’s self-efficacy in their ability to provide psychiatric care.
Nursing Educational Preparation

Nurses constitute the largest professional health care group (Horne, 2011). Currently in Canada, over 270,724 nurses are registered and employed in hospital and community settings. Of this, approximately 10.4% (28,155) identify that they work in the ED setting (CIHI, 2012b). While in 2011, 72% of Canadian RNs held a diploma in nursing, 32.4% of those were enrolled in a post-RN baccalaureate program. Although 3.9% of RNs obtained a masters or doctorate degree, they were primarily employed in either administration or education.

In recent decades, initial education in nursing has been one of the most controversial nursing policy issues in Canada (Lee, 2008). A joint effort between governments, nursing associations and the Canadian Association of Schools of Nursing (CASN) supported a shift in entry-to-practice requirements (CNA, 2004) which was based on evidence that baccalaureate educated nurses enter the workforce with a higher level of preparation than diploma nurses. Evidence suggests that preparing registered nurses with strong skills in clinical reasoning, clinical judgement, critical thinking, ethical practice available in undergraduate nursing programs is essential to their ability to provide safe, ethical, cost-effective and high quality nursing care (CASN, 2011). This shift in education is now being reflected in the Canadian nursing workforce.

Since 1982, with the exception of Quebec, the provincial and territorial nurses associations in Canada have agreed that a baccalaureate degree in nursing should be the entry requirement for nursing. A baccalaureate degree in nursing is the education entry-to-practice standard for registered nurses in Canada (CNA, 2004). As the Bachelor of Science/Bachelor of Nursing is a four year university program, it opens an opportunity to expose students to an increased depth of mental health nursing theory and clinical practice than that of the RN college diploma program. This nursing education prepares candidates to write the Canadian Nursing
Registration Exams (CNRE) which qualifies the successful candidates to enter into the Canadian nursing workforce with the competence required to practice safely (CNA, 2008a).

Undergraduate nursing education provides a broad-based preparation that educates nurses to meet the complex needs of a wide variety of patient populations.

The Canadian Association of Schools of Nursing (CASN) is a national voice for Canadian nursing education, research and scholarship. It creates a platform to establish and promote national standards of excellence in nursing education while promoting the integration of theory, research and practice (CASN, 2014). Within this process, CASN (2003) distributed a survey of clinical/practice education related to mental health/mental health nursing education to all eighty-six schools that offered a nursing baccalaureate program. The purpose of this survey was to assess the current status of undergraduate nursing education in providing mental health/psychiatric nursing education. Results of the survey showed only 32 of the 39 respondents indicated their program included a dedicated mental health component, both theory and clinical, within their curriculum. Additionally, mental health clinical placements, if available, occurred primarily in community settings which may limit exposure and opportunity to gain skills in the assessment and interventions when providing care for the individual experiencing an acute mental health crisis.

Mental illness care is primarily delivered in the community environment but there are situations when more intensive hospital treatment may be required. As an access point, treatment often commences within the ED settings. Canadian statistics reveal that only 1 in 10 people with mental illness will receive some form of treatment in hospitals (CIHI, 2006). Despite changes in mental health laws and policies, as well as improved treatments for mental disorders, the course of many chronic mental disorders may involve periods of symptom
exacerbation where community treatment programs may be inadequate. The advantages of treatment within the hospital setting include expedient access to expert personnel, appropriate diagnostic facilities, and a relatively safe environment (Blader, 2011). As such, the ED nurse must have a level of expertise in the assessment of and treatment of individuals experiencing an exacerbation of psychiatric symptoms, particularly for those with significant mental health issues. Nurses need to stay current to the changes occurring within the health care system as knowledge and best practices continue to evolve through research. This is for instance, evident in recent changes to least restraint practices. The emphasis on evidence-based practices espouses the need for nurses to stay current with health-related knowledge while continuing to enhance skills and abilities (Nalle, Wyatt, & Myers, 2010).

**Continuing education to provide safe and quality ED care**

Professional continuing education is designed to enhance the ability of the professional to provide comprehensive patient care. Nursing education should ideally evolve as a continuum of lifelong learning to maintain and enhance clinical competence. This competence must reflect the real scope of the nurse's clinical practice. The primary goal of learning is the application of knowledge, not simply the accumulation of facts.

Holistic and comprehensive care at the time of crisis can provide support and prevent escalating mental distress and disorder (Hawton, et al., 2007). However, a recurring theme in many non-psychiatric settings is the impression that nurses do not have adequate mental health training and feel unskilled in managing individuals with mental health challenges (McAllister, Moyle, Billett & Zimmer-Gembeck, 2008). This lack of confidence in preparation and skills is significant as it can adversely affect the care provided for those with mental health needs. ED nurses, like other front line health care professionals are not mental health clinicians and are not
expected to provide all the necessary psychiatric care. They need to have and maintain
competency in the specialized skills to at least adequately address and provide the initial
interventions to the individual with mental health issues while maintaining respect for and the
integrity of the mental health patient. These specialized skills include de-escalation, risk
assessment, and mental status exam.

Several studies on the effect of continued mental health education and training have
shown a positive correlation with nurses’ attitudes and confidence levels after educational
interventions (Clarke et al. 2006; McAllister et al. 2008; Patterson, Whittington, & Bogg, 2007;
Samuelsson & Asberg, 2002). Furthermore, accurate assessment of risk could link patients up
with appropriate community resources thus reducing significant mental health concerns such as
suicide. Clarke et al. (2006) conducted an interventional study of triage nurses. Assessing
confidence and accuracy with triage assessment of acuity of illness, the study implemented an
educational program related to assessment of psychosis and suicidal risk, and mental health
issues frequently assessed at triage. They found nurses' accuracy and confidence in assessment
of acuity and risk significantly improved with the educational program.

A significant issue is that effective emergency care goes beyond the mental
health/mental status assessment. Continuing education programs for emergency nurses have been
recommended across the literature. Increasing knowledge, confidence, and accuracy of mental
health assessments have been discussed but it should also be highlighted that education improved
professionalism by deepening the nurses understanding of the patient and improving patient
outcomes (Summers & Happell, 2003).

Continuing education available to nurses related to care of the mental health patient
appears to be currently inadequate. Individual and organizational challenges in providing
education can be costly in terms of time and resources as lengthy curriculum necessitates removal of valuable personnel from the department for extended periods of time (Kutcher, Chehil, Cash, & Millar, 2005). At the individual level, nurses are resistant to programs that require participation outside of the assigned work hours or involve a financial cost to them personally (Nalle et al. 2010).

A standard of professional nursing practice is the goal of continuing education that will enhance the practicing nurse's competence and improve the health of the patient through lifelong learning (Canadian Nurses Association, 2008). The World Health Organization has identified a need for the development of mental health specific educational packages in areas of assessment and treatment of mental disorders for which an intervention exists, so that they can be made available to staff in primary care settings (Goldberg & Gater, 1996).

**Clinical Confidence**

Within health research, confidence has been used interchangeably with the term self-efficacy or the belief that an individual has the ability to successfully perform a specific activity (Bandura, 1982) and furthermore, perceptions of confidence are positively related to the validity of clinical judgements (Broadbent et al. 2010; Nicholls et al. 2011). Clinical confidence is defined as the certainty of a clinician that a professional style or approach will bring about valued outcomes.

With the de-institutionalization of mental health services into the community, general hospital nurses now have increased contact with individuals experiencing mental health problems (Sharrock & Happell, 2000). Increasingly evident is the awareness of the need to address mental health issues within non-psychiatric settings (Sharrock, Bryant, McNamara, Forster, & Happell, 2008b). Research has identified that nurses working in non-psychiatric
settings do not believe they are adequately prepared to meet the mental health needs of patients (Brinn, 2000; Happell & Sharrock, 2002; Platania-Phung & Happell, 2005; Wynaden, Orb, McGowan & Downie, 2000). In a 2004 study, ED staff including nurses, rated themselves as having minimal knowledge, training and confidence to assess and treat patients presenting with mental health problems and related comorbid conditions (Stuhlmeiler, et al., 2004). Furthermore, the study identified ED staff as having negative attitudes and perceptions of this patient population. In these situations, patient care and safety may be compromised due to nurse’s anxiety, fear, stigma, and avoidance.

Research outcomes indicate that a lack of appropriate education can be a critical barrier towards effective nursing care for patients with mental health issues. Nurses strongly advocate the need for further education and indicated they would benefit from the opportunity to engage in knowledge and skills development (Clarke et al. 2006; Rao et al, 2009; Plant & White, 2013). Providing care to individuals with mental health issues outside of the psychiatric setting tends to be delivered by nurses who feel ill-equipped to provide psychiatric care for this population (Lennox, Diggens, & Ugoni, 2000; Lunsky, Gracey, & Gelfand, 2008). An Australian qualitative study of emergency nurses (N=12) investigated the ED nurse's perceived mental health education and training needs. Participants within this study suggested ED nurses avoid patients experiencing mental health problems because of feelings of fear and powerlessness and they perceive care for these patients is more time consuming (Kerrison & Chapman, 2007). Additional qualitative studies identified that non-psychiatric nurses reported a lack of knowledge, skills and confidence in the assessment and management of mental health problems in their patients (Kerrison & Chapman, 2007; Rao, et al., 2009; Wand & Happell 2001; Wand & Schaeckeen, 2006).
There is evidence suggesting that nurses lack confidence and are hesitant in providing care, particularly when patient behaviour is perceived as difficult, threatening or disruptive (Happell & Sharrock 2002; Heslop, Elsom, S. & Parker, 2000; Sharrock & Happell 2002). Care for the acute complex patient, such as the patient with complex mental health issues, requires knowledge in assessment and appropriate interventions in addition to resources (personnel, time, equipment, and adapted environment). Lack of resources, expert assistance and workplace policy in relation to working with people with mental health problems, can have an impact upon the nurse's ability to provide clinically competent care (Bailey 1994; Wand & Happell 2001; Wand & Schaecken 2006).

Individuals presenting to the ED with mental health issues often have dual diagnoses of addiction and mental health issues. Shaw, Cartwright, Spratley, & Harwin (1978) studied the field of dual diagnoses (alcohol addiction and mental health) and sought to understand the dynamics of why primary health care workers did or did not become involved in caring for patients with dual diagnosis. Three major themes of therapeutic attitudes and motivations were influenced by the practitioners’ concept of role adequacy, role legitimacy, and role support. Role adequacy encompasses the notion that practitioners, who feel adequately prepared in their ability to care for patients, view themselves as having appropriate knowledge and skills. It directly relates to the mastery of nursing skills and competencies. Role legitimacy is concerned with the extent to which practitioners view particular aspects of their work as being their responsibility. This includes the scope of professional practice. Role support relates to the support which practitioners receive from colleagues to help them perform their role effectively. Shaw et al. (1978) postulated that the presence of these aspects of role adequacy enhance the motivation to work with mental health patients, the expectation of satisfaction, and their professional self-
esteem when engaging in therapeutic care. Optimum role function occurs where the three areas of role adequacy, legitimacy and support merge (Machin & Stevenson, 1997).

**Stigma**

Individuals presenting to the ED with mental illness routinely experience stigma, regardless of whether they are seeking medical or psychiatric care (Ross & Goldner, 2009). The impact of mental illness related stigma is a reality brought forward from not only the general public but from health care professionals. Stigmatizing attitudes by healthcare professionals are commonly experienced by individuals with mental health issues (Hansson, Jormfeldt, Svedberg, & Svensson, 2011; Rao, et al., 2009; Ross & Goldner, 2009). Emanating from stereotyping, fear, and discrimination, lack of knowledge and superstition, stigma can have devastating implications to an already vulnerable population. Individuals with mental illness are stigmatized as being violent and unpredictable, posing a risk to self and others (Nicholls, et al., 2011). While symptoms of mental illness are perceived to be strongly linked with potential violence, statistics report the prevalence of violence among individuals with mental illness in general is less than 4% (Rueve & Welton, 2008).

The prevalence of stigma towards those with mental illness has been the focus of nursing research, specifically in general medical settings. Conclusions are consistent that stigma impacts the nurses' ability to deliver empathetic and competent care to this patient population (Ross & Goldner, 2009). Individuals presenting with mental health issues have described interactions where they felt devalued and disrespected. They experienced treatment practices where care was void of dignity and respect (Summers & Happell, 2003). Stigma can often translate into delays in receiving services and increased wait times, lack of privacy during triage and assessments. The poor communication and coordination between ED’s and community treatment providers
have resulted in delays in patient assessments within the ED (Summers & Happell, 2003). The Schizophrenia Society of Canada (2008) suggested that individuals in psychiatric distress who presented to the ED had longer wait times and were given a low priority triage score. The impact of stigma experienced from health care providers becomes a barrier to care as the individual with mental illness often delays or avoids seeking timely treatment, is non-adherent to treatment, and/or avoids sharing health issues with family, friends, employers, or the health care providers (Government of Canada, 2006).

In summary, the research to date on care for individuals with mental health issues presenting in EDs, has primarily been quantitative and covered the areas of: violence, aggression, risk for harm to self and others. There is a lack of data related to nurses’ thoughts on the care patients with mental health issues are receiving in the ED and how this might help to improve the quality of the experience of individuals with mental health issues needing ED care. As noted in the literature, little research has been conducted examining the practice of psychiatric care practices within the ED, especially within Canada. Given the changing face of emergency care within hospitals, deinstitutionalization of mental health services, and the general restructuring of health care in Canada, it has been proposed that continued education is a key element in enhancing care practices (Srivastava, Jonston, & Nelson, 2010; Stefan, 2006; Wand & Happell, 2001).

To enhance care practices and establish best practice guidelines, it is imperative that knowledge begins through qualitative analysis of the phenomenon. Understanding the experiences of ED nurses caring for individuals with mental health issues would enable a deeper understanding of the factors related to providing care to this patient population.
Conceptual Framework

The environment within the ED is strongly influenced by the behaviour and attitudes of the staff providing care. Beliefs and views of an individual are driving forces behind how they behave and respond in situations (Pratt & Paterson, 2007). Phenomenological studies seek to explore thoughts, beliefs and experiences of a phenomenon. Although research has explored the experiences of psychiatric nurses, minimal research has focused on the generalist nurse's lived experience providing mental health care in non-psychiatric settings. Researchers have yet to focus on the ED nurses' attitudes and behaviours with respect to mental illness and how to effectively provide care.

Therefore, this study contributes to the body of knowledge about mental health practices within the ED. As a sensitizing framework, this study utilizes Leininger's Cultural Care Theory.

Theory of Cultural Care Diversity and Universality.

Leininger's Cultural Care Theory emphasizes the importance of nurses developing knowledge and abilities related to cultural differences and being aware of patient's values beliefs, health awareness and lifestyles (Leininger, 1988). The theory of cultural care and universality focuses on nursing as the phenomenon being explored and that care is central to nursing. This theory emphasizes care as a focal point for exploring ED nurses’ perceptions. Care is defined as the process of assisting, supporting, and enabling others through the anticipation of needs to improve a human condition (Leininger & McFarland, 2006). This exploration of care seeks to understand ED nurses intentional and instinctual constructs influencing behaviours, actions and beliefs. Culture is viewed as an amalgamation of learned, shared, and transmitted values, beliefs, norms of a group that guides thinking, decisions, and actions in a pattern of behaviours.
(Leininger & McFarland, 2006). The environment of the ED where nurses share common experiences, expectations and values define the culture. The final concept, cultural care, is a synthesis of culturally construed assistive and supportive caring acts that guides, discovers and helps explain and account for expressions of care (Leininger & McFarland, 2006). This theory promotes the use of a qualitative inquiry to improve care practices. Utilized in mental health research, this theory serves as a guide to explore the extent of cultural awareness of mental health practitioners (Chang, Yang, & Kuo, 2013; Leishman, 2006). Cultural care is ultimately to know, explain, account for and predict nursing care.

_Figure 2: Leininger's Theory of Cultural Care Diversity and Universality_

Leininger's theory (Figure 2) begins with the nurse's worldview and the associated cultural and social structure guiding the study of perceptions of the world outside of the culture. The worldview leads the study in exploration of the nature, meaning, and attributes of care. The culture and social structure flow from the worldview and involve environmental, language and ethnohistory. The social, political, economic and educational factors relevant to the ED influence how the nurse approaches a given population and how they deliver holistic care across the wellness-illness spectrum. The nurse's worldview is influenced within the work environment of the ED where interrelated factors shape, alter or refine personal views and cultural care worldviews. For example, previous and current education, availability of resources (manpower, equipment, and space) along with technological factors, significantly influence the care practices of the ED nurse. Further to this, the values/beliefs of the culture within the ED influence care practices. When the culture of the ED prioritizes the delivery of culturally competent care for specific patient populations, the nurse adopts these beliefs and values. In this study, these factors served to provide direction for the development of interview questions exploring the nurses’ perception of care.

The next level involves knowledge about the individual, groups, or communities. An understanding of the experiences, care practices, and unique needs of the individual with mental health issues is essential to effective and supportive care practices. This knowledge provides meaning and expressions to care. The next focus is on the generic or folk care, professional care-cure practices, and nursing care practices. This allows for the recognition of similarities and differences or cultural care universality and cultural care diversity (Leininger & McFarland, 2006). Care decisions and care practices are strongly influenced and supported by the cultural environment. The next level involves nursing care delivered with decisions and actions that are
meant to preserve/maintain, accommodate/negotiate, and repattern/restructure culturally competent care.

In cultural care preservation and maintenance, the nurse's actions must support, assist and enable patients with mental health issues to recover from illness and reach an optimal level of wellness. An example would be to facilitate access to a community outreach mental health program to maintain health stabilization upon discharge. Cultural care accommodation/negotiation involves the nurse's efforts to support the individuals with mental health issues to adapt to their health challenges in a supportive way. Cultural repatterning/restructuring involves the nursing actions that assist the patient to change life patterns to be healthier while respecting the patient's cultural values (Leininger & McFarland, 2006). For example, alcohol and drug use are strongly associated with a wide range of mental disorders (Swendsen, et al., 2010). Providing education and referrals to addiction services support the patient's decision to change maladaptive health behaviours. It is important that care is both congruent with and valued by members of the culture during phases of health, well-being, and dying (Leininger & McFarland, 2006).

**ED Models of Care**

As the demands for urgent mental health care have increased (Atzema, et al., 2012), a variety of emergency psychiatric service delivery models have developed. The most common model is where psychiatrists and other mental health professions also consult patients in a medical emergency department after they have been medically cleared and organic causes of symptoms have been ruled out. The advantages to this model include the relatively low cost and it is easiest to implement. Disadvantages include delay in mental health treatment until psychiatric consultation is available, the limited time available to observe the patient post
intervention, the lack of a therapeutic physical environment, and the lack of nursing knowledge related to mental illness (Zeller, 2010).

A second model involves a dedicated mental health wing of a medical emergency department. This model provides a separate quiet and calm environment within the ED. Staffed by nurses and other healthcare providers who have enhanced education in mental health, this type of unit is more conducive to providing focused psychiatric care. As it is located within the ED, patients have full access to both medical and psychiatric services. The main disadvantage of this model is that it allows for marginalization and increases the potential for stigmatization of this patient population (Zeller, 2010). Additionally, this model may not be feasible in smaller ED’s, particularly those within rural areas.

A third model of care for emergency psychiatric services has been successful in providing dedicated psychiatric emergency services (PES) that is a stand-alone unit that works in collaboration with adjacent medical EDs. The PES unit provides psychiatric evaluation, intensive treatment, and provides an extended opportunity for observation and stabilization with access to outpatient services (Zeller, Calma, & Stone, 2013). The goal of PES programs is stabilization of acute symptoms and when possible, to avoid the need for inpatient hospitalization. The main disadvantage is cost and therefore is primarily available in locations where ED see a large number of acute psychiatric patients and as such, the cost can be justified by minimizing unnecessary inpatient admission and visits to active EDs.

These three models of care influence how ED nurses are able to provide care to individuals with mental health issues. Each model was designed to facilitate ED patient care but have differing emphasis on psychiatric care delivery. As a result, the culture of the ED changes significantly between each model thus influencing how care is provided to this patient
population. In the determination of the appropriate ED model, it is important that the model creates an environment and culture that supports the care practices of the health care provider while supporting the organization in managing the demand for emergency care.
The main purpose of this study was to discover the ED nurse’s experiences of care provided to the individual admitted to the ED with mental health issues. To meet this purpose, a qualitative study using a descriptive phenomenological tradition was guided by the following research questions: a) What are the participants' experiences of the care that is provided to the individual experiencing mental health issues in the ED? b) What are the participants’ description of elements that contribute to or inhibit their ability to effectively care for individuals with mental health issues in the ED? c) What are the participants’ educational experiences related to mental health issues? and d) What are the participants’ recommendations for the enhancement of mental health nursing care in the ED?

First, an overview of the methodology is provided in the “Methodological Overview.” The second section, “Site and Participant Selection”, describes the rationale for the selection of the settings and the criteria for study participants. The third section, “Data Sources and Collection”, addresses the data sources and data collection methods. The fourth section, “Data Analysis”, details the specific procedures that were utilized for analyzing the data collected during the course of this study. The final section, “Trustworthiness”, describes the strategies the researcher utilized to ensure the trustworthiness of the research.

**Methodological Overview**

A qualitative paradigm was used in this study to explore the experience of the ED nurses’ care of individuals with mental health issues while they are in the emergency department. The participants also described their educational needs to enhance the care they provide for this
patient population. Qualitative research was an appropriate methodology for this study as it explored participants’ perceptions of care provided to individuals with mental health concerns. This study was exploratory because little is known about the ED nurse’s experience of care of the patient with mental health issues. A qualitative approach was the best choice for this research study because a qualitative paradigm allows the researcher to listen to the views of the research participants, while focusing on the context in which the participants express their views.

**Phenomenological Design**

Phenomenology is "the study of human experience and of the way things present themselves to us in and through our experience" (Sokolowski, 2000, p. 2). Using phenomenology, the researcher is concerned with the subjective experience of a phenomenon from the perspective of the research participant. Although as many as seven unique phenomenological perspectives have been described in research, two approaches guide the majority of phenomenological investigations in nursing - descriptive and hermeneutic/interpretive (Wojnar & Swanson, 2007).

Descriptive phenomenology has been considered the desired approach when there is interest in gaining a deeper understanding of the meaning individuals assign to their experiences. The aim of this methodology is to gain a deeper understanding of life experiences through its emphasis on the voices of those living the experience (Moran, 2007, Munhall, 2007). The experiences of individuals have been found to be influenced by emotions, motivations, and characteristics within the individual (Berg, 2004). Morse (2006) states that qualitative methodology is useful when examining participants’ perceptions of an event and/or issue because it provides “insight, which is crucial to understanding what is going on, for seeing the implicit, for uncovering, for interpretation and for developing strong concepts and theories”
This was aligned with the goals of this research which were to understand and explore participants’ perceptions, experiences, and insights into caring for the mental health patient within the ED setting. As this was a descriptive study, the interpretation of data was not explored.

A Husserlian phenomenological approach was adopted for this research to best understand the phenomenon of ED nurses’ intent to provide care for the patient with mental health concerns and to explore the meaning of providing care for this patient population. McCaslin and Scott (2003) stated that phenomenology is described as the study of shared meaning of experience of a phenomenon for several individuals. It is the study of the flow of human experience. Studying the experiences of ED nurses in providing care for the mental health patient, guided by Husserlian notions such as bracketing, essence, intentionality and life world, helped uncover questions, themes, and meanings relevant to the phenomenon of interest (Patton, 2002; Husserl, 1983). This approach situated the nurse within the context of the nurse's world of shared meaning, culture, practices, and language, allowing for a description of the full experience of nurses. Using this approach, the researcher synthesized the data generated from in-depth interviews describing the shared experiences of several informants to a central meaning, or essence of the experience. Individual experiences that describe what something truly is (essence) allowed the researcher to understand that the phenomenon may be experienced and described differently by participants (Patton, 2002). In this thesis, the essence of the interview data was about the participants’ perceptions of the care provided, an awareness of the challenges associated with mental health service delivery within the ED setting, the educational needs of nurses and the nurses’ thoughts and feelings related to their skills to competently care for high risk individuals with mental health issues being evaluated in the ED.
Consistent with phenomenology, interviewing was used to understand how RNs who work within the ED, perceive the care for this patient population with mental health issues/behaviours. Participants were interviewed independently in order to capture their view of care for these patients. Interviews provided detailed rich data from ED nurses about their perceptions, experiences, and first-hand subjective description of care for the mental health patient within the ED setting.

Interview questions and the interview guide protocol (Appendix B) were developed based on both Leininger’s (1988) theory of cultural care diversity and universality and, literature related to nursing perceptions of care of mental health patients in other settings (Brinn, 2000; Clarke, et al., 2006; Crowley, 2000; Happell & Sharrock, 2002; Kerrison & Chapman, 2007; Wand & Happell, 2001). Demographic data was gathered regarding the participant’s age, gender, education level, ED worked experience (years), and area of current employment. The interview guide focused on nurse’s experiences of the current care practices within emergency departments. Both negative and positive issues were explored as the nurses described his or her stories of working with this patient population. Within the methodology, it was imperative that the researcher discard their own preconceptions through bracketing which allows the researcher to remain open to all new information (Patton, 2002).

Bracketing, described by Husserl (1983), functions as a way to suspend the researcher’s own preconceived ideas, opinions, and beliefs regarding the natural world in order to allow the researcher to explore the phenomena exactly as it was experienced by the participant and assists the researcher in remaining neutral. In this study, the researcher bracketed her personal experiences in working with mental health patients in the ED before any interviews took place.
This was accomplished by maintaining personal and methodological journals throughout the study that suspended possible prejudices and thus remained open to all new information.

**Personal Biases**

My personal background includes working as a staff nurse within the ED, therefore all participants were colleagues of mine. To minimize the challenges inherent to this type of research, I clearly articulated the purpose of the research as an exploration of experiences that would serve to support the delivery of care rather than a judgment of practice. Prior to the onset of the research study, it was important to bring to consciousness my personal beliefs about the ED nursing care provided to individuals with mental health issues. An exploration of my personal beliefs brought into awareness potential judgements that could influence the outcome of the research (Appendix C). Additionally, I used three strategies to minimize potential personal biases. First, I disclosed my background and interests to all participants. Second, through the use of journals, I was able to express personal thoughts, feelings, and ideas during the research process in order to bracket, or set aside those factors that could potentially bias results. It also allowed for an openness to explore experiences and not allow my thoughts and feelings to interfere with data collection or analysis.

Finally, throughout the interviews, I avoided using predetermined questions. The interview guide was developed with the advisory committee’s support to ensure questions were nonjudgmental and open-ended to guide exploration of the participants' experiences and perceptions of the phenomenon. Research notes also allowed for the identification of potential issues brought up by individual participants that warranted further exploration by subsequent participants.
By using the above strategies, I was able to minimize personal biases, and the participants were encouraged to openly explore in detail their experiences and attitudes towards providing care for individuals with mental health issues in the ED.

**Role of the Research and Participant-Research Relationship Issues**

I have worked as a staff nurse in the ED for over 20 years and have worked at the sites from which the participants of this study were recruited. I have also worked in the adult and adolescent mental health units at these sites. As a staff nurse, I did not hold a supervisory position nor did I have an evaluative position over any of the participants.

Because of my past or current employment in the ED, I addressed the challenges through the lens of insider research (Hockey, 1993). Embraced by research in the humanities and specifically ethnography, the advantages include: a more in-depth knowledge attained from prior experience; closer and regular contact with the field, more detailed understanding of the socio-cultural environment and 'key players'; a pre-established trust and rapport between researcher and participants; and more open communication between the research and participants due to the researcher's continuing presence in the field (Taylor, 2011). From a researcher perspective, advantages I brought to the research study included (a) greater familiarity with the site and participants, and (b) an understanding of policies and practices (e.g. least restraint policies, triage and assessment tools).

Challenges of insider research involved the relationship between my colleagues and I; as Taylor (2011) noted, there was the risk of conflicting roles of researcher versus colleague and issues of confidentiality. As the sole investigator throughout this research project, while interviewing participants, it was imperative that the contact maintained a high level of professionalism. Interviews took place outside of the work environment and I initiated and
maintained a professional and effective researcher-participant working relationship (Hockey, 1993).

**Setting**

**Site and Participant Selection.**

A purposive sampling design with snowballing was used to identify registered nurses who work within the ED and have experience caring for patients with mental health issues. A purposive sample allows the researcher to identify participants who have experienced the phenomenon of study (Patton, 2002). Snowballing is a type of sampling that allows participants to use their professional and social networks to refer participants, who could contribute to the study, to the researcher (Munhall, 2007). Participants were selected based on criteria for phenomenological studies suggested by Colaizzi (1978). The inclusionary criteria suggested participants (a) have experienced the phenomenon (provided care for individuals with mental health issues in the ED) and (b) be able to articulate their experience. Additional criteria consisted of: (a) the ability to read and write in English, (b) Ontario licensed registered nurses working in either an Urgent Care Centre (UCC) or Emergency Department (ED) currently or within the past 2 years, and (c) work a minimum of 50 hours per month. This minimum hour inclusion was based on the part-time definition of 24 hours per two week schedule. Exclusion criteria included the inability to speak English and registered nurses who did not work in the ED. There were no exclusionary criteria based on gender, age, race, or ethnicity. The recommended sample size for phenomenological studies has been consistently cited as between three and ten participants (Dukes, 1984). Following Dukes' recommendation, and accommodating the variety of experience in the ED among participants, the sample size for this study was ten participants who had all experienced providing care for individuals with mental health issues in the ED.
Recruitment and participant interviews ended when redundancy and data saturation was reached. Patton (2002) stated that saturation of data occurs when no new themes emerge from the data and that redundancy occurs when emergent themes are revealed. After the first four interviews, data was analyzed to determine if the research question was still relevant. Interview questions were slightly modified to gain a follow-up on common experiences. For example, the first four participants identified actions that caused an ethical dilemma when caring for the mental health patient. From this, an additional question was added to the remaining participant interviews. Data analysis quickly revealed an emergence of common statements and themes that was further validated in the remaining participant interviews.

Participants were recruited from two ED’s within Ontario. The two sites provide health care services to approximately 500,000 residents and covered approximately 20,000 square kilometers comprising a mix of both rural and urban areas. The sites also partner with some northern Ontario communities. The sites were chosen based on validated statistics related to the number of individuals within this catchment area; those having mental and behavioural disorders are consistent with the Ontario average of 15.0 per 100,000 (Bains, et al., 2011). As well, it has a similar population structure to that of Ontario.

All ED/UCC staff at the study sites were informed about the purpose and expectations of the research program through an internal mailing list, announcements on the local intranet, and through flyers placed within the units. Interested potential participants were contacted by the researcher who described the study in detail and answered any questions related to the study. When the nurse agreed to participate, the researcher provided a Letter of Intent (Appendix D) and obtained written informed consent (Appendix E). A copy of the consent was given to each
participant. The participant was given the demographic questionnaire (Appendix F) to be used later in describing the participant sample.

Interviews took place in a location of the participant's choosing. Sites included private rooms located in the hospital, community or in the participant’s home. The interviewer ensured that all sites were secure, convenient, private and outside of the ED setting.

**Assumptions**

The primary assumptions of this study were that every nurse participant has had at least one experience with providing care to individuals with mental health issues. The second assumption was the participant would speak opening and truthfully about their experiences.

**Data Collection**

In qualitative research, data collection is the product of multiple data collection methods. To ensure credibility, multiple data collection techniques were used – audiotapes of interviews, verbatim transcripts, demographic questionnaires, and a researcher journal.

Before data collection commenced, Institutional Review Board approval was obtained from the institutional sites and Queen’s University – Health Science Research Ethics Board (HREB). Participants were contacted via telephone or email and arrangements were made to meet in a participant selected location.

Interviews were used as the primary method of data collection as this is the preferred method for data collection within phenomenological research, as it enables the researcher to discover the essence, structure, and meaning of the participants’ lived experience with the phenomenon being explored (Colaizzi, 1978). Each interview lasted between 60-120 minutes and follow-up interviews were arranged to validate descriptions and give each participant an
opportunity to add or clarify information. Participants were encouraged to describe, in detail, their experienced and personal perceptions. Samples of questions (Appendix B) asked of the participant included:

- Tell me about care for the mental health patient in the ED
- Tell me about anything that you would like to share about your experience with providing care for the mental health patient in the ED

Additional data collection included relevant researcher reflexive journals, field notes, and methodological notes. The reflexive journal contained the researcher’s perceived biases, assumptions, values, and personal responses to procedures and events that occurred during the study. Field notes and methodological notes were used as a part of the data collection and outlined procedural and observational concerns, recommendation for changes, and responses to the changes. The reflexive journal supplemented the participant discourse, and researcher conclusions.

All interviews were audio-taped and transcribed verbatim. The principal investigator (PI) reviewed the transcripts while listening to the audiotapes to ensure accuracy. To protect participants’ identities, each nurse was assigned a pseudonym and all transcripts and other study material was coded with identification numbers known to the PI. The participant’s true identity only appeared on the signed informed consent form.

Data Analysis

The interviews were analyzed primarily through thematic analysis because it corresponds to the goals of the research, which were to understand the experience of ED nurses in caring for the patient with mental health behaviours including the high risk mental health patient. This approach to data analysis has been associated most commonly with phenomenology (Lunsky et
al. 2008; McAllister, et al., 2008; Sharrock, Bryant, McNamara, Forster, & Happell, 2008b). In phenomenology, words, phrases and sentences identified from an interviewee are labelled into themes (Field & Morse, 1985). Braun and Clarke (2006) define thematic analysis as a method that identifies, analyzes and reports patterns and themes within the data.

Data analysis procedures followed Colaizzi’s (1978) stages of analysis to uncover meaning, structure, and essence of the lived experience of ED nurses caring for patients with mental health behaviours. The intention of Colazzi’s method of data analysis is to incorporate individual participant descriptions of their experiences into a universal description of the phenomenon. This method involves the following steps: 1) immersion in the data; 2) significant statements were extracted from the interview data; 3) significant statements were formulated into meaning; 4) formulated meaning were organized into themes; 5) themes were integrated into an exhaustive detailed description; 6) the essential structures of the phenomenon were formed; and, 7) participants were invited to evaluate the description of their own interview to determine if this was an accurate representation of their experience.

Step 1: Acquiring a Sense of Each Transcript

The researcher was the primary investigator who conducted each individual interview personally. As discussed by Colaizzi (1978), the researcher read the participants narratives to acquire a feeling for their ideas in order to understand them and reviewed the audiotapes multiple times. In order to prevent prior knowledge of the phenomenon being studied, the researcher attempted to bracket, or identify and suspend preconceived beliefs and opinions about the phenomenon being studied. The researcher maintained a journal to record personal thoughts and feelings to facilitate bracketing and articulate reflections of each interview session.
Step 2: Extracting Significant Statements from Interview

Transcripts were analyzed line-by-line and significant statements and phrases were identified that articulated important aspects of their experience in care. Manual transcription and analysis by the researcher facilitated continued immersion in the data. The researcher's associated thoughts and perceptions were transcribed in the researcher's journal to facilitate bracketing used and validated during the analysis process. The transcripts were also assessed by the graduate supervisor to determine if the process ensured rigor and all significant statements were identified.

Step 3: Significant Statements Formulated Into Meaning

While continuing the bracketing process, each significant statement reflecting the participant’s lived experience was examined to extract a sense of deeper meaning. Perceptions of meaning were then transcribed alongside significant statements. The research question guiding analysis of meaning focused on the Registered Nurses' experience of care provided to individuals with mental health issues.

Step 4: Organizing Formulated Meaning into Clusters of Themes

Once meaning was formulated from the extracted significant statements, the researcher then began the process of clustering meanings into themes. The themes were common threads within each participant’s description of their experience working in the ED with the mental health patient. The themes were again evaluated by the graduate supervisor to determine if the process ensured rigor and themes were consistent with the student's analysis.

Step 5: Exhaustively Describing the Investigated Phenomenon

The exhaustive description incorporated the emergent themes, formulated meanings, and significant statement into a comprehensive description of the phenomenon being studied. This
description was then validated by returning to the original transcripts to ensure context and content was accurate.

**Step 6: Describing the Fundamental Structure of the Phenomenon**

Colaizzi (1978) postulated that an exhaustive description of the phenomenon should be reduced to an essential structure. He described this as an explicit statement which identifies all components and how they are interrelated which gives structure to the phenomenon. The structure and description was also presented to the graduate supervisor along with two members of the dissertation committee for validation and feedback.

**Step 7: Returning to the Participants**

The final state of Colaizzi’s (1978) analytical process has the researcher return to the study participants for an additional interview to elicit views on the essential structure of the phenomenon to ensure that it accurately represents the participant’s experience. The conceptual diagram (Figure 3) was given to each participant with an explanation of the key themes and description of the fundamental structure identified. Participants were asked perceptions of the description and to identify any gaps and to validate the accuracy of the themes. The additional participant’s comments were then integrated into the discussion. Through the process of member checks, participants confirmed that the description and conceptual framework represented their experience.

**Ensuring trustworthiness/rigor**

Rigor in qualitative research is demonstrated through the researcher's attention to and confirmation of information discovery (Speziale & Carpenter, 2003). The goal of rigor in phenomenological research is to accurately represent study participants’ experiences. Lincoln and Guba (1985) have identified operational techniques supporting the rigor of the work:
credibility, dependability, confirmability, and transferability. The strategies detailed below were key components of this study and how they were developed.

Credibility is an evaluation of whether or not the research findings represent a “credible” conceptual description of the data drawn from the participants’ original data (Lincoln & Guba, 1985, p.296). It includes activities that increase the probability that credible findings will be produced. Member checks were conducted for feedback from the participants regarding the accuracy of the themes identified by the researcher. If there was discrepancy, the researcher returned to the data for further exploration (Lincoln & Guba, 1985).

Dependability is an assessment of the quality of the integrated processes of data collection, data analysis, and theory generation. It refers to data stability over time and over conditions. It is met once researchers have demonstrated the credibility of the findings. Dependability was established through the independent audit of the data and its supporting analysis by a secondary reviewer (Graduate Supervisor).

Confirmability measures how well the inquiry’s findings are supported by the data (Lincoln & Guba, 1985). It is a process criterion. In order to ensure confirmability, the researcher documented all findings to leave an audit trail (Lincoln & Guba, 1985). This required the recording of the activities that occur during the interview so that another individual can follow. An independent audit was conducted from the supervisor who examined the original transcripts, data analysis documents, field notes, comments from member checks and the text of the dissertation itself to allow for confirmability.

Transferability refers to the probability that the study findings have meaning to others in similar situations. This was achieved by providing rich detail related to the context of the study.
These four criterion are crucial for judging the rigor of qualitative research. They define for external audiences the attention qualitative researchers render to define their work (Speziale & Carpenter, 2003).

**Ethical considerations**

The primary ethical considerations within both quantitative and qualitative research are safety and protection of human rights. Study involvement should only take place with the participant aware of the potential cost and benefits of their participation. According to Speziale and Carpenter (2003), the researcher follows the ethical principles of freedom from exploitation and respect for human dignity. These ethical principles are embedded in the research design as the researcher consciously avoids doing potential harm to the participant during the interview process. Informed consent addresses these ethical considerations using careful and honest full disclosure informing the participant of the research in detail. It is essential that consent forms be written in a simple and clear manner so that all research participants can understand. Additionally, consent forms should contain options to withdraw from the study without any blame or negative effects. Other conventional ethical considerations include the right to privacy and protection from physical or emotional harm. All of these ethical considerations were addressed in the Letter of Information (Appendix D) and Informed Consent (Appendix E). All rights of the participants were upheld throughout the study.

Research Ethics Board-Delegated Review (REB) approval for this research was obtained from Queen's University. Participants were provided the opportunity to share their experience of providing mental health care in the Emergency Department. The study was explained in detail to each participant. The Letter of Information was given to each participant to explain the research
in detail and later reviewed with the researcher in order to answer any related questions and address participant concerns. Each participant signed a written consent form and a copy of the informed consent was given to each participant. All demographic information and transcriptions were numerically coded. Informed consent forms were kept separately from demographic and interview data in a locked file cabinet in the PI's office. The researcher transcribed verbatim all audio-recorded interviews. All identifiable information related to either participant or institution were removed during transcription. Transcriptions and audio recordings were maintained in a locked file cabinet in the PI's office and all electronic information was encrypted and protected with a password only known to the researcher. Upon completion of this study, transcripts will be kept in a secured setting for a period of 5 years after publication of the research after which they will be destroyed.
Chapter 4
FINDINGS

For this study, the patient population presenting to the ED include: those who have already been identified as a psychiatric mental health patient, those who are seeking assessment and diagnosis for a variety of physical and mental health issues, and who present to the ED with mental health related issues. Therefore, the terms used within the findings section reflect the various stages of diagnosis. Terms of reference include: 'psychiatric patient', 'mental health patient', and 'individual with mental health issues'. Participants were assigned pseudonym to ensure confidentiality.

In response to the research questions, ED nurse participants believed that the care they provided to individuals with mental health in the ED is not adequate and does not meet the patient’s needs. Thematic analysis of the data revealed seven major themes that detracted from the nurse's ability to provide quality care: lack of knowledge (education), ethical treatment, stigma and fear, limited time and care implications, role ambiguity: assessment of the individual presenting with mental health related issues, environmental constraints, and effectiveness or quality of care. These themes are interrelated and develop from both organizational (dark blue) and individual (light blue) influences (Figure 3).

This chapter will include: a description of study participants, a description of common characteristics of patients presenting to the ED with mental health issues, the participants experiences described as facilitators and barriers to adequate care, and the perceived effectiveness of care provided by ED nurses.
Figure 3: Conceptual model of perceptions of care

- Limited Time & Role Ambiguity
- Lack of Knowledge (Education)
- Ethical Issues
- Environmental Constraints
- Stigma

Ineffective Care
Ten individuals met the eligibility criteria for inclusion of the study (Table 1). All ten participants completed the demographic questionnaire. All participants were female and their ages ranged from 24-55 years of age with a mean age of 36.8 years and a SD of 10.27 years.
Education was evenly dispersed as five participants identified the highest education attained being college RN diploma preparation and five participants' were university BScN prepared. There were equal numbers of participants from each site and all participants were female registered nurses. Years worked in the ED varied between two years to 22 years.

**The profile of the psychiatric patient receiving care in the ED**

Although the ED provides care to a diverse patient population, individuals presenting with mental health issues can be complex. Mental health related issues comprise a significant proportion of the overall patient visits within the ED, whether the patient is seeking treatment for mental health reasons or a combination of both physical and mental health issues. To gain an understanding of the participants’ perception of this patient population, participants were asked to describe the 'typical' patient seeking care in their ED, specifically in relation to mental health and psychiatry. They stated visits for mental health reasons were perceived to comprise a significant portion of emergency visits. This includes individuals seeking care for physical complaints who have a current mental health issue or who had a past medical history of mental illness. The nurse participant’s perception of the percentage of individual’s receiving care for mental health concerns in the ED (50%) conflicts with the published statistics (5-10%) related to ED visits.

**ELLEN:** "I wouldn't be surprised to see in the emergency room, probably more than 50% of people that come in, even if it's for a non-mental health related complaints."

Individuals were perceived to enter the ED in a variety of different modes. This includes ambulatory (alone or with family), via ambulance, and with police escort. The symptoms associated with mental illness were perceived to significantly impair cognition, mood, and judgement. This impaired cognition and judgement was perceived to limit the individual's ability
to actively seek treatment, especially when in crisis. In comparison to the 'typical' medical patient who were perceived to appropriately self-determine need for ED evaluation, individuals requiring care for mental health reasons were often escorted to the ED by police for psychiatric evaluation against their will.

CLARA: "Some patients will come voluntary, some are brought in by families who are concerned, some are brought in against their will (involuntary) by the police or some are brought in by paramedics."

Participants described the mental health patient who was 'in crisis' as lacking the mental capacity to process events and understand treatment provided in the ED. It was perceived that the more extreme the behaviours and symptoms, the less connected or aware the individual was to their environment. Patients exhibiting behaviours such as verbal and physical aggression who required the application of control interventions such as seclusion, were believed to have significantly impaired cognition and awareness.

HELEN: "Some of them don't understand what you are doing. Do they understand the concept of seclusion? They don't understand the concepts of what you're doing to them and why. The ones that the police have to bring in [against their will], I think they are the ones that are, they are in their own world."

GRACE "[Coming to the ED] is something they don't want to do, whether or not they are in the right mindset to understand that it is in their best interest or not, I don't know if they understand."

Commonly cited presenting complaints for individuals seeking care for mental illness related issues tended to be acute exacerbation of chronic mental health issues. These included symptoms of increased depressed mood with or without suicidal ideation, intentional medication overdose, and symptoms of psychosis including auditory and visual hallucinations. Symptom
exacerbation was thought to be associated with non-adherence or refusal to comply with treatment. Symptom exacerbation was often aggravated by substance abuse.

CLARA: "They're probably not compliant which creates a situation that brings them into the department. There are, depending on, I think their mental health ah, underlying diagnoses, will determine um, their ability for compliance. People are quite escalated, agitated, ah, whether that's due because they've stop taking their routine medications.. or ingesting illegal drugs, and alcohol."

Participants stated the most predominant psychiatric conditions treated in the ED were Concurrent Disorder, Generalized Anxiety Disorder (GAD), Depression, Schizophrenia, and Bipolar Disorder.

The bulk of psychiatric services for this population was believed to be provided in the community. It was felt, that when these community programs were inaccessible and/or failed to meet the needs of this population, individuals with mental illness would seek treatment in the ED as they see no other options available to them. They felt that some mental health patients presented to the ED when they lacked basic needs such as food, clothing, or shelter and it was stated that they misrepresented their clinical condition in order to received inpatient treatment where shelter, food, and clothing would be provided. Accessing mental health care in the ED was often deemed to be inappropriate and a misappropriation of healthcare services because community resources and mental health programs had failed to provide support for this patient population.

ALICE: "People are in desperate needs of assistance, and it's just not out there [in the community]. They want to be admitted to the psych unit. And I don't know if because they are having an actual crisis. They just know that they need some help and think that's [the ED] is the only way to get help. They don't know where else to turn ... so they come to the emergency departments
looking for help."

ALICE: "Maybe it's just that they want something to eat, or they need an extra sweater or something. But they feel that they have nowhere else to go, so they make [their reasons for seeking care] into a bigger issue than what it actually is."

The trajectory of many chronic illnesses, whether of a physical or mental health nature, encompasses stabilization followed by periods of symptom exacerbation. This translates into increased use of health services, typically through the use of the ED, to manage symptoms during crisis episodes. The nurse participants described the population of those who seek ED treatment for mental health reasons; the negative label of 'frequent flyer' was used to describe an individual who frequently and repeatedly presented to the ED within a short period of time. Even without the label of 'frequent flyer', it was a common perception that a significant number of mental health patients repeatedly sought care in the ED.

ELLEN: "A frequent-flier is a person that you know them by name and you can see in our emergency chart. It is not uncommon that it might be a couple of days or a couple of weeks since they were last seen in the ED."

GRACE: "a lot of them are quote unquote frequent flyers. They are coming back a lot."

FRANCIS: "With mental health patients, it's not like .. get the medication going, it's like, 'oh boy, he's here again'. That is the perception."

The first point of contact when entering the ED is the triage nurse. The principle role of triage is to assess and identify the priority of care needs. The Canadian Triage and Acuity Scale (CTAS) is used by all ED nurses to categorize care priority, evaluate acuity level, resource needs and performance against certain operating “objectives” (Beveridge, et al., 1999). The negative
'frequent flyer' label and perceived 'legitimacy' of the ED visit impacts the nurse's determination of CTAS.

FRANCIS: "one patient in particular who for three weeks, every day would come in and tell us he was going to kill himself. And we more and more, got um, "okay alright". And now he would be one of those (frequent flyer) people who got CTAS 4 (non-urgent). They got to sit in the waiting room. And then he would always leave and nobody was concerned about that."

Issues and challenges related to patient and staff safety were identified with individuals with mental health issues. This patient population was described as violent, aggressive and often "out of control" and this crisis state was often the result of non-compliance with medication treatment regime.

BETH: "The mental health patient is typically in crisis and out of control."

ALICE: "The majority that are coming in with mental health issues... there is a higher proportion of them with violent tendencies than nonviolent tendencies."

**Facilitators and Barriers to Adequate Care**

Nurse participant were asked to describe situations when the care provided met the needs care. Participants consistently articulated the positive outcomes associated with rapid assessment and appropriate disposition of care.

BETH: *They get referred to psychiatry and they get a bed sooner than later... but that doesn't happen very often.*

CLARA: *His stay in the department was not a lengthy stay and he was admitted to the admission ward within a few hours of arriving and being assessed. So that was a good outcome... but this is not typical.*

ELLEN: *Um, an ideal situation would be a quick assessment,*
"admission, and immediate transfer to the inpatient mental health ward."

Although ED nurse participants were motivated to provide optimal care to patients, they had difficulty articulating situations where the needs of the mental health patient were met. Positive patient encounters were described as situations where nurse patient contact was minimal.

Nurse participants described situations where they felt constrained by barrier within the ED care setting. The barriers that negatively impacted the participants nursing practice included a lack of knowledge (education), ethical issues related to the use of control interventions, stigma, environmental constraints, limited time and role ambiguity.

**Lack of knowledge (Education).** A lack of knowledge and understanding about the needs of the mental health patient was identified by participants as the most significant barrier to providing them with patient centered quality care. Education is ongoing and attained through multiple sources: basic entry to practice programs and then education is provided through ED orientation, in-service support and continuing workshops and courses.

**Nursing education.** Education to establish competency related to mental health nursing is attained through their post-secondary education (undergraduate or diploma preparation) and at the ED unit level (orientation and in-services). The perceived lack of focused mental health education and clinical experience at the undergraduate level was thought to be a factor that limited the nurse’s ability to provide comprehensive care to the individual seeking treatment in the ED.

ELLEN: "When I was in nursing school, we did have mental health. There was a theoretical course and a mental health placement, although your experience very much depended on your placement. I was in the community with Alzheimer’s patients and so ... I didn't have a lot of clinical experience
with quote unquote mental health patients that we see prior to working in an emergency department."

ALICE: "Not enough training in school for mental health... unable to develop interviewing skills or assessment skills."

CLARA: "There's not a lot of education in background psychiatric. [nursing care]. It makes it very difficult for an Emerg nurses to just pick up and try to provide therapeutic environment and therapeutic interactions for patients suffering with different mental health backgrounds."

HELEN: "I haven't really had any education. I know in University, I had ... we had a course, it wasn't just the mental health but we touched on it. I did not have a clinical placement in mental health."

Nurse participants felt unprepared to provide adequate and competent care for the individual seeking care for mental health issues in the ED.

ALICE: "I think that it's very hard to treat a psychiatric patient when you don't have the skill set or the background knowledge. I find it very hard to treat psychiatric patients because I don't have a background in it. So I'm going in, blindsided per se, and trying to help the situation, that I am not confident that I can help. So I don't know sometimes how to approach a patient appropriately."

**Orientation and in-service education.** Orientation for new employees commencing employment in the ED is a requirement for all staff regardless of past experience and education. Orientation included both in-class education and peer buddies with an experienced RN. During orientation to the ED unit and the position of triage, participants identified minimal support and education in mental health nursing care.

BETH: "No special mental health assessment training (is given) for triage nurses."

BETH: "As nurses in the emergency department there's not a whole lot of training that is out there, offered to you, to
Due to their lack of perceived education preparation and in-service training, participants stated they relied heavily upon experiential learning combined with observation which became the means of gaining knowledge in care practices. The ED nurse observer had no basis to evaluate the appropriateness of the observed care of the role model.

ELLEN: "Well I think part of it is experience. Just, you know dealing with different patients. Kind of getting used to, I don't want to say abnormal behaviours... but someone who was yelling or kind of upset about being in the department. Once you have seen that a couple of times it's not as anxiety inducing. Other information... I got from colleagues."

FRANCIS: New nurses to the department "I would hope that the nurse who is orientating you has some sort of level of experience and would try to pass on to you what they have learned or what they've known."

HELEN: "I know there is one nurse that I really rely on because I work with her a lot. And if she was there, I would ask her to help. We would go in together to do the vital signs and I would just listen to what she would ask. When the police would come in, they want to give you report but she would never listen to the police. She would go talk to the patient even if they were yelling and screaming and, you know, she would go talk to the patient."

This experiential learning also took place during their nursing education while working in their clinical placement(s).
GRACE: "My mental health rotation was at CAMH in Toronto on a schizophrenic inpatient unit. It was an eye-opener because that was the very first experience I’ve ever had with mental health and I wouldn’t really say that I learned a lot because of my experience there. I wasn’t too pleased with the treatment that the patients received for the staff in the department.”

**Continued education.** ED nurses described available continuing education courses relevant to ED nursing practice as primarily medically based and identified a lack of opportunity to engage in continuing education supporting the delivery of safe and competent mental health care. Only three of the ten participants confirmed they had engaged in a continuing education program related to mental health/psychiatric care.

FRANCIS: "I wouldn’t say I have any specific training at all. We learned Non-violent Crisis Intervention but I have been in the emergency department for 10 years. I've only taken the course once. I have never been recertified or anything."

HELEN: (Non-crisis violent intervention) " I don't think it was that effective. I did try to use it, especially the stances where you use non-confrontational stances and they may have helped but I am not um, I don't feel confident in assessing mental health in those situations, so other than that, not really."

GRACE: I completed "one course in regards to psychiatric nursing and it kind of went over .. different types of presenting diagnoses or how to handle psychiatric patients and kind of things to do and not to do. I didn't really find it very effective but it was more than I have had before that. It was a course offered in the Emergency RN Certificate Course".

Although deemed relevant, participants indicated that nursing staff were not necessarily motivated or required to complete continued education program.

DACIA: "No, the (mental health) training that has been offered is few and far between. I know of only one workshop that has been offered and I think that it was by another hospital actually and there was just a bulletin that nurses could go.
There is not a lot of opportunity for additional training. Additional education is not encouraged by department and are not mandatory.”

ELLEN: "I have had limited to no education that has prepared me for working with the psychiatric patient"

FRANCIS: "I personally think they (mental health in-services) are very much relevant to the emergency room setting. Absolutely but um, I certainly think they are but I know some nurses that would be more interested in taking in EKG course than a mental health course."

HELEN: Education something that is not supported by my hospital. I don’t feel there is support, like we don’t even get education in the department.”

Barriers that may impact participant’s desire and ability to engage in continuing education were primarily related to cost and time.

DACIA: "Time is a big barrier" to engaging in additional education for mental health. I would say you would have less of a compliance rate if there is a large cost.”

GRACE: "What would be great if the hospital wanted to pay for my education however, laugh, that often is not feasible. Um yes, and having time to you know, like when you are writing papers and going to school, you have to still be a mom, still go to work... it's tough.”

Participants put forward some ideas for educational programs that would meet the needs of the nurse. They argued that all ED nurses need to have a basic understanding of common mental health illness and basic treatments, especially those that related to assessment and de-escalation.

DACIA: "Knowing about mental illness and what we can do for patients initially when they come in."

GRACE: "Nurses come from all different backgrounds and for a lot of people like myself as well, have very limited psychiatric experience. So even going over basics, even if it's just a refresher for some people or for others that
could use that, anything would be useful for caring of this patient population."

HELEN: "Assessments because if you're good at your assessments it can tell you a lot. It can tell you if this patient is at risk, this patient is going to escalate, um so good assessments is a big need. And even, I know even about the different diagnoses like schizophrenia and bipolar, and personality disorders.

These skills would have to be made available through various delivery methods and organized at the schedule of the individual nurse.

DACIA: "Workshops are great but then again it's very hard with schedules. I would prefer an online course ... making something that's interactive, you know that you could answer questions and actually learn."

Education was viewed as a having a key role in nursing preparation at both the undergraduate level and as a method of continued education when providing mental health care in non-psychiatric settings.

An essential role of the ED nurse is the mental health assessment. These occur in two settings within the ED - triage and the assigned nurse initial assessment. All participants felt they lacked relevant skills in mental health assessment. The nurse's perception of their ability to complete a mental health assessment will be explored within the role of the triage nurse and again as completed by the assigned unit nurse.

**Ethical issues related to the use of control interventions.** Participants described various ethical dilemmas related to control interventions (physical restraints, chemical restraints and/or seclusion). Individuals exhibiting serious psychiatric and behavioural problems threatening the safety to themselves or others, were perceived to routinely require interventions involving restraints and/or seclusion because this patient population is viewed as aggressive, emotional, violent, and unpredictable. When discussing their use of control interventions,
participants described feelings of shock, sadness and guilt, particularly when they place a mental health patient in a seclusion room.

ALICE: "When police officers had them handcuffed and brought into the department and thrown into um, what they call a [seclusion room] and it’s a locked room. The patient would be kicking and screaming and I actually had to help with the security guards, 4 of them, pin this patient down and give them an injection to help settle them down. It’s a huge eye, a huge eye opener. I was very shocked at how (they were) treated and how it went about."

BETH: "I was also saddened that people, I don't know if it's the right word, had to be treated be treated in that way but were treated that way. I know why that given that they have a tendency to be so violent but it's very sad to see that a person of emotions and feelings has to be pinned down and yelled out and you know, held against their will."

CLARA: "It actually made me feel very guilty. Because it felt as though she was .. a criminal. She was being locked in a cell and there was really, she did nothing wrong"

Seclusion rooms were described as restricting rooms typically located in a central location within the ED. These rooms were small, foul smelling, dark and confining rooms that were viewed to lack basic comforts.

DACIA: "That room has a very small window otherwise is a oddly shaped and has two benches that are attached to the walls and that's it. Um, so, it can be very dark, it doesn't smell nice, there is very little air flow, um, it's, it's just not a nice environment."

The purpose of the seclusion room was to ensure safety of the patient, nurse and others in the ED. The room restricted movement, minimized risk of abscondment, and eliminated items that could be used in acts of self-harm. Cameras were positioned in the room so staff members could actively monitor patient actions.
HELEN: "Sometimes [the patients] have basically been placed on the floor with nothing else. The reasons [for no stretcher] .. is that they can ram it up against the door so that you can’t get into the room and that they can flip it over. Um, the blankets and a pillows - they could try to hurt themselves like choke themselves. It is for safety."

When dealing with an individual exhibiting violent or aggressive behaviours, the nurse's decision to use control interventions balances the need for patient safety versus appropriate and ethical care. Three specific applied interventions are classified as control interventions within the ED: chemical restraint, physical restraint, and seclusion. The use of control interventions was applied with the intention to protect an individual from self-harm or preventing harm to another individual's patient safety.

ALICE: "I think that given the situation that you're fearing for harm to the patient from themselves and harm to yourself. Even though it's ethically wrong to pin them down and I, it's a gut wrenching feeling having to do that the patient. I think that, if you flip the other side of the coin, getting the medication that they need to help calm them down so they don't harm themselves or you, is something that needs to be done.

BETH: "I don't think it's the appropriate treatment at the time but I think it's the safest treatment they can be given that time."

GRACE: "If it is for their safety and the safety of the department versus one patient ... I think that is necessary."

HELEN: "I engage in activities that I may not become comfortable with that you find hard on the patient, for the outcome of patient safety".

Nurse participants describe feelings of being stuck between a rock and a hard place. Using control interventions may result in increased psychological harm to the patient, but failure to use them could result in staff or others being harmed. Thus, the use of restraint or seclusion elicited significant ethical concerns to the ED nurse participant.
ALICE: “Given the situation that you're fearing for harm to the patient from themselves and harm to yourself. Even though it's ethically wrong to pin them down and it's a gut wrenching feeling having to do that to the patient. I think it's an awful way to treat a human being.”

ELLEN: [There are] "anxiety inducing aspects of dealing with the mental health patient is that very violent, agitated patient who has to be restrained and you have to administer medications that the patient doesn’t want... I feel awful um, because I think it yes, (it's) for the safety of the patient... I think how we go about it is, you know, I don't see how it is therapeutic.”

HELEN: "I feel scared for them because I would be scared if I were to go into that room. But I am also scared for myself because I don't know what is going on with this patient and maybe they need to be in that room to protect me and other people."

The decision to use control interventions was perceived to be based on the subjective assessment of the ED nurse. Most participants stated they were not aware of any specific evaluative criteria or policies that had been established at an organizational level that were accessible to ED staff to support the decision making process.

GRACE: “I am not aware of them [policies or tools]. There might be or should be.”

HELEN: "It is a personal decision [to use control interventions]. I have never seen anything that says this is what the criteria that has to be met for the door to be locked. So I definitely think it’s a personal subjective decision.”

Two participants were aware of an organizational Least Restraint Policy but identified that this policy was not followed by staff in the ED. In addition, they described a sense of support and acceptance from their institution and other healthcare team members within the ED when the decision was made to use control interventions.

BETH: "There is a least policy ... only use as a last-ditch effort ..."
and with permission from the family member ... but... we don't [get permission] when we use them."

FRANCIS: "Yes, I would say they [administration and ED staff] are okay with using restraints. Our hospital has least restraint policy but ... we don't think, we're not following the policy of least restraint."

ED nurses, whether in the role of triage nurse or providing care within the ED use a variety of subjective and objective criteria to determine the need for control interventions. This involves the observation of patient's presenting behaviour, assessment of symptoms, the need for close observation, and the available room resources.

DACIA: "It's a subjective risk assessment um, of the patient's behaviour when they arrive and they're presenting complaint... are they anxious or ...are they at risk to themselves. If we anticipate putting them on a Form 1 and they are a flight risk. If they don't want to be there and they are brought in against their will."

BETH: "It's based on the nurse's assessment... if the patient doesn't want to be here, I am assuming they are a flight risk. If I catch them wandering around the hall... or if the police bring them in... they go right into that room."

Another strong criteria for the use of control interventions was the individual's past history of mental illness. Participants spoke of the decision to use control interventions even when the subjective assessment did not validate their use.

ELLEN: "If the patient is there for mental health complaint, they often just get placed into the seclusion room regardless of and even if, even if they are completely cooperative, and not that we would lock them in the room. But if they are completely cooperative and pleasant, they will be placed in that room most cases."

HELEN: "A lot of the psychiatric patients that do come in ...
we are afraid of them so we have a seclusion room and they go in there."

Although all participants agreed the application of control interventions was a nursing decision, two participants did identify the requirement of a physician’s medical order in order to lock the door of the seclusion room, thereby forcibly restricting patient from leaving the department. The participant further explained that the order was often written after the locks were engaged. ED nurse participants were not required to consult with the attending physician beforehand but often requested written support after the intervention was applied.

HELEN: "The guidelines that I know of have to do with the locked door ... and you have to have a doctor’s order to have the door locked. That is the only policy that I know of. It is done after the fact. I think that sometimes people need to lock the door so they lock it and then they'll say, go to the doctor later and say I have to lock the door, can you write me in order?"

FRANCIS: "I understand that there was, at one point, where we would have to have a physician’s order to lock the door of his room. Um, checks and balances, I am trying to think...."

Patient observation while in seclusion was primarily achieved via camera surveillance and not one-to-one nursing care.

CLARA: "There is a camera in the corner that monitors patients. There was a [television] monitor in front of a unit clerk [linked to the camera in the seclusion room].... [The television placement] was not really convenient for the nurse in that area to watch what was going on [with the patient in seclusion]. It was um, I believe it was put there.... so that somebody could watch that patient."

After control interventions were removed, as a method of quality control, no formal or informal review took place in either facility. Documentation of the intervention was only believed to be within the patient record as a part of nursing progress notes. Participants did not
document the use of these interventions as part of a critical incident. No post-intervention review or evaluation process took place. Participants were not required to validate the decision to use either restraints or seclusion beyond what was written in the progress notes. Interestingly, although debriefing was not practiced in either institution, participants were receptive to integrating a post-intervention debriefing process when control interventions were used.

HELEN: "There is no debriefing after restraint use for the nurse or the patient..... I think that would also help us or it would prevent maybe getting to that point (of applying control interventions)."

The effectiveness of the control interventions was questioned by participants. Use of these interventions was believed to potentially increase patient aggression and anxiety.

BETH: "I'm fairly confident that it doesn't help calm them down because they pound and yell at the door. Um, they probably feel trapped but there is really not much I can do about it."

DACIA: "Seclusion room may actually escalate due to the lack of ventilation, the hard bench that's nailed to the wall, the camera, the locked door...Lack of sunlight, lack of..., you know, the noise, the sound of people speaking around you is muffled in that room as well so those things as well."

The potential psychological impact to the patient when placed in seclusion was not a variable when making the decision to use this control intervention. When participants were asked to describe the psychological effect the seclusion room may have on the patient, they used descriptors such as "overwhelmed" and "de-valued" indicating the potential for psychological harm was moderate at best.

BETH: "A lot of them are probably familiar with the room because they are in so frequent. For the patients they may be it's the first time you ever laid eyes on the patient, I'm sure it's overwhelming."
ELLEN: "I don't know [how the patient feels being in seclusion], I have never really asked them. Um, but I think if it was me I'd, I'd feel as though well, I mean, I mean if the door is locked and, and how I was treated I wouldn't feel as though I was a priority."

GRACE: "I'm not really sure why they don't like that room. I think maybe it is just the locked door and it is not an inviting room."

As an alternative, three participants identified alternatives for forced confinement in seclusion. Communication and verbal de-escalation were considered as potentially beneficial alternative to the use of control interventions.

BETH: "If a patient does not want to go into the seclusion room, I will move them to another room where all the sharps have been cleared out and if they try to leave, they are told that they will be moved to the seclusion room."

GRACE: "We would perform verbal de-escalation prior to seclusion room."

ALICE: "I've had times where you actually try to approach them and sometimes it works for you. If you talk to them and try to empathize with them. They will be pleasant and take their medication and then that will help with their, with their demeanour."

Due to the need for rapid assessment and treatment, this therapeutic communication was not easily accomplished. The use of restraint (chemical or physical) was an intervention that required minimal time and skill from the nurse. Participants described it as benefiting the nurse at the expense of the patient.

CLARA: "... in order to avoid that risk, you would lock the door. So it's basically convenience for the nurse because she hasn't got time to sit down and go through a process to um, interview with this patient to, you know, what brought them there because she's busy doing other things. So, it's when you're locking a patient in a room, you're doing it because you don't want their health at risk if they leave, and as a convenience for the department."
ELLEN: "The door gets locked instead of there being some type of other intervention and/or patients get medications to calm or control them to make things, I don’t want to say easier for the staff but just when it is a busy department, um, kind of to reduce that risk maybe for staff and patients but not in their best interest."

When control interventions were utilized, care and evaluation was compromised. Due to the perceived safety measures of a locked windowless room, the patient's need for close observation was challenging.

ELLEN: "And there is observation on them but um, but probably not as constant as would be needed. It could be considered care but I don't know if peeking your head in the door to make sure your patient is still breathing is the same care as talking to patients."

HELEN: "We have video cameras that are in the room um, but really the light has to be on in the room to have a good picture. You can see a, kind of a lump if they are lying on the floor."

A final ethical issue identified by ED nurse participants is the challenge of maintaining patient confidentiality. The lack of confidentiality for the mental health patient was an identified issue due to the close proximity of patients to each other, as they are often only separated from each other by curtains. Participants were aware of this issue but indicated that maintaining confidentiality was not perceived to be a priority by the ED staff.

HELEN: "There is no confidentiality for certain mental health people that come in. I don't think that anyone thinks about it when it happens. Anyone could walk by and see in the seclusion room. It includes other patients. There are often times where I have had to ask patients to go sit in their own area or go around the corner a bit because they will watch what is going on the patient."

While the use of video surveillance in the seclusion room allows for the nurse to monitor the actions of the patient, it feeds into monitors that are centrally located on the walls of the nursing station. Participants state the monitor is clearly visible to patients and family members who
approach the nursing station thus posing significant breaches of patient confidentiality and dignity.

DACIA: "The monitor is actually pointed out towards traffic. Patients or family members that are walking by actually are able to see the monitor as well."

This allows for the visual identification of patients in designated seclusion rooms. Additionally, the close proximity of patients that allows for personal information to be heard by patients and visitors.

FRANCIS: "Confidentiality is a problem because... other patients are listening and watching in that regard. [We live in a small city and the psych assessment rooms that we have... are right in the front area. They do have a window in them, so if the door is closed or the door is not closed, people can walk right by and see the person they work with or someone from school and think...’ what were they here for?’ Because, you know, it's not the type of room that you would be assessed in a gown, it's a psychiatric room, it's a talking room."

**Stigma.** Stigma was believed to be pervasive within the ED by all levels of health care providers. The effects of stigma significantly impact the assessment, treatment and evaluation of the individual with mental health issues.

ALICE: "As soon as someone sees somebody even with a history of psychiatric background of any sort, that there is always, that there is already put a stamp... oh, they've got an illness. Oh my God, it's a mental illness. I think (ED nurses) are very judgmental."

HELEN: "Stigma is a big barrier because sometimes (nurses) think that they can't be helped. It is a stigma that they are just in this circle (frequent flyer). That it is the same patients that come in and we can't really help them because they don't want to be helped and they just want to come in for some meds or admission for a couple of days. So we don't want to take the time to help them."
Negative labels were often used with this population. These labels influence the nurse’s approach to treatment.

*BETH: "Stigma means they are labelled as a set type of person - aggressive, you are worried maybe they're going to harm you, harm other patient."

*CLARA: "Stigma ... involves staff calling patient's crazy. Anyone with mental health issues are crazy."

Due to the lack of confidentiality, close proximity between patients, and level of overt stigma and prejudice, participants suggested the individual seeking support for their mental health concerns were liable to be aware of the nurse's perceptions. Although ED staff may not be conscious of making discriminatory statements, the result can be psychologically damaging to the patient.

*ELLEN: "Stigma in the department is not uncommon. Staff might roll their eyes [saying] "oh, another mental health patient" and, I think hearing comments like that would make you feel undervalued."

*FRANCIS: "I heard a nurse say once... 'oh, so-and-so is in again and he wants to kill himself'. Um, we see the same patients over and over again. She goes 'every once in a while they do us all a favour and knock themselves off we don't have to see them again'."

Prioritization of care judgements were based on the perceived validity of the patient's voiced concerns. Medical patients were given a higher priority than mental health patients and thus their care needs were addressed before those of the mental health patient.

*ELLEN: "We had frequent patients that come in and they do receive lesser care um, as nursing staff to know them. There is also the weighting of what nurses perceive as a severity of the issue and I think the general perceptions is that medical/surgical issues are weighted higher than a mental health issue."

Participants spoke of the perceived legitimacy of patient's expression of suicidal ideation.

*HELEN: "Suicidal patients aren't taken seriously because I think that people have had those experiences where people
say that and not mean it so that patient may come in three weeks later and say it again and mean it and they may not be believed."

FRANCIS: "We often know that people who really want to commit suicide often do it anyways, regardless of intervention, regardless of everything. The person who really wants to do it, will go off and do it. Um, the patient who comes in often and often and often and keeps complaining of it, um, saying they are thinking of it. I don't think that eventually that they're not going to do it, I mean, someday it could happen. It's just like the boy who called wolf. Like it's just an ongoing here we go again. That is $500 every time they come into our health care system."

HELEN: "The nurse doesn't always take the concerns or the statements of the mental health patient appropriately with due diligence or... really listens and understands and believes the mental health patient."

Some participants felt that through changes in treatment, education, and the raising awareness of mental health in society, the impact of stigma is decreasing.

CLARA: "I think it's getting better. I think more people are becoming empathetic to mental health problems, I think because they... they're trying to clear up the stigma."

**Fear of patient violence and aggression.** The theme of fear is interwoven between multiple themes in the discussion of perceptions for care. Fear of potential for violence and aggression in the ED was an overarching theme emergent in the data. This pervasive expression of fear was associated with the perceived unpredictablity of the mental health patient. Fear emanated from inexperience and lack of knowledge that rose exponentially when the patient was unknown to the nurse and experiencing an acute mental health crisis.

ALICE: "I was very nervous. Very, I was scared for myself. I think nurses would be afraid (of the acute mental health patient). Especially if they don't have the background experience with them."

HELEN: "My experience caring for the mental health patient is mostly negative because, a lot of psychiatric patients that do
come in are in crisis so, we always tend to be afraid of them."

The fear reaction hinders the participant's ability to provide appropriate care while maintaining safety of the patient and others.

BETH: "There have been a few that have really scared me ... you don't even want to be in the same room as them ... I'm sure it does [impact on the quality of care] because you're concerned about your own safety."

ELLEN: "It makes me feel that I don't want to be involved in that patient's care for fear, fear of being hurt."

GRACE: "Going in there, I was a bit apprehensive so, for me to calm my nerves, I was trying to make small chat with her and she kind of just wanted to get what needed to be done and not have any interaction about."

HELEN: "In my experience, it is mostly negative ... a lot of the psychiatric patients that do come in are in crisis here so, we always tend to be afraid of them I find and we have a seclusion room and they go in there."

Participants describe how fear is exacerbated in the presence of inadequate knowledge. Without adequate knowledge, participants often relied on the experiences and perceptions of others. During interviews, participants sometimes questioned the accuracy and validity of their ideas and practices in regards to effective mental health nursing care. Lack of education and knowledge of knowledge also was felt to exacerbate the nurse's fear of the mental health patient.

GRACE: "I don't think that there is proper training for emergency nurses, in my experience anyways, so it makes it that much more challenging to deal with the population because it seems like there are either a lot of either misconceptions or just, for me anyways, anxiety around the population in general."

Lack of time and role ambiguity. Another theme that emerged from the interviews with the participants was the issue of time and caring for the individual with mental health issues.
in the ED. All participants spoke of a perceived lack of available nursing time to complete required nursing care within the ED setting. This posed significant challenges as therapeutic communication was believed to be central to mental health nursing. When compared to physical assessments, mental health assessments and many nursing interventions were thought to be time intensive.

HELEN: "Time is an important component in providing care for the mental health patient. I feel you don’t have enough time when working with them."

DACIA: "I think my number one issue would be a time factor. I think that nurses need more time to spend with mental health patients."

At triage, the ED nurse focuses on quick assessments in a fast paced environment. The expectation of the nurse is to complete a rapid assessment to determine acuity, risk, and appropriate disposition of the patient. Despite the desire to provide appropriate care, engaging in a prolonged assessment disrupts the normal flow both at triage and within the department.

ALICE: "At triage you are always trying to keep the flow going .. you can’t stay with the mentally ill patient as long as you would hope to because you need to keep moving on to the next patient."

BETH: "Not enough time to perform (a mental health) assessment at triage."

CLARA: "Once you have assessed the safety, personal safety beyond that to you find that not you’re able to provide that assessment or engage in that assessment of the individual with mental health issues ... I don't think time is on our side."

FRANCIS: " In triage, they told us lately, that we have 90 seconds to do a triage. You have to pull the dirt, what you can there and hope that the rest of it is continued on in the department."

HELEN: "At triage I try to ask them a couple of questions and I don’t think that they should go into (detail) ... it is not the right spot."
Similar to triage, when providing care within the ED, the lack of time posed a significant barrier to effective care to the individual seeking care for mental health related issues. Multiple patients, low priority of the mental illness compared to physical illness, the need to prioritize care needs between patients, and the amount of time required to complete a focused mental health assessment posed insurmountable challenges to the ED nurse.

**BETH:** "The number of people that we're dealing with alone in the emergency department just doesn't allow you the time to even properly assess the psych patient. You have about 10 plus patients, so your time spent with the psych patient who is medically stable is at a bare minimum cause you're dealing with any medically unstable patients first."

**ALICE:** "Your time is being taken away from the patient because of other situations that may come about so you might not be able to be focused completely on that patient... Because the ED focuses on an in-and-out basis, it's not really allotted time (required by the individual with mental health issues)."

**FRANCIS:** "Physicians who are [saying] 'can we get more patients in, can we move, move, move, move, move more patients ... and the patient who wants to talk to you in the seclusion room isn't going to die if they don't get their ginger ale or if you don't get a moment to go in and talk and sit down with them."

Time constraints can be a deciding factor in the determination of applied interventions regardless of the perceived effectiveness of the intervention. When patients were assessed to pose a risk to self or others, nurse participants validated the use of control interventions as they required the least amount of nursing time and the outcome was equally prompt.

**BETH:** "I feel stressed there is a flight risk amongst all these other patients. I just don't have time to deal with this.

**ELLEN:** "Perhaps, the door gets locked instead of there being some type of intervention and/or patients get given medications to calm or control them to make things,
I don’t want to say easier for the staff but…”

HELEN: "Chemical restraints are probably not as effective as de-escalation, it's just easier on us because I can go and given an injection 10 seconds and then go do the other orders on another patient."

When control interventions are used with the high risk mental health patient, time requirements increase related to observation and assessments. When time demands are high between assigned patients, the nurse feels they are unable to provide adequate observation of the patient.

BETH: "I think, now I need to watch this person make sure they don’t leave, I feel stressed that there is a flight risk and amongst all these other patients, I just don’t have the time to deal with this.

DACIA: "nurses may be in doing a procedure or a blood draw for more than 30 minutes at a time, caring for five or six other patients while that um, while that patient may be in the psychiatric room unmonitored."

Role ambiguity: assessment of the individual presenting with mental health related issues.

Primary assessment of patients entering the ED is the responsibility of the triage nurse. Triage is a decision-making process that prioritizes the individual's need for care on arrival at an ED. The purpose of the triage assessment is to ensure time-sensitive evaluation of the individual based on the triage assessment of mood, symptoms, and behaviours. Established departmental time guidelines underscored the requirement for rapid triage assessments. Participants stated the average allocated time available for a single triage assessment was to be limited to approximately 90 seconds. Although this limited time for assessment was restrictive, this time frame was
applicable for both the medical and mental health triage evaluation. The limited time prevented
the nurse from engaging in a complete assessment.

FRANCIS: "In triage, they told us lately, that we have 90 seconds to
triage. You have to pull the dirt [obtain health information],
what you can there and hope that the rest of it is continued
on in the department. At the same time, I am triaging this
patient, I might have 10 other patients out there
that I don't know what's wrong with them."

HELEN: "Assessments should be of the same depth level as the
medical patient but sometimes it isn't because, if it is a busy
department and, you know, there is someone with the
patient, like a family member, then the mental health
assessment could very well slip to the wayside and we would
talk to the family."

GRACE: "Assessment time, or your depth of the assessment of
the mental health patient differs in that the medical patient -
it is less [rigorous] for the mental health patient."

The process for mental health triage assessment primarily involved a subjective nursing
assessment involving a brief interview and observation of patient behaviours. No standardized
assessment template was available to the triage nurse in any of the participants' facilities.

DACIA: "[The triage nurse] completes a subjective
risk assessment um, of the patient's behaviour
if they come in through triage. So it does depend on the
patient's behaviour when they arrive and they're presenting
complaint... are they anxious or are they at risk to themselves".

During the triage assessment, the primary focus was to determine acuity and immediacy of care
needs focused on the patient's potential for self-harm or harm to others.

CLARA: "Mental health would be assessed at triage uh, -- threat
to self or others and they would be placed in a room according
to their presentation at triage."

Once the patient has been triaged, they are transferred to a room within the department.
In the ED, it is the responsibility of the assigned nurse to complete a comprehensive head-to-toe
evaluation focusing on a mental health assessment. The mental health assessment is conducted primarily through an oral interview and observation with the patient. The physical assessment requires a hands-on assessment of systems (cardiac, respiratory, gastrointestinal, etc) including the attainment of vital signs. All ED's where participants were employed required nurses to complete both the mental health and physical assessments for all patients. A comprehensive focused mental status assessment was required for all mental health related issues however, participants discussed the lack of assessments for individuals requiring care for mental health reasons. Assessments were brief, superficial and more focused on ensuring the patient was medically stable. The mental health assessment and determination of mental status was minimal especially if patients presented in a calm and controlled manner.

BETH: "You might spend 5-10 minutes on an initial visit with [the mental health patient]. As long as they are stable and they haven’t, you know, inflicted injury onto themselves or drink anything. If they’re stable, you talk to them for a few minutes um, check your vital signs again and if you feel that they can wait to be seen by the physician, then they sit and they wait.”

CLARA: "Our role is to make sure that they are medically stable... a nurse would be asked to do blood work or cardiogram or a set of vital signs... that would be the bulk of nursing in the area. Uh, we wouldn’t really make any, um, other than looking to make sure that they were not in acute distress, there was no therapy offered to them, there was no real interaction.”

Communication is an essential component to the mental health assessment. Participants experienced challenges when communicating with individuals with mental health issues specifically, they perceived a lack confidence and competence in communication strategies used in mental health nursing.

GRACE: "Sometimes they just don’t want to talk; for me personally, it could be my limited experience and knowledge with psychiatric
patients and kind of a fear of saying something that could escalate the situation and try and get the information that is just pertinent as to why the patient is here and leave it at that.”

The aim of the nursing assessment / interview was to elicit information about presenting issues, history and psychosocial background. Interviewing the patient was found to be particularly challenging for both the novice and experienced nurse. Fear of exacerbating the patient’s condition was a significant concern and as a result, the interview was often reduced to superficial conversation in an effort to avoid subjecting the patient to emotional harm.

GRACE: "I think even sometimes just asking too many questions about why they are here and going too much into depth if they are having thoughts of self-harm or hurting someone else ... that asking too many questions could potentially upset them and put myself and others in harm. That’s kind of at the forefront of my mind when I assessed psychiatric patients, mental health patients."

Participants were asked to describe the components of a focused mental health assessment. ED nurse participants discussed the need to obtain information related to the patient's physical appearance and manner of speech.

FRANCIS: [I observe] "just demeanour. Can they made eye contact? Are they looking down? Can they make... are they just completely ignoring me? Are they engaging with me? Are they laughing or smiling?"

GRACE: "[My assessment is] based on their presentation - if they make eye contact, if they you know, are showing any emotion or anything like that. That type of assessment. It’s just eyeballing the patient when they come in."

HELEN: "I know that decreased eye contact is, they are kind of introverted, they are, it kind of means they don't want to see the outside world. They are kind of .... they are in their shell. Pressured speech, if they have really pressured speech, it could be a sign of escalating [behaviour]."
There was a perceived lack of confidence in the nurse's ability to complete the psychiatric assessment. Participants were more confident in their ability to complete medically based physical assessments. Despite seeking help for mental health issues, the physical assessment often became the focus in both the triage and initial assessment of the individual with mental health issues.

DACIA: "I don't feel comfortable enough to do a mental health assessment."

HELEN: "I am more comfortable and confident in my ability to provide assessments and care for the medical patient."

In addition to the initial triage assessment, participants presented conflicting views in regards to the need and responsibility of the assigned staff nurse to complete a more comprehensive mental health assessment once the patient has been assigned to a room. Participants felt that the mental health assessment was avoided by many nurses.

DACIA: "Due to a lack of training, I am not certain, I think that um, nursing staff are not assessing mental health patients... (maybe) about 50% of the time, nurses assess the patient's mental health status."

HELEN: "No (I would) probably not (do a mental health assessment). But to be honest with you, I wouldn't really, I don't feel comfortable enough to do that, in terms of, I wouldn't want to say something that would be more harmful to their care... I am comfortable and confident in my ability to provide assessments and care for the medical patient."

While obtaining a focused mental health assessment was challenging to the nurse, the nurses focused on information obtained in the interview. Statements were challenged by nurses, particularly expressions of intent to harm self or others. These claims were sometimes viewed as
an attempt to be admitted to hospital and not an accurate description of their current state of mind..

HELEN: "The nurse doesn't always take the concerns or the statements of the mental health patient appropriately with due diligence or... really listens and understands and believes the mental health patient."

HELEN: "Patients lie about mental illness to get admitted, "it is usually related to suicidal ideation and plan. Also about homicidal ideation and homicidal plans."

When these expressions of intent were articulated by the patient, the participants did not identify any health assessment tools to support evaluating potential risk. The participants did not use any mental health assessment tools to facilitate accurate evaluation or risk and were not aware of any standardized assessment guideline for the evaluation of the mental health patient. No policy or procedure had been adopted by the organizations to support their need for further evaluation.

DACIA: "There is no, there are no specific mental health components to it [ED flow sheet], as a template... the nursing staff aren't doing a thorough assessment of those patients."

Nurses relied on subjective assessments and past experience to guide practice. Additionally, participants spoke of a perceived lack of time to complete assessments, therefore were unsure if completing a comprehensive mental health assessment was feasible.

**Environmental constraints.** The time constraints within the activity of the ED negatively impact on the nurse’s ability to form trusting and therapeutic relationships with the patient.

BETH: So you don’t have the time to sit and you know, be loving and caring with them ... and really dive deep into their problems just because you don't have the resources or the time.”
FRANCIS: "It is not often that I have time to sit and talk with the patient."

HELEN: "Like I myself don't know them and I don't have time to sit and talk to mental health patients."

Issues related to assessments are not solely between that of the nurse and patients. Assessment delays also occur between the physician and patient and also there was a delay in referral to psychiatry.

CLARA: "The time frame from the physicians seeing the patient to actually seeing a psychiatrist is a very long ... it could be hours."

When resources were available, the use of social workers within the health care team was viewed as supportive and potentially more appropriate to meet the needs of the patient with mental health issues. Social workers were assigned to one mental health patient and perceived to have the time to provide supportive care.

ELLEN: "The social work would spend 45 minutes to an hour or longer talking with patients which is something that we don’t have that amount of time as nursing staff to spend communicating with patients."

As identified by participants, the environment of the ED is not conducive to providing appropriate and time intensive care to the individual with mental health issues. The impact of time constraints and the lack of time available by nurses both at triage and when caring for the patient was discussed.

Due to the volume and acuity of patients treated in the ED, nurse staffing issues were a major concern because of the effects it had on the ability of the nurse to provide the time sensitive care required for quality patient-centered care. Participants were assigned an average of 8-10 patients at a time with a rapid turnover of many of these patients.

BETH: "Because the volumes of people that you're dealing with. You are not just dealing ah, with one patient to one nurse or two patients to one nurse, you are dealing with 8 to 10
patients to one nurse. You know, with your psych patient messed in with that. You don’t have the appropriate resources to manage them”

Inpatient bed shortage is a significant issue, especially when treating the high risk psychiatric patient. In response, patients under psychiatric hold (Form 1) pose significant challenge to ensuring patient safety is maintained. Frequent to constant observation must be maintained for all patients while on a Form. To support nursing, when available, security is used to provide visual surveillance.

CLARA: "Anyone can have security present especially a person on a Form 1. Having extra security is helping.”

Despite the significant challenges identified by nurse participants, there was a strong desire to improve and enhance the care provided to the patient with mental health related issues. While identifying constraints to care, nurse participants were able to provide viable solutions. At the forefront, organizational change that supported nurses in providing quality care was identified as critical to care.

DACIA: "There is a huge need for an organizational change to make mental health services better."

BETH: "A separate department in the emergency department that specializes or deals with psych patients. So one nurse doesn’t have a whole pile of other sick medical patients along with the psych patients to try to manage."

DACIA: "There should be an emergency psychiatric clinic by itself. There are so many things that go on in the emergency department that are not conducive to a healing environment for mental health patients”

CLARA: "I've worked in other institution that had a very good mental health set up for their emergency patient. They actually had a crisis team. And in the crisis team would consist of a
physician and um, a nurse um, or a social worker and they would come in and they would do their assessments and they could actually either admit or refer to community services such as shelters or different types of community mental teams to get these people connected.

Effectiveness and quality of care

Nurse participants spoke of an underlying desire to provide effective care to all patients seen in the ED. In contrast to providing the timely and appropriate assessment and treatment of the medical patients, participants suggested nursing care provided to individuals with mental health issues was inadequate and failed to meet their needs.

ELLEN: "It's more often than not I am left with not as much as a positive [feeling], I don't feel that I have had a positive impact upon their care. This is something that I am not 100% pleased about."

BETH: "I don't think that they think they get cared for. Because they're just put through, it's almost like I um, an assembly-line. Right? You're just, you just turning over volumes and volumes of people."

FRANCIS: "We make a very big effort to care for our clients. I certainly see lots of incidences where patient's slip through the cracks."

CLARA: "I am not confident in the care I provide the patient with mental health issues. I do not believe it meets the needs of the psychiatric patient ... I don't really feel that I'm a value to help these patients and it just seems more of .... babysitting."

ELLEN: "I don't think the (individual with mental health issues) needs are really being met ... things get done that maybe aren't in the patient's best interests."

Prioritization of patient care was identified as a challenge for ED nurses. With high patient volumes and heightened acuity of care needs, prioritization of care was a constant challenge to nursing staff. Triaging and prioritizing patient care was identified as particularly
challenging when providing care to multiple patients. Patient needs are evaluated based on the nurse’s perception of symptom urgency, significance/severity, and acuity. Participants reported symptoms of the body maintain a higher priority than symptoms of the mind.

**BETH:** "When you look after a multiple number patients, it's the individual who presents the most critically ill with visible symptoms would be a priority over someone presenting with mental health issues. Unless they have a life-threatening injury they rate very low."

**DACIA:** "Most of the time the nurse's going to see the patient with the medical issues first."

**ELLEN:** "If the patient is there for mental health complaints and even if they're suicidal or risk to themselves... they are not perhaps as high-priority as a very sick medical patient."

Patient centered care involves allowing patients' opportunities for making choices and decisions involving treatment. This can be challenging when the patient is experiencing a mental health crisis, but unless they are assessed as incompetent to make decision, input from the patient should be utilized whenever appropriate. Supporting involvement of the mental health patient was not a priority as the participants expressed a sense of responsibility and authority over the patient. Decisions were primarily made for the patient and interventions were validated by maintaining safety for the patient and others.

**HELEN:** "I don't think having patient input into their care happens very often because you are always taught psychiatry and safety go hand-in-hand ... we are responsible for them."

Mental health related issues are often viewed as chronic and time intensive. Within the ED, the nurse participants spoke of a need for quick prompt interventions that had visible, timely results that were often associated when treating the medical patient. From the interviews, participants spoke of the chronicity of the illness and an identified lack of immediate response to
treatment. This underscored their rationale for the ED’s lowered priority of psychiatric concerns.

ELLEN: "On a medical patient, you have to do those orders within a certain timeframe because .. the doctors are going to be expecting results. Um, whereas with the mental health patient, there isn’t a lot of nursing care that is done.”

FRANCIS: "Mental health is not a priority because the mental health patients that we see, we often keep seeing and keep seeing. It is an ongoing problem that continues and continues and continues. Whereas, medical/ surgical intervention things are quick, get in it, do it, let’s fix it."

BETH: "Unless the mental health patient has a life-threatening injury their priority would rate very low because ... [ED nurses] are there to save a life”.

The priority for the mental health patient increased only when their actions and/or behaviours became disruptive or aggressive.

HELEN: "The screaming and yelling person, the mental health patient is a priority because if you have a mental health patient in the department, it kind of mesmerizes everyone else and even the sick people won't ring their bells is often because they are preoccupied watching the situation or listening for the situation."

Due to the rapid pace and chaotic environment of the ED, nurse participants questioned the appropriateness of the ED in the treatment of the individual with mental health issues.

ELLEN: "It is a noisy and busy environment for people who do not need all that extra stimulation, it's not really the appropriate place (for the mental health patient)."

BETH: "I don't, the emergency department is not an area to even commence beginning to tackle mental illness. So it's to stabilize them medically and refer them appropriately.”

In addition, nurse participants discussed their thoughts on the mental health patient’s perceptions of care received in the ED. Nurse participants believed that the patient was aware of
the lack of appropriate care received and strongly believed patients were dissatisfied with the
quality of care they provided.

FRANCIS - "I think patients certainly look to nurses and physicians
and social workers and staff for help, and arrive there and
think that they will get help, but I don’t think that is always
the case."

The participants felt confident in providing effective ED nursing care when the individual with
mental health issues presented and remained calm, cooperative and compliant with care.

GRACE: "I think the mental health patient feels adequately cared for
because…. it depends on what somebody was here for and how
they were behaving and interacting with staff. If someone was
overly pleasant, I would hope that they would have a more
pleasant experience."

There was a general belief among the participants that the ED was not the appropriate
environment to both provide care and to meet the unique needs of the mental health patient. The
lack of available nursing time, insufficient mental health education at both the undergraduate and
continuing education level, and inadequate nursing knowledge in mental health assessment and
treatments were arguments against the appropriateness of the ED in providing care for individual
with mental health issues.

ALICE: "I don’t think there is an appropriate area in the ED for
the psychiatric patient."

ELLEN: "I don’t think they're prioritized um, I don't think their
needs are really being met. It's busy, it's over-stimulated
and I think sometimes things get done that maybe aren’t
in the patient's best interests.

ALICE: "If someone is in acute episode of a psychiatric issue, I think
that they need to be treated by a person that knows how to treat them.
I don’t think that someone who has zero background should be involved
in that situation because they really don’t know, they don’t handle it.
I think that it’s unfair to the patient’s and I think that it unfair to the
professional as well."
Summary

In summary, the perceived high prevalence of individuals seeking care in the ED for mental illness related issues emphasized the importance of mental health education and support for nurses employed in the ED. Through the exploration of nurse perceptions of care, participants identified significant barriers that impeded their ability to provide effective care. The nurse participants viewed their roles in the assessment and management of individuals with mental health issues to be inadequate within the ED environment. This translated into ethical challenges when implementing interventions. Common themes emerged including: lack of knowledge (education), assessments, ethical issues related to the use of control interventions, stigma, environmental constraints, limited time and role ambiguity all of which have an effect on the quality of care. These challenges often contributed to a negative perception of mental health patients. Fear of aggression and potential for harm to self and others contributed to the decision to implement control interventions that were often ethically distressing to the nurse. Proposed strategies to improve care included access to mental health nurse specialists, psychiatric teams, designated treatment areas, and improved education and development opportunities. Overall, nurse participants perceived the ED was not the appropriate environment for treating individuals with mental health issues and current care practices fail to meet the needs of this patient population.
Chapter 5
DISCUSSION

This study explored the experiences of nurses’ regarding care provided to individuals with mental health issues in the ED. From the sole vantage point of the ED nurse, this study provided a unique opportunity to explore participant’s personal reflections of care practice to this unique patient population. The findings suggest there are seven key themes that arise when trying to provide effective quality care to those with mental health issues in the ED.

According to the Continuum of Care for Mental Health Patients (Figure 1), the ED often becomes a point of entry for individuals seeking care for mental health related issues. Although part of the continuum, participants questioned the role of and the appropriateness of the ED for mental health care. As will be discussed in this chapter, the participants identified significant barriers both at an organizational and individual level that had an impact on not only the effectiveness of care practices but also the quality of care provided to this patient population. ED's tend to function under a bio-medical model where staff are primarily trained to assess and treat acute physical problems (Stuhlmiller, et al, 2004). To maintain patient flow within the ED, the nurse needs to engage in timely assessments and treatment to meet ministry dictated time benchmarks for disposition of care. This is in direct contrast to the needs of the mental health patient. From their perspective, the individual requiring psychiatric evaluation and care requires more nursing time and ED resources than medical patients, thus significantly disrupting patient flow and increasing wait times for all ED patients (Clarke, Dusome & Hughes, 2007; Schumacher Group, 2010). Further to this, the provision of care in the ED is challenged by the absence or lack of psychiatrists available to the patient, limited access to psychiatric emergency services, and a distinct lack of mental health education for nurses. These in turn, impair the
quality of mental health assessment and treatment (Zun, 2012). These resources are vital to providing adequate psychiatric emergency care.

The ED nurse participants perceived the care provided to mental health patients failed to meet the needs of patients who have mental health issues. Understanding the ED nurses perceptions of care and the facilitators and barriers to care becomes fundamental for the delivery of safe, ethical, and quality patient-centered care for this patient population. Figure 3 provides a conceptual image to portray the themes that arose through the findings which influence the quality of care provided to individuals with mental health issues. Perceived challenges in providing effective quality care included: lack of knowledge (education) in mental health care; ethical issues related to the use of control interventions; stigma and fear; environmental constraints; and, limited time and role ambiguity. The perception of fear for personal safety, was often discussed by participants and was interwoven through this discussion section as it applies to a number of themes including lack of knowledge, time, and ethical treatment. A discussion of the known theory to practice gap will then be followed by the suggested implications for nursing practice.

**Lack of knowledge (Education)**

Current nursing entry to practice requires educational preparation at the undergraduate level. Nursing education has been evaluated and criticized for insufficient focus and for undervaluing the importance of mental health education and practice (Happell, 2008a; Happell, 2008b; Henderson, Happell & Martin, 2007; Wynaden, et al., 2000). With the prevalence of patients with mental health issues receiving care in all areas of nursing, an evaluation of mental health education within nursing undergraduate curriculum was warranted. In 2006, the Canadian Association of Schools of Nursing surveyed all Canadian universities offering a
nursing undergraduate program (Tognazzini, Davis, Kean, Osborne, & Wong, 2009). Of the thirty respondents, 20% did not offer a dedicated mental health course and did not offer any clinical experience in this area while others stated mental health was interwoven throughout the curriculum. Eighty percent of the school respondents offered a dedicated theory course although the number of hours of theory ranged greatly from 1.5 to 7.5 hours a week for a 12 week period. Clinical experience also varied as some schools offered the option of either a clinical rotation in mental health or another area of clinical specialty. Of those who offered a mental health clinical experience, the hours also varied from 25 to 330 hours over a 12 week period.

Clinical experience in a psychiatric mental health rotation positively influences nursing students’ attitudes and confidence in their ability to work with mental health patients (Happell & Gaskin, 2013). Through clinical exposure to this patient population, stigmatizing attitudes decreased and students expressed a sense of preparedness and heightened self-efficacy following the completion of clinical experience in mental health (Happell, 2008b). The development of more positive attitudes towards mental health treatments especially as it relates to front line health care providers, can be facilitated through a strong undergraduate mental health program.

Undergraduate education that lacks a strong mental health component in both theoretical and clinical experience left graduate nurses with the perception of inadequate knowledge, skill, and self-efficacy in the treatment of individuals with mental health issues (Brinn, 2000; Happell, 2008b). This poses significant concern and questions related to the justification of a curriculum that ignores a significant area of health. Graduate nurses are entering the workforce lacking the ability to perform basic mental health status examinations and lack basic psychiatric knowledge of diagnostic categories and symptomology (Happell, 2008a). This is congruent with the present study's findings that undergraduate education often fails to adequately prepare the nurse to
competently care for this patient population in the ED. The Canadian Federation of Mental Health nurses recommend that all undergraduate nursing programs incorporate psychiatric/mental health theoretic and clinical component within their curriculum (Tognazzini, et al., 2009).

Nurses function as a key member of the health care team within the ED. As there is no standard patient population receiving care within the ED, staff nurses must have a comprehensive knowledge base in all areas of health practice. Due to the diverse patient population seeking care, ED nurses must maintain current competency across a wide range of medical and psychiatric conditions. To achieve this, ED nurses participate in advanced continuing education to maximize knowledge and competence for critical situations such as Advanced Cardiac Life Support, and Pediatric Emergencies. Nurses within this study had completed continuing education programs that focused on acute medical conditions. These programs were perceived to be supported and prioritized within an acute care environment that was guided by the medical model approach to care. In contrast, participants perceived a distinct lack of psychiatric mental health education during both orientation to the ED and within the nursing triage role. Continuing education and support related to psychiatric-mental health was perceived to be neither available nor encouraged by nurse leaders within their organization.

Non-psychiatric nurses struggle to provide client centered and appropriate care to individuals with mental illness who are hospitalized in general environments. These nurses feel challenged when providing care to individuals with mental health issues. The study participants frequently discussed their lack of knowledge. This finding is similar to the reviewed research finding of the lack of knowledge about mental health and concerns about competence (Happell & Sharrock, 2002; Plant & White, 2013; Sharrock & Happell, 2000). Nurses identify a lack of
competency and resources to provide appropriate care. Patients with mental health issues may exhibit abnormal behaviour, requiring time intensive care (assessment and treatment), be difficult to engage with, and challenge the comfort of nursing staff. Up to 50% of patients in non-psychiatric general hospital settings have a psychiatric comorbidity (Furlanetto, daSliva, & Bueno, 2003).

Participation in continuing education was an integral part of professional practice of the nurse participants. Barriers to continuing education programs include cost, lack of time, and a limited availability of mental health courses (Al-Majid, Al-Majid, Rakovski, & Otten, 2012; Nalle et al. 2010). Participants clearly articulated that work related educational endeavours must not be at the cost (financial or time) of the nurse. For active participation, nurses felt the programs should be supported by the organization and delivered in a format that it did not impinge upon their time away from work.

Particularly within the ED, providing care has become an increasingly complex task that can be filled with uncertainty and risk due to the increase in patient acuity, complexity of health related issues, multiple co-morbidities, and the use of technology (Simmons & Sherwood, 2010). Judgments and decisional tasks when based on subjective assessment that lack a strong knowledge base become uncertain, particularly in nursing. When decisions are made that are based on incomplete knowledge, the lack of awareness of available options, and a lack of understanding of the risk and consequences of these alternatives (Vaismoradi, Salsali, & Ahmadi, 2011) then the ability to provide quality care is significantly affected.

The Canadian Nurses Association supports fundamental competencies in key specialties within nursing practice. Core competencies for emergency medicine hold 170 specific competencies the ED nurse needs to master, and they serve as a measure of capability in
providing client centered care (CNA, 2008b). Within the 170 competencies using a systems approach, only 8 were specifically classified as related to mental health. The ED nurse must be able to interpret subjective and objective mental health assessment data related to the patient including but not limited to: presenting complaint; manifestation of symptoms including suicidal/homicidal risk factors, hallucinations, delusion, perception, and judgment; symptom manifestation in terms of mood, affect, agitation, behaviour, cognition, and thought process; and, related diagnostic results (CNA, 2008b). The lack of perceived education and availability of assessment tools left the nurse participants feeling inadequate and vulnerable to the high risk behaviours of the mental health patient. These competencies hold that each registered nurse has the responsibility to provide safe, competent, compassionate and ethical nursing practice.

In summary, these findings suggest that nurses, who are on the front lines providing care to these individuals within the ED, should have a strong voice in future interventions to improve care. In addition, to annual mental health education provided to staff, the formation of a mental health ED nurse position, similar to the nurses trained in specialty areas such as the Geriatric Emergency Management (GEM) Nurse or the Sexual Assault Domestic Violence (SADV) nurse was suggested by participants. These clinical nurse specialists would function as a member of a mental health crisis team who assessed and guided treatment for the high risk psychiatric patient. In addition, they would provide expert advice, support and ongoing mental health education to staff.

**Ethical issues related to use of control interventions**

In Canada, the actions of registered nurses are governed by a code of ethics based on societal values, laws and practices. The Canadian Nurses Association (2008a) has established a code of ethics that is supported at the local level by the College of Nurses of Ontario (2009)
Ethics Standards. In caring for individuals with mental health issues within the ED environment, balancing patient safety with patient choices/rights is challenging. It is sometimes necessary to carry out actions that limit the patient's freedom and restrict their movement. The use of control interventions are designed to forcibly confine patients, often against their will, thereby infringing on both rights and freedoms. As a result, control interventions have received significant focus at both the organizational and governmental level over the past decade due to the intrusive nature and high level of risk associated with their use (Bonner, Lowe, Rawcliffe, & Wellman, 2002; Haimowitz & Urff, 2006; Steinert, et al., 2010). While control interventions have been researched within psychiatric settings, minimal research has focused on the use and implications within the ED.

Different forms of control interventions are used with individuals exhibiting serious psychiatric and behavioural problems including chemical, physical, and environmental. Chemical restraints, the most common form of restraint used in the ED, are medication used to both treat symptoms and manage individuals who exhibit aggressive and self-injury behaviours (Steinert, et al., 2010). Physical restraints, devices used to physically restrict movement, are never to be used as treatment other than as an intervention of last resort when behaviour cannot be managed by other means (Ryan & Happell, 2009). Physical restraints can range from mild restrictive techniques such as engaging all side-rails on a bed to forcibly securing an individual to a stretcher using up to 4 point limb restraint (Emanuel, et al., 2010). Environmental restraints include locked units and seclusion rooms. They are generally used to ensure the safety of the patient who is at risk of harming self or others or when an individual is unable to control his or her violent emotions (Steinert, et al., 2010). The rooms are designed to keep a patient safe and allow for close observation by clinical staff.
General hospital EDs often are the first point of care for individual experiencing mental health related issues (Durbin, et al., 2007). A recent Canadian study evaluated the use of restraints and seclusion in general hospitals in Ontario. An individual with mental health issues was found to be 76% more likely to receive at least one type of control interventions and more than 2.5 times more likely to be treated with physical or chemical restraints (CIHI, 2011). The use of restraints in the ED is significantly higher than in inpatient facilities (Zun, 2003). Restraints are described as physical, environmental or chemical interventions that are used to control the behaviour or activity of an individual or a portion of his/her body (CNO, 2009). Physical and manual restraints are never a part of treatment but an intervention of last resort when a person's behaviour cannot be managed by any other means (Zun, 2003). Seclusion, with the possible addition of restraint, is designed for the short term management of an incident of violent and aggressive behaviour (Dumais, Larue, Drapeau, Menard, & Giguere Allard (2011). The goal of these interventions include: (1) prevention of injury to individual and others; (2) reduction in sensory stimulation; and (3) isolation of the individual from others (Oberleitner, 2000). Restraining a person can have serious physical, social, and psychological effects and no one form of restraint is less traumatizing than another. Control interventions, when used in the ED are temporary measures but may exacerbate distress and causes of suicidal ideation (Emanuel et al. 2010).

Due to the significant impact to the individual both physically and psychologically, legal and ethical concerns have driven the Canadian government to review the use of restraints and to implement policies. In 2001, new legislation was introduced minimizing this use of patient restraints within hospitals and health care facilities. Bill 85, Patient Restraint Minimization Act identifies the circumstances in which restraint, confinement, and monitoring devices could be
used. The purpose of the Act was to minimize the use of patient restraints and to encourage health care providers to use least restraint interventions when it is necessary to prevent an individual from serious bodily harm to him/herself or others. Hospitals are further required to set in place specific policies to guide the use and monitoring of the patient while mobility is restricted. The substantiation for the need to reduce the use of control interventions include respect for autonomy, human dignity and the negative consequences and trauma experienced by the recipient of these interventions (Prinsen & van Delden, 2009).

Supporting this bill, the College of Nurses of Ontario (CNO) has mandated the policy direction of least restraint. This involves the nurse using restraints only after all possible alternative treatment or interventions have been utilized (CNO, 2009). Organizations thus are required to develop and institute policies that support the least restrain law. The organizations from which participants were recruited had active least restraint policy statement(s) outlining the indication, procedures, safety considerations, and documentation required for their use.

Given the passage of Canadian legislation controlling restraint use, the application of various types of seclusion and restraint may be applied in specific situations. With the decision to use control interventions, it is expected the nurse will consult with the attending physician and with a written order, employ the least intrusive method of restraint that is appropriate to the situation. There must also be consensus on the degree of force to be used. Close or continual observation and monitoring is indicated when control interventions are applied to ensure the safety of the patient (Emanuel, et al., 2010).

Within this study, participants indicated that decisions to implement control intervention were primarily within the scope of the nurse, with or without physician input. When policy dictated a physician order was needed, such as engagement of a locking system that forcibly
restrained the patient in a designated room, it was usually attained after the procedure had been implemented. Justification for deviation from ascribed restraint policies were based on the immediacy of the risk for harm. Based on the collaborative environment between emergency health care providers, participants indicated restraint orders were often written by physicians 'after the fact' in support of nursing action rather than through collaborative discussion among team members. Notwithstanding the nursing standards of practice, legal laws, and institutional policy, the determination to use control interventions is highly complex and somewhat subjective. Participants indicated that these decisions are often influenced by the attitude, knowledge and experience of the nurse.

Participants used control interventions as a means to ensure patient safety yet they indicated not all restrained patients in the ED had met the objective criteria of either combativeness and/or posed significant risk for self-harm or harm to others. In actuality, there were some identified situations where the ED nurse participant used control interventions when the only objective criteria for use involved a history of mental illness or a previous episode of aggression within the ED. These findings may be an indication of significant issues involving control interventions in both psychiatric and non-psychiatric settings. In Ontario alone, individuals with mental illness who receive care in general hospitals are over one and a half times as likely to experience some kind of control interventions and over two and a half times as likely to receive physical or mechanical restraint (CIHI, 2011). Between 2006-2007 and 2009-2010, control interventions were used on more than 30,000 individuals or 24% of individuals receiving psychiatric care. Subjective assessment of behaviour and/or previous behaviours exhibited by the patient validated the present use of control interventions. Interestingly, if an individual was assessed to pose a risk for self-harm, they were more likely than 50% of the
patients seen in the ED to be subjected to control interventions. Alternately, if the individual was assessed to pose a threat to others, they were 70% more likely to received control interventions (CIHI, 2011). This raises the question of control interventions being used as a fear reaction rather than a measured reaction based on least restraint practices. The application of control interventions in response to fear now translates into a violation of human dignity.

The use of control interventions, especially those involving seclusion and physical restraint has become a complex ethical dilemma within health care as they conflict with issues of an individual’s human right to self-determination, human rights, and the ethical responsibility of healthcare staff (Perkins, Prosser, Riley, & Whittington, 2012). The Canadian Nursing Association (2008a) Code of Ethics for Registered Nurses underscores the nurse’s responsibility to recognize and respect the intrinsic worth of each person and to preserve human dignity. As such, the violation of human dignity can be applied as a strong argument against the use of seclusion. From the participant’s point of view, the use of control interventions, particularly seclusion caused an ethical dilemma for the practicing nurse. There existed an internal conflict whether to place the patient in the seclusion room or not. Both options entailed advantages and disadvantages because the use of control interventions conflicted with the participants’ feelings of professional, ethical and personal responsibility to protect patients. Yet despite this, participants still engaged in this practice and further applied the use of control interventions even without relevant assessments that supported their use. Past or current disruptive behaviour(s) influenced decisions to use control interventions even without overt displays of aggression (CIHI, 2011). Thus, even the potential for violence met the criteria for this intervention.

Environmental restraints were commonly applied to individuals based on mental health diagnosis and previous admission, regardless of current presenting behaviour. ED nurses are
under pressure to complete rapid assessments and treatments while maintaining control of their environment (Marynowski-Traczyk & Broadbent, 2011). The busy, overcrowded environment, and minimal psychiatric resources available within the ED may inadvertently promote the use of control interventions. Participants expressed significant internal discord as their desire to provide time sensitive quality, patient-centered care conflicted with the ED environment and situations where patient and staff safety were potentially at risk. Ultimately, it was identified that both fear and the perceived risk to patient safety justified the ED nurse's decisions to use of control interventions despite expressions of ethical conflict with this intervention.

There are many documented reports of adverse events due to the application of control interventions. Problems with elimination, aspiration pneumonia, impaired circulation, cardiac stress, skin breakdown, dehydration and accidental death have been associated with physical restraint use (Steinert, et al., 2010). These interventions also had an impact on the establishment of a therapeutic nurse-patient relationship. The use of control techniques breaks down the communication and damages the perceptions of trust between the patient and nurse. Patients' psychological wellbeing is negatively influenced by the use of control interventions, as their use is associated with increased emotional distress, loss of dignity, humiliation, guilt, anger, increased agitation and depression for the patient (Bonner et al. 2002; CNO, 2003; Haimowitz & Urff, 2006; Ryan & Happell, 2009).

The study participants were aware of the negative psychological impact that seclusion and restraints can have on both the patient and themselves. In fact, they clearly empathized with the patient. Nurses continuously balance beneficence (do good) and non-maleficence (do no harm) with the need to provide safety for the patient, other patient's in the department, and themselves. Anecdotally, the participants within this study cited the use of restraint and other
control interventions to be the most ethically challenging aspect of their practice. Nurses felt unsupported by their organization in providing more ethical, least restrictive and patient centered alternatives to control interventions.

Nurse participants may have also justified the ethical challenges of using control interventions as they perceived the patient’s cognition was significantly impaired when they were experiencing a mental health crisis. Research shows that impaired cognitive functioning increased the likelihood of restraint, possibly due to the individual’s difficulty in communicating their distress (Emanuel, et al., 2010). An inability to communicate or make decisions negatively influenced the nurse’s ability to provide client centered care and limited the probability of more moderate treatment approaches being used (CIHI, 2011). The nature of providing patient centered care in a caring and compassionate manner and the practice of using control interventions ethically conflicts with the ethical principle of human dignity and respect. Yet if the negative impact of control interventions are perceived to be in any way minimized, as the participants description of the mental patient being 'unaware of their surroundings' due to a perception of impaired cognition, the impact to human dignity could be rationalized by the ED nurse.

No standardized tool for assessment of aggression was identified as available to nurse participants in the ED. Additionally, there were no supporting evaluative tools to validate the decision to implement interventions of restraint and seclusion beyond risk for harm. In fact, no participant could identify standardized or specific criteria for the assessment of risk for violence. Research provides minimal information on the use of agitation scales in the ED. Those cited most often include the Agitated Behaviour Scale (Corrigan, 1989), a 14 item observation of behaviour from absent to extreme agitation; and the Overt Aggression Scale (Yudofsky, Silver,
Jackson, Endicott, & Williams, 1986), a scale that assesses verbal aggression, and physical aggression against objects, self, and others. The availability of a standardized scale to assess the need for restraint or seclusion would help support the least restrictive intervention. As the main indication for using control interventions is the prevention of harm to self or others, the tool would need to account for the level of agitation and risk for violence and elopement of the suicidal/homicidal patient. This would prevent the use of control interventions for the patient who does not meet criteria for use. In addition, understanding the potential risk to the patient, the tool should also identify those individuals where control interventions were contraindicated such as when the patient is medically unstable. Confining a patient to a supine position increases the risk for emesis aspiration, impairs the ability for effective cardiac monitoring, and delays treatment time for critical medical interventions when restraint removal is required (Zun, 2003).

Although not all participants could identify their institutions least restraint policy, each ED did in fact have such policy(s). According to this policy, a physician’s order was required for the application of both chemical and physical restraints and informed consent from the patient or substitute decider needed to be obtained prior to the use of all restraints, the exception being in emergency situations. The application of control interventions must be made after collaboration among members of the healthcare team. Nursing responsibilities include: (1) close or constant observation, and (2) accurate documentation of the steps leading to restraint use, assessment, reassessment, and monitoring. Organizational responsibilities include the provision of orientation for new staff and in-services education regarding least restraint policy and procedure, restraint use, and use of alternative methods. This study indicated a breakdown in both nursing and organizational responsibilities. Participants describe nursing actions that oppose least restraint policies. This breaches ethical nursing practice that advocates to maintain human
dignity for all patients. Legislation will be rendered impotent if access to resources such as risk assessment tools, education in non-control interventions, and organizational policies guiding restraint practice are unavailable to staff.

Contrary to the Least Restraint Act and established hospital least restraint policies, there was a significant knowledge deficit and compliance rate by ED nurses within this study. Participants were unsure of legislation and organizational restraint policies and all felt supported by their institution in the continued use of control interventions. This clearly indicates a need for education in the use of control interventions. Additionally, there were no policies or strategies identified where evaluation post-incident of control intervention application was required by participants. The lack of accountability by staff from the organization encouraged restraint use despite a lack of clinical indications supporting its practice. Policies and practices that support evaluations and de-briefing of these critical events protect the rights of the patient and hold health care providers accountable for their actions (Ryan & Happell, 2009).

ED nurse administers must make it their mandate to actively support best practice surrounding patient-centered care and the use of control interventions in efforts that support a reduction in use. Various strategies include early identification of potential aggressive patients, control intervention education, routine review of restraints, and debriefing after critical events using restraints. The decision to use control interventions should involve specific attention to the impact on patient dignity and the rights of the individual. When these factors become a priority, the quality of care will be optimized.

**Risk assessment in the use of control interventions.** Early assessment of risk, often completed by the triage nurse or at the stage of initial nursing assessment, can have a positive impact upon clinical decisions and potentially minimize the use of control interventions such as
chemical/physical restraints and seclusion (Hawley, et al., 2006; Yang, Wong, & Coid, 2010). Abderhalden et al. (2008) in a randomized control trial used the Broset Violence Checklist to evaluate risk for violence. Staff were provided with a list of interventions aimed at preventing violent episodes and implemented appropriate measures as required. The outcome was a decrease in the number of incidents of severe aggression and a decrease in the implementation of control interventions within this population.

Efficient patient flow management of the ED requires nursing staff to correctly identify patient needs, potential risk to self and others, set priorities, implement appropriate treatment and disposition (Affleck, Parks, Drummond, Rowe, & Ovens, 2013). When an individual seeks care in the ED, it is often the triage nurse's task to assess the level of risk for both violence and self-harm. Care determinations such as immediacy of disposition becomes critical when providing care to individuals with mental health issues as many disorders are associated with the risk of self-harm (Nordentoft, Mortensen, & Pederson, 2011). The accuracy in the determination of risk perception, especially high risk for violence (McDermott, Edens, Quanbeck, Busse, & Scott, 2008) or self-harm (Nordentoft, et al., 2011) has significant consequences for both the patient and the health care provider who make erroneous clinical judgements. Injuries sustained to the nurse while implementing control interventions could have legal implications to the organization if inadequate education was the source of the injury.

The importance placed on accurate prediction of risk is evidenced by both legal and organizational policy changes that emphasize risk aversion coupled with the protection of patient's rights. The Least Restraint Act exemplifies this direction as it clearly directs the health provider to use minimal restraint while protecting the psychiatric patient from further emotional and physical harm. Significant challenges occur when the health care provider lacks the ability
to accurately evaluate risk and/or lacks the knowledge to administer the treatment options that are least restrictive. Structured short-term risk assessment results in improved clinical decision-making thereby avoiding application of unnecessary control interventions (van de Sande, et al. 2011).

**Control intervention education.** ED nurses indicated a significant lack of understanding of least restraint policies. Individuals who received care in general hospitals were 76.3% more likely to have experienced control interventions than those in a psychiatric facility (CIHI, 2011). This may be due to a lack of knowledge and experience in dealing with individuals with psychiatric illness (Huckshorn, 2004). Nurse participants indentified a knowledge deficit both in the mechanics of restraint application and in the potential negative psychological patient outcomes. Educational programs involving the use of control interventions increase knowledge, change attitudes, and reduce the use of physical restraints (Koczy et al. 2011; Pellfolk, Gustafson, Bucht, & Karlsson, 2010). Behavioural emergencies are often precipitated by unmet health or psychosocial needs that when addressed can be managed, reduced, or resolved (Emanuel, et al, 2010). Education programs focusing on identification and treatment of the source of aggression rather than controlling symptoms decreased restraint use by 34.6% (Pellfolk, et al., 2010).

At an organizational level, resources to support nurses in preventative strategies should be available. Education in de-escalation and non-violent crisis intervention are validated alternatives to control interventions but require specialized training and ongoing supportive education. The American Psychiatric Association Task Force on Psychiatric Emergency Services recommends annual education on managing behavioural emergencies that is

The ED nurse plays a key role in assessing, preventing, and managing the use of restraints. As such, they require specialized education in risk assessment for violence and/or aggressive behaviours, understanding the indications of restraints, and recognition of which intervention provides the least restraint approach appropriate for the situation (Emanuel et al., 2010). The significant concerns of the participants related to their perceived lack of mental health education, knowledge, and self-confidence in caring for this patient population needs to be prioritized within ED education and development programs in an effort to minimize use of control interventions and improve the quality of care provided that both respects the individual while maintaining dignity.

**Debriefing and review of control interventions.** Debriefing is an intervention that is used to assist people in coming to terms with negative feelings and emotions associated with traumatic experiences and has the potential to improve outcomes (Raphael & Wilson, 2000). As ethical distress was associated with the use of control interventions within this study, nurses indicated they would be receptive to a process that both reviewed the decision to use control interventions and would be receptive to a post-intervention debrief. The decision to utilize restraints within the ED must adhere with both legislation and organizational policy. Decision making, indications for use, and behavioural outcomes must be thoroughly and accurately documented to allow for review and evaluation. All critical events utilizing restraints need to be reviewed through debriefing and a formal review process that identifies situations that were inappropriate or led to negative outcomes for the patient and/or staff (Emanuel et al., 2010).
Organizational policies must be based on a least restraint approach that balances patient/staff safety with dignity and respect of the patient.

Accurate documentation and monitoring on the use of control interventions allow for critical evaluation of use, identify educational needs of staff, and may be a stimulus to reduce the use of these measures. Routine quality control interventions such as auditing, benchmarking, and outcome measurements has been shown to reduce the use of control interventions (Steinert, et al., 2010). Furthermore, providing a committed obligatory education of routine control interventions and the availability of specialized teams can further maximize care practices providing safe care for patients and providers. Nurses, regardless of their work environment should have a basic knowledge of the mental health related issues and be able to identify, assess and provide appropriate interventions inherent to patient centered care.

Both the organization and the nurse must work collectively to ensure least restraint policies are practiced within the clinical environment. The ED provides care to individuals who are vulnerable and in crisis thus the healthcare team is responsible for ensuring the quality and delivery of services actively support client-centered care.

**Stigma**

Mental health stigma research seeks to understand the attitudes of health care providers in an effort to identify and understand how potentially discriminating attitudes and behaviours of the provider are projected towards people with mental illnesses. The literature emphasizes the negative and stigmatising attitude of health professionals towards people diagnosed with mental illness (Bertram & Stickley, 2005; Goodwin & Happell, 2006; McCann, Baird, Clark & Lu, 2008; Petersen, Hounsgaard, & Nielsen, 2008). While minimal, the bulk of this literature has focused on the primary mental health practitioner. Even less is known about non-psychiatric
health care provider’s attitudes towards the individual with mental issues, such as the ED nurse. What is known is that negative attitudes promoting stigma occur not only in the general population but also with health care providers (Corrigan, 2000). Research suggests that many health care providers, despite their knowledge and awareness, share the same stigmatizing views as the general public (Schulze, 2007). Individuals with mental illness feel unwelcome due to staff attitudes and/or the physical layout of the ED (van Nieuwenhuizen, et al., 2013). The effects of mental illness stigma and related discriminating behaviours can significantly influence an individual's access to appropriate mental health services and psychiatric treatment (Angemeyer, Schultze, & Dietrich, 2003; Government of Canada, 2006; Sartorius, 2004). Stigma significantly influences whether the individual will seek treatment, take prescribed medications or accept counselling (Government of Canada, 2006). Efforts to treat individuals with mental health issues are often influenced by knowledge, attitudes, and beliefs of those who are providing care.

Prioritizing care delivery when assigned multiple patients is a constant challenge to health care providers in the ED. When medical and psychiatric patients are cared for simultaneously, the validity and significance of their care needs are evaluated. Patients seeking treatment for medical related symptoms were prioritized over mental health related symptoms/behaviours. Rettenbacher, Burns, Kemmler, and Fleischhacker (2004) asked mental health practitioners to rate the severity of schizophrenia as compared to medical issues of cancer, diabetes, and epilepsy. Health care professionals judged medical conditions as more significant than schizophrenia. When providing ongoing care for the mental health patient who is awaiting admission, many of these admitted patients do not receive medication or psychiatric interventions beyond treatment of agitation (Zun, 2012). This is in direct contrast to care provided to the admitted patient exhibiting medical/physical symptoms.
Aggressive/volatile behaviour, legitimacy of suicidal ideation, and impaired mental processing were described by the participants regarding individuals with mental illness. These false impressions have the potential to impact assessments, disposition, and treatment within the ED. Many standard psychiatric treatments such as seclusion and restraints were perceived by participants as distressing and insensitive to the patient but were utilized more frequently than non-invasive procedures such as communication and de-escalation. Furthermore, there is a lack of evidence supporting the effectiveness of seclusion or restraint in reducing or alleviating patients` aggressive behaviour (Scanlan, 2010).

Globally, individuals with significant mental illness, such as schizophrenia and bipolar disorder are most stigmatized due to both fear, the perception of aggression and threat to others (Peluso & Blay, 2011; Phelan, Link, Stueuve, & Pescosolido, 2000; Rao, et al., 2009). Consistent with this study, expressions of suicidal ideation elicited negative expressions among nurses that when ignored may lead to adverse outcomes such as delayed treatment or premature discharge of the potentially suicidal patient (Rossberg & Frills, 2003).

The ED nurse will interact with the mental health patient when the patient is at their most vulnerable and when they need significant support and appropriate treatment. The perception expressed by nurse participants was that some patients were undeserving of treatment provided in the ED. In a review of published literature addressing stigma and mental health professions, Schulze (2007) found health care practitioner's beliefs about mental illness are more negative than the general population viewing their illness as incurable and difficult to manage. The negative label of "frequent flyer" vocalized by participant ED nurses disrespects the patient and significantly damages the nurse-patient relationship.
Nurse’s articulation that confidentiality, especially when patients are placed in seclusion, was not a priority in the ED is cause for significant concern as it is in direct violation of the College of Nurses Standards of Practice (CNO, 2009). The lack of a private setting for patient evaluation and treatment, the centrally located seclusion rooms in high traffic areas, and the placement of patient monitors that breach patient confidentiality as expressed by nurse participants is especially concerning. When the individual seeking care feels isolated, stigmatized, and disrespected, treatment outcomes and future interactions with staff can be negatively influenced (CNA, 2008a).

Environmental constraints

The environment was a significant issue as it served as a barrier to providing confidential care that met the needs of the psychiatric patient. Participants all felt that the environment of the ED was not an appropriate setting that allowed for effective care of the mental health patient (van Nieuwenhuizen, et al., 2013). Findings from this study support the need for a separate area in or near the ED for patients with mental illness. This would separate the individual from the general population of the ED. Patients would receive the specialized care they needed and nurses would be allowed the opportunity to engage in quality therapeutic interactions. Their environment would need to meet the needs of the patient population thereby providing a quiet, low stimuli setting with the availability of video monitoring of those at highest risk for self-harm. Current practices have the video monitors located in a position that is not readily viewed by the assigned staff.

Confidentiality is an important issue in health care. It becomes particularly challenging within the ED where there is the lack of specialized rooms that simultaneously allow for close patient observation. The crowded environment of the ED forces nurses to care for patients within
confined areas where they are positioned in close proximity to other patients, visitors, and others (Miskop, et al., 2009). As such, privacy and confidentiality may become compromised.

The establishment and maintenance of patient confidentiality is emphasized in the College of Nurses of Ontario and the Canadian Nurses Association codes of ethics as it helps to facilitate trust, shows empathy, and strengthens the nurse patient relationship (Younggren & Harris, 2008). Health care providers must protect the patient's confidentiality to the fullest extent possible, to meet their ethical obligations. Despite this, participants reflected that confidentiality is not a priority within the ED to the point that most clinicians make little to no attempt to ensure the confidentiality of the patient is maintained.

**Governmental solutions.** In 2008, the Ministry of Health and Long-Term Care worked with associated mental health and addiction organizations to developed solutions to address emergency wait times for people with mental illness and improve access to mental health and addiction services. Strategies developed by the Ontario government to address mental health service care delivery shortfalls, included a budget of $180 million to address emergency department wait times and $80 million to community mental health and addiction services (Schizophrenia Society of Canada, 2008). Strategies currently being implemented to address the ED wait times for people with mental illness needs range from community-based crisis workers, discharge planners and social workers located in the ED and inpatient settings to peer support management and innovative community-based crisis programs (Canadian Mental Health Association of Ontario, 2008; Derlet & Richards, 2000). In 1990, a Calgary ED pilot project examined the provisions of care for individuals with mental illness. Best practice guidelines were developed, and some were adopted as national standards for ED care by Accreditation
Canada. As a result, individual experiencing mental health issues are provided a private space for consultations.

In response for a need of standardized assessment tools available for use in the ED, a pilot project involving 11 sites is trialing a customized version of the Camberwell Assessment of Need (CAN-C) tool which is a consumer-led decision making tool that allows key information to be electronically gathered in a quick and secure manner. Another pilot project, eReferrals and Access Tracking Project was established to promote communication between community mental health agencies and hospitals to electronically share client information to facilitate coordinated care (Canadian Mental Health Association of Ontario, 2008). These initiatives can only be actualized with the allocation of adequate and sustained funding.

**Limited time and role ambiguity**

Overcrowding in the ED has become such a problem nationally that it significantly influences the quality and delivery of patient care (Atzema et al. 2012). Research and governmental organizations have devoted significant funding and research to identify resolution strategies. The overcrowding issue occurs when the demand for emergency services exceeds the ability to provide quality care within an appropriate time frame (Affleck et al. 2013). The Canadian Association of Emergency Physicians in conjunction with the Ministry of Health and Long-Term Care has adopted national Emergency Room Targets that supports a four hour benchmark for total time spent in the ED (Ovens, 2011). This encapsulates total time spent from triage until discharge including assessment, diagnosis including lab testing, and treatment (Ministry of Health and Long-Term Care, 2010). When the environment prioritizes the rapid completion of tasks rather than supporting nurses in their managing a patient at risk, fostering relationships with patients and providing the resources that are necessary to engage in purposeful
encounters, patient care will be compromised and optimal outcomes may not be achieved (Zolnierek, 2011). Rapid assessment and treatment may not occur in the ED due to excessively high patient volumes and limited appropriate space available for the mental health patient. Delays in addressing and providing psychiatric care may, in turn escalate behaviours in ways that increase risk to the patient, staff and other patients (Leung, Lee, Ng, Ting, & Li, 2013). Additionally, the use of restraints increased the time spent in the ED by an average of 4.2 hours (Weiss et al. 2012).

Psychiatric clinical liaison nurses within the ED can help to resolve some of the issues of time. The liaison nurse focuses on the individual with mental health issues without the distraction and need to provide care for a multiple number of patients. As such, they are able to provide timely and appropriate psychiatric assessment and interventions. The employment of a psychiatric clinical liaison nurse also supports inter-professional collaboration to ensure need specific care is provided. Inter-professional teamwork within healthcare is key to managing the diverse and often complex care needs of the patient. This is especially evident within the complex and multidimensional environment of the ED (Hall, 2005; Hansson, Foldevi, & Mattson, 2010).

The lack of available time to provide adequate care was a significant barrier identified by participants within this study. Effective psychiatric assessment and treatment is a complex task relying on communication between the nurse and patient. Mental health care can often be a slow and time intensive process. Individuals presenting with vague psychiatric symptoms (depression or anxiety) or who experience challenges in communication/cognition (disordered thoughts, psychosis), often require a more time intensive assessment that may disrupt patient flow within the ED (Clarke, et al., 2006). With the governmental guidelines of target to assess, treat and
admit or discharge ED patients within 4 hours, nurses often are forced to make decisions that may not be in the best interest of the patient. In addition, nurses often cited an organizational specific time constraints of the '90 seconds triage'. From the development of the trusting therapeutic relationship to various interventions such as de-escalation, the length of time required to care for this patient population is perceived as time intensive compared to medical patients (Marynowski-Traczyk & Broadbent, 2011).

Critical care nursing, particularly within the ED is associated with high levels of emotional stress and heavy workloads (Hayes, Bonner, & Pryor, 2010). The rapid pace and ever-changing work conditions require a complex interaction and coordinated effort in the delivery of care. Although not explicitly stated, nurse participants describe a sense of role ambiguity when caring for the individual with mental health issues. There was a lack of defined responsibility for care when patients were placed in seclusion as multiple personnel became involved in care. Security presence with video surveillance was used during situations that required the use of control interventions such as seclusion or physical restraint. When security was present, nurse participants described a transfer of the care where security monitored not only the behaviour of the patient but also their overall observed medical condition. Similarly, video surveillance of the patient in seclusion was directed to monitors at the main nursing station. When the assigned nurse was not present at the nursing station, the unit secretary assumed unofficial responsibility for patient observation via video surveillance. This is outside of the role expectations for both security and secretarial support staff. Role ambiguity was expressed due to unclear role expectations when control interventions were utilized. Communication breakdown or an unclear expectation of role and performance is detrimental to not only quality patient care but to the mental wellbeing of the nurse (Dasgupta, 2012). In addition, when the
work expectations conflict with the nurse's values or ethics, moral conflict becomes an issue. This ethical conflict was clearly experienced by nurse participants within this study. Role ambiguity and role conflict are associated with causes of work-related stress, decreased performance, and impaired efficiency (Lambert & Lambert, 2001).

A nurse’s commitment to provide quality care includes safe, competent and ethical care. Frustration and conflict occurs when their attempts to perform this become hindered. Role conflict exists when an individual has two or more role requirements that work against one another and involves uncertainty about what should be performed within a job (Chang & Hancock, 2003). The contrasting care needs between the medical and the psychiatric patient cause such conflict. Nurses are required to prioritize care and often the needs of the medical patient outweigh those of the psychiatric patient. Patients seeking mental health treatment in the ED were generally given a lower triage category status than patients who presented with medical symptoms (Summers & Happell, 2003).

The establishment of a therapeutic nurse patient relationship fundamental to psychiatric nursing care is based on respect, therapeutic communication, active listening (Townsend, 2011). Nurse participants identified the use of control interventions as a routine practice within the ED had a negative impact upon this relationship. These interventions contradicted their professional ethical principle of non-maleficence, meaning first, do no harm. (CNO, 2009). This role conflict transformed into a sense of moral distress. Stress of conscious or moral distress occurs in situations which nurses cannot fulfill their ethical obligations and commitments or fail to pursue what they believe to be the right course of action, or fail to live up to their own expectation of ethical practice (CNA, 2008a). This distress evolves when nursing practice is hindered by the organizational environment and the nurse's care practices are perceived to demonstrate neglect of
needs. Nurse perception of care for the mental health patient was described as inadequate and did not meet the needs of the mental health patient. Ethically, the nurse knows the right thing to do but institutional constraints make it nearly impossible to pursue the right course of action.

The use of restraints and seclusion were perceived to be unjust and excessive; role conflict emerged as their need to maintain safety through control was inconsistent with their value system. The availability of a structured evaluative tool that supports psychiatric interventions would serve to transfer decisions from a subjective assessment where the decision stems from the nurses perception of risk to a more structure evaluation based on need. To resolve this ethical challenge, disassociation or rationalization helps to mediate the moral conflict.

Depersonalization or distancing within the nurse-patient relationship and engagement in counterproductive work behaviour may be used as a coping strategy (Garrosa, Moreno-Jimenez, Rodriguez-Munoz, & Rodriguez-Carvajal, 2011). The practice of mental distancing helped objectify the patient in order to minimize moral distress and mediate the relationship between job demands and the perceived stress involved. Bakker and Demerouti (2007) conceptualize disengagement as a form of unconscious cynicism. Nurse participants' describe a disconnection with the mental health patient. Due to the perception that symptoms of mental illness include impaired cognition in the form of a lack of awareness of treatment and surroundings, the negative psychological impact of treatment interventions are not prioritized. It can be argued that the perceived high level of stigmatizing behaviour and participant’s determination of the legitimacy of patients within the ED is a direct reflection of this disconnection with the mental health patient. Disengaged workers have negative attitudes towards their work, their practice, and most significantly, their patients (Bakker & Demerouti, 2007).
Although inter-professional care is paramount to high-quality patient centered care, when multiple professionals are providing care, role ambiguity may occur (Bower, Jerrim & Gask, 2004). This occurs when a lack of coordination among team members produces a pattern of inconsistent expectations that fail to take into account the needs and abilities of each team member. While using control interventions, constant nurse-patient evaluation is required both at an organizational and legal level. Role ambiguity occurred when there was a decision to use support staff for observation. Security and ward clerks were routinely responsible for the monitoring and evaluation of the patient while in seclusion. Security also played a significant role in the application of restraints and the close observation that is required when using these control interventions. Justification for this practice involve the nurse's heavy workload, lack of staffing resources, and the time intensive requirement involved in close observation practices.

Job related stressors include workload, role conflict, emotional demands, role ambiguity and uncertainty have a significant impact on the level of nurse engagement (Andrews & Wan, 2009). Burnout of health workers results in lowered quality of care, higher levels of absenteeism and job turnover (Dasgupta, 2012). Role conflict, work overload and role ambiguity also affects the self-efficacy of the nurse. The fast paced work environment of the ED is stressful. This stress was intensified when providing care to the mental health patient. Lacking psychiatric education and perceived knowledge, nurses felt they were not prepared to care for the psychiatric patient in crisis. This is particularly concerning as individuals with high levels of self-efficacy perceive problems as challenges, are highly committed to the activities they perform, and invest time and effort into to succeed (Bandura 2001). The low self-efficacy of the ED nurse becomes a stimulus for the negative perceptions and related stigmatizing actions of the nurses towards the
individual with mental health issues and impairs the nurse's ability to provide effective patient centered care.

The Mental Health Commission of Canada's Opening Minds (2009) is the intensive anti-stigma programs targeting health care professionals among others. The goal of this initiative is to reduce mental health stigma and change behaviours and attitudes towards individuals with mental health issues in order to ensure that patients receive appropriate, timely and fair treatment within healthcare and society as a whole.

**ED nurses’ experiences of care for those with mental health issues**

Client centered, holistic, and culturally competent care involves acknowledgment that the individual is the focus of care (RNAO, 2010). Care must be multifaceted incorporating biological, psychological, social, cultural, and spiritual aspects. This is the first Canadian study to explore the perceptions of ED nurses about the care and treatment of the individual with mental health issues. It provided the opportunity for ED nurses to openly discuss their experience and highlight some of the significant perceived barriers to providing effective care. They described the quality of care provided to the individual was inadequate to meet the needs of this patient population. They reported that both individual factors of fear, lack of mental health knowledge, stigma, role ambiguity and ethical concerns with treatment options as well as the organizational factors of lack of time, the inappropriate environment of the ED, and a lack of resources detracted from their ability to provide quality care for this unique population within the ED. As a result, they were able to highlight the need for enhanced education and support.

Consistent with the literature review, the findings of this study identify that ED nurses do not have the confidence or knowledge to provide effective care for this population. In response,
the mental health patient is somewhat avoided in favour of the medical patient. It is not that they don't want to provide care but the ED nurse is more comfortable addressing the concrete physical needs of the medical patient whose rapid response to interventions, such as intravenous infusions bolsters the nurses' self-confidence (Crowley, 2000). The lack of knowledge to effectively provide nursing care for the mental health patient negatively influences the nurses' clinical confidence. This is of particular concern as the ED is often the first point of care when individuals are in mental health crisis. Barriers were perceived as so significant that participants felt that mental health patients' needs were not being met and treatment practices were potentially doing more harm to the psychological state of the patient.

Based on the study's findings, education both at the undergraduate level and as a continuing education initiative needs to provide a better level of education on all aspects of psychiatric care. Of particular importance, intervention education will ensure the least restraint policy can be met as all members of the health care team will implement treatment measures that are based on the needs of the patient and not the knowledge and experience of the nurse.

The lack of resources within the ED was of significant concern to participants. Resources which included time to provide care, bed availability in a therapeutic environment, and human manpower were issues that needed to be addressed to facilitate client centered care. Support in the form of psychiatric nurse specialists, either as an independent practitioner or as part of an interdisciplinary team would resolve many of the barriers identified. Additionally, alternative models of ED care should be explored.
Theory to practice gap

Using Leininger’s Theory of Cultural Care Diversity and Universality (Leininger, 1988), this study described structures within the ED having a strong influence on nursing practices for the individual receiving care for mental health issues. The ED nurse’s worldview or desire to provide quality patient centered care becomes transformed by the barriers pervasive within the ED. The participants identified that education, political/legal, stigmatizing culture, and social structures within the department were perceived to serve as barriers to care rather than facilitators. These barriers had an impact on care practices that resulted in significant ethical issues and dilemmas for nurses as their desire to provide quality care was hindered within the constraints of the ED. Participants agreed that the needs of the mental health patient seeking care were not being met to the point where they questioned the appropriateness of the ED being part of the continuum of care for mental health patients.

Other frameworks similar to Leininger that espouse ‘therapeutic caring’ where the ‘person’ is the central concept include Watson’s (1985) theory of human caring, Boykin and Schoenhofer’s (1993) theory of nursing as caring, Roach’s (1987) conceptualization of caring relationships, and McCormack and McCance (2010) person-centred nursing theory. Of significance is the person-centred model of care that served as a framework for the organizations from which the study’s participants were recruited. This framework links four concepts: (a) prerequisites or professional attributes of the nurse (b) the care environment, (c) the person-centered processes through which care is provided, and (d) expected outcomes as a direct result of effective person-centred nursing (McCormack & McCance, 2010). The application of person-centred nursing strategies would enhance the ED nursing care provided to patients with mental health issues, this model supports practitioners and organizations through restructuring practices
that need to be changed. The person-centred approach is established through fostering therapeutic relationship between all care providers. It is based on respect for persons, the individual right to self-determination, mutual respect and understanding (McCormack & McCane, 2006). Adoption of this approach within nursing has been shown to enhance teamwork, improve patient satisfaction with care, and reduce anxiety among staff (McCormack & McCance, 2006).

Nursing knowledge has expanded to include evidence emerging from theory, scientific research and evaluation. This evidence-based practice involves the seeking, appraising and implementing of research-based knowledge to guide practice (Graham, et al., 2006; Kitson, 2009). Nurses who practice from a scientific and research foundation can facilitate improved patient outcomes (Fink, Thompson, & Bonnes, 2005). Yet despite this, although nurses realize the importance of evidence based practice, the majority of nurses do not incorporate research findings into their practice (Curran, Grimshaw, Hayden & Campbell, 2011). This is best illustrated in relation to the study participants’ expression of moral distress (Pauly, Varcoe, Storch, & Newton, 2009; Vaismoradi et al. 2011) in the application of control interventions despite their knowledge of ethically sound nursing practice (Doane, Pauly, Brown, & McPherson, 2004; Varcoe, et al., 2004). Participants expressed knowledge of more appropriate least restraint practices, such as verbal de-escalation, yet often chose more restrictive interventions. This illustrates a knowledge to practice gap within ED nurse practice.

**Knowledge translation.** Knowledge translation (KT) is the process of moving from what has been learned through research to application in different decision-making contexts. The Canadian Institute of Health Research (CIHR) defines knowledge translation as “a dynamic and interactive process that includes the synthesis, dissemination, exchange and ethically-sound
application of knowledge to improve health” (CIHR, 2014). In essence, KT addresses this gap between what is known from research and the application of research into practice.

To close the gap between research and practice, it is essential that nurses begin with a strong foundation in research utilization and evidence based practice within their undergraduate education. The critical evaluation of nursing research and the skills to implement finding into practice require knowledge, support and mentoring. Additionally, within the work environment the organization must foster a supportive environment through a strong supportive leadership, mentorship, staff education related to research utilization, time to conduct or utilize research, routine performance expectation in research use, and fiscal incentives may be beneficial (Fink et al. 2005). It is essential that nurses’ feel supported and mentored by nursing leadership. Therefore, offering and promoting an organizational culture that values research use and support nurses to participate in such activities is crucial to the organization’s success.

Conclusion

ED nurses identified they lacked the knowledge, skills, and self-confidence to provide appropriate client centered care to patient's exhibiting mental health issues and this was at the root cause of moral and ethical distress. Nurses also experience moral distress when they believe they are not providing appropriate care and they are negatively contributing to the patient’s misery (Vaismoradi, et al. 2011). Lethoba, Netswera & Rankhumise (2006) identified that the non-psychiatric nurses often lack the required knowledge and skills to address the psychiatric needs of patients with mental health issues. The impact of uncertainty in care practices can have a harmful impact on the nurse both in self-confidence, self-efficacy, and job satisfaction (Dasgupta, 2012) causing significant moral distress (Pauly et al. 2009).
The study provided an opportunity for nurses to express their experiences, fears, and concerns when caring for and treating this patient population. As a result, participants clearly indicated that although they had a strong desire to provide optimal care for all patients, those individuals seeking treatment for mental health related issues pose significant challenges at an individual and organizational level. This is concerning as the number of patients seeking mental health treatment in the ED has been increasing over the past decades. Additionally, poor environmental design of the ED, lack of confidentiality, significant use of control interventions and most importantly the lack of nursing knowledge in providing patient centered care for the mental health patient can result in negative patient outcomes. Education, experience, skill, organization, and strong leadership determine the effectiveness of nursing care (Kane, et al., 2007).

**Implications for nursing practice**

This study provides a number of implications for ED nursing and administrators to enhance the delivery of high quality care for individuals with mental health issues.

**Education.** Quality nursing care requires nurses who are educated with a strong foundation in mental health nursing and have a positive attitude towards individuals experiencing mental health issues. Undergraduate nursing programs are responsible to provide nursing students with foundational theoretical knowledge and clinical practice in mental health nursing. A current evaluation of Canadian nursing programs is essential to gain an understanding of the depth and variability of mental health nursing within nursing curriculum across Canada. Evaluating and encouraging comprehensive psychiatric nursing theory across the curriculum that is augmented with diverse psychiatric clinical exposure can be supported through the accreditation process.
A significant need was identified for regular and on-going educational initiatives provided through a variety of learning methods. Suggested educational sessions included: common mental health issues with the associated symptoms; mental health assessment strategies, triage assessment support; and knowledge including the 'hands-on practice' of interventions particularly involving de-escalation of the aggressive patient. Education would be supported by the organization and participants clearly indicated the need for these programs to not be associated with significant personal financial cost. It is often difficult for organizations to allocate large blocks of time for education workshops, but it is essential to allow adequate time for education. Self-guided educational programs such as internet or technology based programs have the advantage of allowing nurses to work at their own pace. Often with mental health continuing education, a face-to-face designed program is desirable and appropriate based on the content presented, such as verbal de-escalation. When this form of education is required, providing workshops that can be broken into small blocks of time allow for minimal disruption of patient care but also allow for information to be reflected upon (Woltmann, et al., 2008). The participants of this study all requested the educational support courses incorporate individualized interactive support in addition on one-on-one practices. This is important as many educational programs were identified as either online or during intensive 2 days onsite programs.

**Time and resources.** The findings of this study support either an increase in staff ratios or availability of mental health experts or teams to support care provided to the individual seeking care for mental health reasons. Participants expressed the need for a dedicated assignment of only mental health patients and enhanced time to engage in appropriate assessments and treatment of the mental health patient. Current time benchmarks provided by the Ministry of Health and Long Term Care need to be re-evaluated in relation to psychiatric care
in the ED. As psychiatric evaluation, assessment of risk, and interventions supporting least restraint practices often require dedicated nursing time, modification is needed to address the needs for effective mental health treatment.

Collaboration with mental health experts within the ED or at minimum, available for consultation is needed. Participants advocated for the addition of a mental health ED nurse, similar to the nurses trained in specialty areas such as the Geriatric Emergency Management (GEM) Nurse or the Sexual Assault Domestic Violence (SADV) nurse. These clinical nurse specialists would function as a member of a mental health crisis team who assessed and guided treatment for the high risk psychiatric patient. In addition, they would provide expert advice, support and ongoing mental health education to staff. The value of the mental health liaison nurse or nurse practitioner has shown to improve quality of care by providing timely and appropriate clinical management of individuals presenting to the ED with mental health issues (McNamara, Bryant, Forster, Sharrock, & Happell, 2008). Delays in accessing psychiatric specialized services may exacerbate situations so that patients' behaviours escalate in ways that potentiate risk to the patient, staff and others (Leung, et al., 2013). These strategies will provide additional assistance to ED staff and support the management of crisis situations.

Environment. An evaluation of the current structure and organization of ED’s is needed to determine if improvement can be made to enhance care, provide safety, and maintain patient confidentiality. As outlined in the literature review, there are various ED models that facilitate psychiatry in the ED environment. It was suggested that the sites where participants were recruited for this study were ineffective and posed significant challenges to the nurse providing care to the individual with mental health issues. Restructuring the ED to provide a dedicated area away from high stimuli situations would support care conducive to the needs of the mental
Participants provided the following suggestions that included the provision of a separate area within the ED that is exclusively used for psychiatric assessment and stabilization; the need for the adoption of standardized tools supporting accurate assessment of needs and risk; and resources of specialized treatment teams that have the skills and ability to care for the individual experiencing psychiatric crisis.

**Control interventions.** Although Bill 85 requires health care providers to only use control interventions (restraints) as a last resort, when utilizing control interventions, it is both the organization and nurse's responsibility to follow least restraint guidelines. If used, it is imperative to address the negative psychological impact the control interventions have on the patient. The mandatory documentation, collection and reporting of control interventions as critical events is paramount to the monitoring and evaluation of use. This strategy, either within the institution or through an external review committee, would provide staff with an effective review process. This could promote the development of standards and protocols while highlighting the organizational commitment to least restraint practices. This data can be compared both within the institution, among other EDs, and to the broader community.

Additionally, another important strategy is the debriefing process following the use of various control interventions (post-incident). Research indicates that negative outcomes are minimized for both the patient and the nurse through the practice of debriefing following the critical incident of control intervention application. Debriefing is a post-incident intervention that assists the individual to work through any negative thoughts and feelings and to assess the patient's well-being and need for follow-up care (Needham & Sands, 2010; Raphael & Wilson, 2000). Involving the patient or patient representative, as appropriate, provides a valuable
opportunity to discuss or 'debrief' about the restraint or seclusion and the events surrounding the intervention (Allen, Carpenter, Sheets, Miccio, & Ross, 2003; Whitecross, Seeary, Lee, 2013).

Both the organization and the nurse must work collectively to ensure least restraint policies are practiced within the clinical environment. The ED provides care to individuals who are vulnerable and in crisis thus the healthcare team is responsible for ensuring the quality and delivery of services actively support client-centered care.

**Risk assessment tools.** Accurate suicide risk assessment is a fundamental issue to nursing practice in both psychiatric and general nursing units. In particular, ED nurses need to be able to identify potential risk factors and associated behaviours in order to provide safe and preventative care until the patient can be transferred to the appropriate setting. Nurse participants were unable to identify a standardized tool for risk assessment available in the ED. A joint Ontario Hospital Association and Canadian Patient Safety Institute report identified the need for risk assessment tools related to patient safety including suicide and self-harm; violence and aggression; and, seclusion and restraint (Brickell, et al, 2009). A defined process for both suicidal risk and violence should be used for patients who present to the ED with emotional or behavioural disorders (National Institute for Clinical Excellence, 2011). Suggested tools relevant to the ED include: The Mental Health Triage Scale (Smart, Pollard, & Walpale, 1999); Risk Assessment Matrix (Patel, Harrison, & Bruce-Jones, 2009); Agitated Behaviour Scale (Corrigan, 1989); Overt Aggression Scale (Yudofsky, et al., 1986); and the Violence and Suicide Assessment Form (Plutcik, van Praag, Conte, & Picard, 1989). The use of computer-based tools for screening and assessment meld with current electronic documentation practices within the ED supports current electronic documentation practices within ED’s. Assessment and screening should be part of a routine assessment and not as a separate exercise. Additionally, standardized
training in and use of risk assessment tools is needed to minimize subjective assessments and provide objective measurement to guide nursing practice.

Finally, there remains a need to establish national standards for mental health services that focus on ED services. This research suggests a need for standards including: (1) improved referral, sharing of resources and/or sharing of expertise between EDs and other mental health service providers; (2) a 24 hour on-call intake team that is responsible for the assessment, treatment and referral for individuals presenting to the ED who are experiencing a mental health crisis; (3) mental health staff who provide specialist mental health services available to support and educate ED staff; and (4) risk assessment protocols and the development of an emergency psychiatric triage scale that is consistent with national mental health policies.

**Strengths and limitations**

All research methodologies and studies have limitations and strengths (Marshall & Rossman, 2010). The identified limitations should not be seen as a deficit but rather how the study results can and cannot contribute to overall understanding of the phenomenon. A discussion of this study's strengths and weaknesses is as follows.

The qualitative design of this study indicates how broadly applicable this study may be in other homogeneous settings. This study has only uncovered the essence and meaning of care provided to the individual with mental health issues from the perspective of the nurse who works in the Emergency Department. Due to the in-depth nature of this qualitative study and the rigorous analysis of the data that followed, the sample size within this type of study is appropriate. Qualitative researchers attempt to show how the findings can be transferred and may have meaning or relevance in other contexts and situations (Finlay, 2006).
This study had several potential limitations. Potential limitations of the study that affect the study's ability to be transferred to other EDs and ED nurses include the following: (a) sample size, (b) issues surrounding the selection of study participants from only one LIHN, and (c) the degree to which ED nurses would openly and honestly discuss their experiences, thoughts, and feelings about providing care to individuals with mental illness.

Due to the interview process, only a limited number of nurses were able to participate in the study. Although data saturation was attained, the number of participants could potentially restrict the ability to uncover further issues and concerns. Generalizability is not an expected outcome of phenomenological research and the meaning or relevance in other contexts and situations cannot be inferred from this study. Further studies are needed to uncover the lived experiences of nurses who work with similar populations in diverse settings with a variety of psychiatric resources available.

Another potential weakness is that participants chosen for the study volunteered. Although there is a relatively small proportion of male nurses employed within the ED sites chosen for this study, they did not express a willingness to participate in this study. Exploration of the male perspective may provide further insight into care practices.

It is also possible that the participants who readily volunteered for this study had a particular interest in mental illness or high levels of frustration in providing care to this patient population. Past experiences of the participants may have affected their perceptions and attitudes, but that was the intent of the study - to explore ED nurse's experiences and attitudes toward caring for individuals with mental illnesses.

Participants’ willingness to openly explore their experiences may have further limited this study. There may have been the influence of social desirability, defined as the propensity for
participants to misrepresent their attitudes by giving answers or responses that are consistent with societal view or expectations (Speziale & Carpenter, 2003). Participants knowing the researcher's background may have restrained the participant’s willingness and comfort to engage in open and frank discussion. Participants may have been cautious within the discourse potentially trying to make a positive impression or please the investigator. Fearing judgment within the study or at an organizational level upon dissemination of the study findings may have also influenced participant responses. To minimize this limitation and encourage participants to openly express their personal attitudes and experiences, the study was conducted in a private setting of the participant’s choice. Using one-on-one interviews allowed the participant to share their experiences and provide in-depth responses to this potentially sensitive research topic.

Strength of the study is represented in its rich description of the experience of ED nurses in their perceptions of care and the meaning assigned to their care practices. Another strength is the use of multiple sites including those that were transferring inpatients from one clinical site to another. This allowed for an exploration of nurse perspective of the allocation of resources and supports that were associated with an active inpatient unit.

**Suggestions for future research**

The present research focused on the ED nurses’ experiences of care provided to individuals with mental health issues. Given the fact that patients with mental health issues are cared for in a variety of health care settings, it is important to gain an understanding of nurse perspectives within other healthcare settings. Gaining an understanding of the factors influencing mental health care within this non-psychiatric settings, will help to establish programs, policies, supports that will enhance the quality of care provided. Even though this
study recruited participants from one area within Ontario, some of the findings were similar to Marynowski-Traczyk and Broadbent's (2011) results from a similar study involving ED nurses in Australia. That is, in general, ED nurses perceived the lack of education and time to provide care for the mental health patient in the ED significantly hindered their ability to provide quality, patient-centered care. I would recommend repeating the study with participants working in both rural and urban settings that had access to a variety of resources to determine what resources supported quality care.

There is a need for Canadian-based patient safety research in mental health, especially in non-psychiatric settings. The emotional and psychological outcomes associated with nursing interventions, particularly control interventions, are areas of future research. Future studies might explore the experience of mental health patient’s experiences of care. Although both qualitative and quantitative research exists on patient/nurse perceptions of care within the psychiatric setting, minimal research has focused in the non-psychiatric setting. A neglected area of research involves the inclusion of the family and/or caregiver’s perspective on ED care.

Development and evaluation of educational initiatives specific to mental health nursing in non-psychiatric settings is needed. As the need for educational support was consistent across the literature, evaluating the implementation of education based programs using a variety of modalities is warranted. As the availability of validated risk assessment tools is minimal, there is a significant need for empirically validated risk assessment tools in both risk for suicide/self-harm, and violence and aggression. These tool can support nursing decisions related to various control interventions.

Finally, a review is needed to discover what current models of care are in place in EDs and the effectiveness of these models for managing the care of mental health patients. This
review would be used to identify challenges faced by ED and the quality of care provided. This information could assist hospitals in managing the demands for emergency care, restructuring their EDs in efforts to improve access to timely, safe, ethical, and quality care for individuals needing emergency care related to mental health issues.

**Changes in Personal Perception**

I began this research due to a personal passion and work experience in both emergency and psychiatric nursing. Although both settings provide care for the mental health patient, I was aware of both similarities and differences in care practices. I had a strong desire to understand the collective experiences of ED nurses as I had witnessed a wide variety of care practices. During the study, I engaged in the practice of journaling to bracket my thoughts and feelings to maintain an unbiased approach to this research study. The process of bracketing was less demanding than I had originally anticipated as from the first interview, the participant's description of perceptions of care went far beyond my expectations. This encouraged a deeper exploration of the nurse participant’s articulation of thought and beliefs. After reflecting upon the findings of this study, I gained a deeper insight into the experiences of ED nurses and their care of the mental health patient. I was able to understand the ED nurse experiences with and attitudes towards mental illness were often met with a frustration and lack of perceived self-efficacy to provide quality care. This extended to the point that many participants perceived that the ED was not appropriate for and did not meet the needs of the mental health patient. However, I also realized that although they perceived significant challenges and barriers in care for the mental health patient, all participants had a strong desire to improve the quality of care.
they provided. In addition, all participants expressed a strong desire to improve their knowledge of mental illnesses, accurate assessments and effective interventions that did not conflict with their ethical and moral values. Therefore, as a result of this study, I will expand upon the findings to develop educational support and advocate for policies to meet the needs of non-psychiatric nurses caring for individuals with mental illness. I will also advocate as an educator for an increased focus on mental health nursing education in undergraduate nursing programs.
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review of the literature. *Issues in Mental Health Nursing, 32*(1), 46-72.


### Appendix A: Literature Review

<table>
<thead>
<tr>
<th>Author (date)</th>
<th>Study design</th>
<th>Participants</th>
<th>Variables</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| **Brinn (2000)**<br>United Kingdom | Quantitative Survey | N=64 nurses Non-psychiatry | - to measure emotional reactions and expectations to vignettes describing patients with psychiatric diagnosis | - nurses fearful of people with mental health problems  
- concern re unpredictable behaviour  
- education during initial nursing training improve confidence |
| **Broadbent, Moxham, Dwyer (2010)** | Literature review | - summary of issues associated with emergency triage of clients who have a mental illness | - Australian triage scale not reliable tool for accurate mental health triage assessments  
- staff feel supported when ED uses mental health clinicians  
- must understand and adopt recovery model  
- need for mental health triage system that is comparable to one used for physical injuries or illness |
<table>
<thead>
<tr>
<th>Study (Year)</th>
<th>Research Design</th>
<th>Country</th>
<th>Sample Size</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chang, et al (2011)</td>
<td>Prospective study</td>
<td>United States</td>
<td>N=1092 individuals treated for mental health issues - 2 sites</td>
<td>- length of stay for adult patients receiving psychiatric evaluation - median times for ED length of stay from: triage to request for psychiatric evaluation, start to finish for psychiatric evaluation, to disposition - academic medical centers had shortest door-to-door request time - access to mental health services lowered wait time - those discharged home had shortest times - admission to psychiatric wards had longest length of stay - utilization of ED by psychiatric patients linked to overall mental health systems</td>
</tr>
<tr>
<td>Clarke, Brown, Hughes, &amp; Motluk (2006)</td>
<td>Quantitative Interventional study</td>
<td>Canada</td>
<td>N=10 full time triage nurses</td>
<td>- staff comfort with mental health triage - triage nurse confidence level - CTAS fails to guide triage assessments of mental health pat. - before education intervention, 50% of MH patients triaged as non-urgent required hospitalization - post intervention, 20% of non-urgent required hospitalization - intervention - increased confidences in assessing presentation complaints</td>
</tr>
<tr>
<td>Crowley (2000)</td>
<td>Participatory Action Research</td>
<td></td>
<td></td>
<td>- mindset - values - strategies - lack of mental health knowledge, skills development - lack of staff with mental health training</td>
</tr>
<tr>
<td>Study Authors</td>
<td>Study Type</td>
<td>Sample Size</td>
<td>Findings</td>
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</table>
| Hansson, Jormfeldt, Svedberg, & Svensson (2011) | Cross sectional study | n=40 staff n= 141 patients | - mental health professionals attitudes towards people with mental illness  
- comparison of attitudes of patients in contact with mental health services  
- negative attitudes prevalent among health care professionals  
- staff treating patients with psychosis or working in inpatient settings had most negative attitudes |
- importance of mental health education regardless of practice setting |
<table>
<thead>
<tr>
<th>Australia</th>
<th>Quantitative Retrospective chart review</th>
<th>N=7344 Patients presenting to ED for self-harm</th>
<th>- profile description - age, sex, method</th>
<th>- more training in detection/treatment of mental health problems of patients - mandatory undergraduate education focusing on mental health as all nurses will be caring for patients with mental illnesses</th>
</tr>
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<tbody>
<tr>
<td>Hawton, et al, (2007) United Kingdom</td>
<td></td>
<td></td>
<td></td>
<td>- 57% female - 2/3 under 35 years of age - those receiving treatment strongly associated with admission to hospital - 80% method was drug overdose</td>
</tr>
<tr>
<td>Hickey, et al. (2001) United Kingdom</td>
<td>Retrospective chart review -comparison of those assessed vs those who LWBS n=144 non assessed n=101 assessed</td>
<td>- identify characteristics and outcomes suicidal patients discharged from the ED without being seen</td>
<td>- d/c patients- 59% did not have psychiatric assessment - LWBS - likely had past history of deliberate self-harm, (20-34 yr old age group, exhibited difficult behaviour - LWBS - presented between 5-9pm - DSH occurred in 38% of LWBS and 18% of assessed patients (within 2 yrs) - assessed pts more likely to have psych treatment</td>
<td></td>
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<tr>
<td>Study</td>
<td>Methodology</td>
<td>Sample Size</td>
<td>Findings</td>
<td>Key Areas</td>
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</table>
| Kerrison, Chapman (2007)       | Qualitative Focus groups         | N =12 ED nurses | - investigated the education and training requirements for non-psychiatric ED nurses need to enable them to effectively care for psychiatric patients presenting in ED | - lack knowledge, assessment and communication skills to provide adequate care for complex mental health issues  
- concerned re safety in workplace when caring for aggressive patients  
- key areas |
- for low and middle income countries | - increases knowledge  
- matches mental health competencies to mental health population  
- incorporates non-formal health care leaders - ie community elders and traditional healers |
- awareness of self-injury  
- clinical reasoning | - solution focused education intervention  
- education raised nurses understanding of and skills for caring for pts with self-injury  
- positively changed attitudes towards patients |
| Nalle, Wyatt, & Myers (2010)   | Online needs assessment for      | N=672 Registered nurses | - understanding personal and professional motivations for continuing nursing education | - continuing education needs to be timely, affordable, and of high quality |
| Nicholls et al (2011) | Discursive paper | Contemporary practices described in relation to:  
- special care areas  
- psychiatric emergency centers  
- short-stay units | - introduction of mental health nurse practitioners in ED increases staff competence and confidence in interacting with mental health patient  
- decreased stigma |
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<tr>
<td>Australia</td>
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</table>
| Plant & White (2013) | Qualitative Focus group | - impression of mental illness (first encounter)  
- comfort level  
- effectiveness of care | - powerlessness  
- lack of knowledge  
- impaired communication and skills  
- lack of resources, management, people |
<p>| United States        |                  |                                                 |                                                                  |</p>
<table>
<thead>
<tr>
<th>Rao, Mahadevappa, Pillay, Sessy, Abraham, &amp; Luty (2009)</th>
<th>RTC</th>
<th>N=108</th>
<th>- forensic admission, - patient with schizophrenia, - patient with substance disorder</th>
<th>- time consuming care, - no other place to go</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>- questionnaires</td>
<td>Health care professionals working in mental health setting</td>
<td><strong>HCP</strong> have significant stigmatized attitudes towards patients with mental illness</td>
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</tr>
<tr>
<td></td>
<td>- read vignette and answered questionnaire</td>
<td></td>
<td>- worse stigmatized group are people with schizophrenia, etoh, and drug addiction</td>
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<td></td>
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<td>- worse when history of psych. admission</td>
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<td></td>
<td></td>
<td></td>
<td>- those in remission or in recovery have somewhat less stigma</td>
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<tr>
<td>Ross &amp; Goldner (2009)</td>
<td>Literature</td>
<td></td>
<td>nurses have negative attitudes towards individuals with mental illness</td>
<td></td>
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<tr>
<td>Canada</td>
<td></td>
<td></td>
<td>- hold stereotype patients are dangerous, predictable, violent - increased fear</td>
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<td></td>
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<td>- separation of care into physical or psychiatric - devalue psychiatric</td>
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<td>- lack of skills and education</td>
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<td>- lack of resources/infrastructure to support provision of safe competent care</td>
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<td>nurses with mental health issues can be stigmatized</td>
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<tr>
<td>Study Authors</td>
<td>Country</td>
<td>Study Design</td>
<td>Sample Size</td>
<td>Main Findings</td>
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<tr>
<td>Samuelsson &amp; Asberg (2002)</td>
<td>Sweden</td>
<td>Quantitative Intervention (training)</td>
<td>N=47 psychiatric nurses</td>
<td>- psychiatric nurses attitudes toward mental health patient (suicide attempt) examined pre and post training program in suicide prevention - general understanding and willingness to nurse increased - suicide risk estimated more accurately after intervention</td>
</tr>
<tr>
<td>Schaecken &amp; Ward (2006)</td>
<td>Australia</td>
<td>Quantitative Survey</td>
<td>N=100 mental health patients</td>
<td>- evaluation of a mental health liaison nurse role in the ED - quicker evaluation - treated with respect - collaborative with other health care providers - improved communication</td>
</tr>
<tr>
<td>Sharrock et al (2008)</td>
<td>Australia</td>
<td>Qualitative (exploratory study) Survey</td>
<td>N=56 ED nurses (mental health consultation liaison nurse)</td>
<td>- description of the role of psychiatric consultation liaison nurses in the ED - education, work satisfaction, Organizational structure - supportive to ED nurses for consultation - provide education to staff - valuable in the ED - cross roles in both psychiatry and ED</td>
</tr>
<tr>
<td>Stuhlmiller, et al.(2004)</td>
<td>Australia</td>
<td>Quantitative Pretest posstest Emergency Mental Health Alcohol and</td>
<td>N=182 emergency staff n=40 medical</td>
<td>- evaluation of confidence of staff working with individuals with mental health issues in the ED. - clinical confidence, knowledge and skill improvement post intervention - knowledge retention was high - integration of information into practice</td>
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<tr>
<td>Study</td>
<td>Methodology</td>
<td>Sample Size</td>
<td>Findings</td>
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<tr>
<td>Summers &amp; Happell (2003)</td>
<td>Qualitative Telephone interview</td>
<td>N=276</td>
<td>- Level of psychiatric patient satisfaction with care received in the ED</td>
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<td></td>
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<td>- Lack of privacy and length of waiting time</td>
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<td></td>
<td>- Satisfied with staff psychiatric qualifications</td>
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<td></td>
<td></td>
<td></td>
<td>- Satisfied with care received</td>
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<tr>
<td>Wand &amp; Happell (2001)</td>
<td>Qualitative Focus groups and questionnaire in ED</td>
<td>Focus N= 22 nurses Questionnaire N=53</td>
<td>- Evaluation of need for and effectiveness of mental-health consultation-liason nurse role in a teaching hospital</td>
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<td></td>
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<td>- Measured skills, confidence, and perceived knowledge of ED nurses and medical staff</td>
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<td>- Generalized uncertainty and lack of knowledge</td>
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<td>- Difficulty in nurses providing efficient and caring services to mental health patients</td>
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<td>- Lack of communication skills and showing respect for those who resist treatment, are intoxicated or paranoid</td>
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<td>- Lack of knowledge of community resources</td>
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<td></td>
<td>- Lack of knowledge re suicide risk assessment</td>
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<tr>
<td>Wyanden, Orb, McGowan, &amp; Downie</td>
<td>Quantitative Pretest Posttest Questionnaire</td>
<td>N=62 nursing students</td>
<td>- Level of preparedness to work with mentally ill patients</td>
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<td></td>
<td></td>
<td></td>
<td>- Less emphasis was placed on mental health/psychiatric nursing in education</td>
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(2000)  
*New Zealand*

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<tr>
<th></th>
<th>- perceptions of clinical</th>
<th>- clinical positive experience but it lacked integration of mental health nursing concepts</th>
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<tr>
<td></td>
<td></td>
<td>- undergraduate education does not adequately prepare students to care for mental health patient</td>
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</table>
Appendix B: Interview Guide and Protocol

Questions

1. Tell me about your experience of care provided to the patient with mental health issues within the ED setting.

2. Tell me something that went well when treating the psychiatric patient in the ED.

3. Tell me a story about something that did not go well when treating the psychiatric patient in the ED.

4. Have you ever experienced an ethical dilemma while providing care for the psychiatric patient?

5. Tell me about the education you had to prepare you for working with the psychiatric patient.

6. Tell me anything that you would like to share about your experience when treating a psychiatric patient in the ED.

7. What are the challenges in our work environment as it related to the psychiatric patient?

8. Please describe what emergency psychiatric care means to you?

9. What are the barriers to effectively caring for the psychiatric patient, if any?

10. How open and prepared do you think ED nurses are to provide adequate care to the high risk acute psychiatric patient?

11. What is your perception of the care mental health patients receive in the ED?

12. Tell me what helped to prepare you to work with the psychiatric patient?

13. How has the experience of caring for unstable mental health patients impacted your confidence in caring for this patient population?

14. What are the educational needs for caring for mental health patients?

15. What is your choice in educational training delivery method that will enable you to complete in-service training?
Interview Guide Protocol

INTRODUCTION:
What you share in this interview will be kept confidential. You may be identified in the study report in a way that will not reveal your individual identity such as, “(site) ER full-time nurse said,” so please tell me what you really think and feel; this will be the most helpful in trying to find out how to improve health care delivery by the Emergency Room nurse to the patient with mental health issues. I will be tape recording the interview to try to make sure that we have an accurate record of your views and I also will be taking a few notes for the same purpose.

Do you agree to allow me to tape-record this interview?

If NO: I will be available to meet with you for an individual interview where the audio recorder will be turned off.

If YES: Thank you, I will proceed with the interview.

INTERVIEW INFORMATION

Date of interview: Time: from _________ to __________

First Name: Participant ID #
Appendix C: Reflexivity Statement

My interest in researching the Emergency Department (ED) nurses’ experiences of care provided to individuals with mental illness evolved over many years. I have worked as an ED nurse for over 20 years and have work part time as both a nurse on adolescent and adult inpatient psychiatric units. As an educator, I have worked as a lecturer and clinical instructor in a BScN Psychiatric Nursing course and other nursing courses. It has always been my desire to enhance the nursing care provided to individuals with mental health issues in both settings. As a nurse, I made it a priority to engage in various continuing educational opportunities to strengthen the skills related to both medical and psychiatric care. Those related to psychiatric nursing included Non-Violent Crisis Intervention, Suicide Risk Assessment, Suicide Intervention (ASSIST), De-Escalation (Verbal and Physical), and various control interventions use and application. This combined with a master's thesis exploring depressive symptoms in shift-working registered nurses strongly reflect a desire to provide optimal care to this patient population.

As a nurse, I believe I have a personal responsibility to ensure that my nursing care reflects best practices that is attained through continuing education and being aware of related nursing research. I view this to be the responsibility of the nurse regardless of their area of specialty. As an ED nurse, I have witnessed a general lack of nursing care provided to individuals with mental illness. This includes both nursing assessments and interventions. I believe the most significant barriers to care within the ED are a lack of general understanding of psychiatric nursing interventions, especially those of least restraint. I believe that for too often, ED nurses utilize control interventions because they lack proficiency in least restrictive alternatives. I have also witnessed a high level of
stigmatizing behaviours towards those with mental illness. This seems particularly prevalent toward the suicidal patient. I have repeatedly been witnessed degrading statements towards the mental health patient. Often the ED nurse has dismissed the credibility of patient statements related to risk for self-harm and this translates into their failure to complete appropriate assessments of risk. This is not only visible with the nursing staff but also within the medical staff. Finally, I believe the environment within the ED does not support psychiatric nursing care practices. Psychiatric assessments and interventions take time that is not available to nurses who are assigned multiple patients. In addition, the ED is a high stimuli, active, loud environment that is not therapeutic to the agitated patient.

As a lecturer, I desire to promote a nursing culture that prioritizes psychiatric nursing care and stress the importance of accurate psychosocial assessment within and beyond the psychiatric settings. Students often enter the psychiatric nursing course with reluctance and express a sense of apathy towards this nursing specialty. Once they progress through both the theory course and the clinical rotation, they begin to understand the importance of mental health nursing and their confidence increases. When working as a clinical instructor, it is validating to witness their skills and confidence increase as they applied the theory content into clinical practice. I strongly believe in the association between knowledge, confidence, and competence.

I acknowledge that nurses are not solely responsible for care practices. I believe the organization has a strong responsibility to support nursing care practices. The organization from senior management to unit staff need to work together to ensure the skills and tools are available to medical staff. The environment strongly influences care and if the organization does not value psychiatric care on all units, the nurse may not validate the need for effective care for this patient population.
Finally, I believe that ED nurses want to provide the best care to all individuals entering the ED but through years of working in this environment, I feel that psychiatric nursing care is not valued on the same level of medical care. I have witnessed frustrations from both the nurse providing care and the recipient of care. From this, I feel motivated to gain a deeper understanding of the experiences of care provided in order to enhance the care delivery those seeking care for mental health related issues.

Thus, as I interview nurses about their experiences with providing care to individuals seeking care in the ED for mental health reasons, I bring with my a history of working with this patient population in a variety of settings and roles. My educational, teaching and work history serve to guide this research into the ED nurses' experience with care for the mental health patient.
Appendix D: Letter of Intent
Letter of Information

“Nurses experiences of care provided to individuals with mental health concerns within the Emergency Department”

This research is being conducted by Jane Tyerman under the supervision of Dr. Diane Buchanan, in the Department of Nursing at Queen’s University in Kingston, Ontario.

What is this study about? The purpose of this research is to discover the ED nurse’s experiences of care provided to the individual experiencing mental health issues. The study will require participation in individual interviews. There are no known physical, psychological, economic, or social risks associated with this study.

Is my participation voluntary? Yes. Although it be would be greatly appreciated if you would answer all material as frankly as possible, you should not feel obliged to answer any material that you find objectionable or that makes you feel uncomfortable. You may also withdraw at any time with no effect on your standing in school.

What will happen to my responses? We will keep your responses confidential. Only experimenters will have access to this information. To help us ensure confidentiality, please do not put your name on any of the research study answer sheets. The data may also be published in professional journals or presented at scientific conferences, but any such presentations will be of general findings and will never breach individual confidentiality. Should you be interested, you are entitled to a copy of the findings.

Will I be compensated for my participation? No, there will be no monetary compensation for participation within this study.

What if I have concerns? Any questions about study participation may be directed to Jane Tyerman at jjt@queensu.ca. Any ethical concerns about the study may be directed to the Chair of the General Research Ethics Board at chair.GREB@queensu.ca or 613-533-6081.

Again, thank you. Your interest in participating in this research study is greatly appreciated.

This study has been granted clearance according to the recommended principles of Canadian ethics guidelines, and Queen's policies.
Appendix E: Letter of Consent

Consent Form

“Nurses experiences of care provided to individuals with mental health concerns within the Emergency Department”

Name (please print clearly): ____________________________________________

I have read the Letter of Information and have had any questions answered to my satisfaction.

2. I understand that I will be participating in the study called Registered Nurses experiences of care provided to individuals with mental health issues in the Emergency Department. I understand that this means that I will be asked to participate in one focus group and two training programs.

3. I understand that my participation in this study is voluntary and I may withdraw at any time. I understand that every effort will be made to maintain the confidentiality of the data now and in the future. Only experimenters in the School of Nursing will have access to this area. The data may also be published in professional journals or presented at scientific conferences, but any such presentations will be of general findings and will never breach individual confidentiality. Should you be interested, you are entitled to a copy of the findings.

4. I am aware that if I have any questions, concerns, or complaints, I may contact Grad Student Jane Tyerman jit@queensu.ca; project supervisor, Dr. Diane Buchan (533-2668); diane.buchanan@queensu.ca; Head of the Department Dr. Dana Edge (533-2668), or the Chair of the General Research Ethics Board (533-6081) at Queen’s University.

I have read the above statements and freely consent to participate in this research:

Signature: ___________________________ Date: ________________________
Appendix F: Demographic Data

| Participant Demographics | Age  
|                         | Sex  
|                         | Education level  
|                         | Number of years as a Registered Nurse  
|                         | Number of years working in an Emergency Department  
|                         | Number of years working in present position within the ED  
|                         | Previous experience in psychiatric nursing  
|                         | Previous training in risk assessment  
|                         | Previous training in de-escalation  
|                         | Number of aggressive incidents participant has experienced when working in ED  
|                         | Type of aggressive incident participant has experienced when working in ED (brief description)  

| Institutional | Inpatient psychiatric unit within hospital  
|              | Distance to nearest inpatient psychiatric unit  
|              | Availability of psychiatric crisis team within department  
|              | Designated seclusion room  
|              | Tools used by institution to identify potential risk of self-harm by either triage or staff nurse |