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Improving the Relationship between Emergency Nurses and the Behavioral Health Patient

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Improving the Relationship Between Emergency Nurses and the Behavioral Health Patient

by

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Abstract

There is an increasing number of behavioral health patients entering through the emergency department for behavioral health treatment and crisis intervention every day. Workplace violence against nurses has also increased leaving some nurses feeling anxious and fearful of interactions with behavioral health patients. The increase of behavioral health patients and unstable situations have created a gap in communications and has strained the nurse patient relationship yielding poor patient outcomes. The purpose of this project is to educate nurses on the care of the behavioral health patients and improve nurse-patient relationships for better outcomes for the patient. The framework for this project was influenced by Peplau's Theory of Interpersonal Relationships.

Acknowledgments

I would like to thank my advisors Dr. Gayle Casterline and Dr. Julia Knauff for their guidance, wisdom, and patience throughout this project. I would also like to thank my husband Rick for his continued support and his faith in me throughout this process. Finally, I would like to thank God for his mercy and his blessings as well as for giving me the strength and determination to pursue my dreams to make a difference in the lives of others.

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CHAPTER I

Introduction

Emergency room (ER) nurses face many challenges in an uncertain and ever-changing environment. ER nurses must make quick, lifesaving decisions, recover quickly from emotional trauma, and be able to move on to care for the next patient without any down time. According to Goodarzi et al. (2015), the emergency department (ED) is considered the most challenging and highly stressful work environment. According to Healy and Tyrell (2011) repeated exposure of ED staff to stressful events such as sudden death, trauma, patients in pain, resuscitation, aggression, and violence can have devastating effects on their physical, psychological, and emotional health and wellbeing, and can reduce the quality of their working lives. (p. 32).

Personal professionals experience uncomfortable situations with behavioral health patients due to lack of expertise and education regarding the care of the behavioral health patient. According to Marynowski-Traczyk and Broadbent (2011) it is well documented that emergency department nurses are poorly prepared to care for patients with mental illness and the lack of preparedness leads to a suboptimal clinical environment (p.173). ED nurses often experience behavioral health patients who act unpredictably in an acute crisis. Ryan and Macguire (2006) stated 20% of the nurses in the ED had experienced sexual intimidation, harassment, or assault in the past month (as cited in Llor Estaban et. al, 2017, p. 34) The unpredictable nature of these encounters with behavioral health patients often create fear in the ED nurse and trigger a reactionary response. In many cases, this response leads to negative outcomes for the nurse, the patient or both. The goal

of this project was to improve the relationship of the ED nurse and the behavioral health patient leading to improved patient outcomes.

Significance

According to Kalter (2019), one in every eight ED visits in the U.S. is related to a mental disorder or substance abuse issue. Most facilities require the patient to enter through the ED for screening, labs, and placement. The behavioral health patient is sent to the ED where emotions are high, the environment is unstable, and the patients are critical. Kalter (2019) stated due to the lack of capacity in the mental health care delivery systems, a substantial volume continues to fall on the emergency departments as the primary care for behavioral health patients (p.1).

Personal observation has shown that the behavioral health patient is sometimes seen as an inconvenience despite his or her presenting crisis or need. As explained by Kerrison and Chapman (2006), ED nurses are uncomfortable providing this type of care because of lack of experience or education. Kerrison and Chapman (2006) stated non-mental health trained nurses are ill-equipped in their psychiatric knowledge, assessment, and communication skills to provide best possible care to the one in ten patients presenting to the emergency department with a complex mental health issue (p. 48). This lack of experience and education can create discord between the patient and the ED nurse. Many times, the behavioral health patient becomes violent and verbally abusive. According to Kerrison and Chapman (2006), ED nurses are concerned about their safety in the workplace since patient aggression and violence is increasing. The concerns can create discord between the ED nurse and the patient. This discord pushes the nurse away leaving the patient misunderstood and their needs unmet.

Purpose

The purpose of this project was to enhance the care delivered to patients with behavioral health issues in the ED by improving the nurse patient relationship, which will ultimately increase positive patient outcomes. According to Kerrison and Chapman (2006), the assessment and management of patients in the ED, presenting with acute mental health problems, is inadequate due to the lack of knowledge and skill related to the lack of mental health education and training. By the end of this project, ED nurses will be able to:

1. Identify personal feelings or views of patients with behavioral health issues
2. Recognize personal feelings associated with patients who suffer from behavioral health issues
3. Understand the needs of the patient with behavioral health issues without stigma
4. Demonstrate awareness of needs for the patient with behavioral health issues

By educating the nurse and helping he or she to identify feelings and stigma associated with the behavioral health patient, the relationship between the patient and nurse can be improved for better outcomes for the patient.

Theoretical Framework

According to Senn (2013), nursing practice requires thoughtful and effective communication and good interpersonal, which can produce positive health outcomes. Communication is a critical component of caring for the behavioral health patient. Therapeutic and purposeful communication techniques are most effective in most situations. Hidlegard Peplaus' nursing Theory of Interpersonal Relationships was the influence for this project. Peplau believed that "through the devise of the therapeutic

nurse-patient relationship, the nurse could be most beneficial to human beings". (as cited in Senn, 2013, p.32) Peplau developed this middle range nursing theory and defined nursing as the therapeutic relationship between the nurse and the patient. By making the communication between the nurse and the patient more purposeful and meaningful each party can understand one another better without discord. Peplau (1991) emphasized that the terms relations and relationships should not be used as one in the same and that the nurse patient relationship is a process with overlapping phases. According to Peplau (1991), her process of communication was a means to promote positive changes in patient behaviors.

Peplau (1991) discusses three phases of interpersonal relations. In the first phase, known as the orientation phase, the patient presents with a need or a health problem. Peplau (1991) expected that nurses greet patients with respect and positive interest accorded a stranger. This is a quick phase of first impressions. It is this phase where one party is attempting to be understood by the other party. Peplau (1991) goes on to explain the second phase, known as the working phase. It is during this phase the nurse spends a large portion of time with the patient. This is the listening and accepting phase in which the nurse actively listens to the needs of the patient, and the nurse uses therapeutic communication in a helpful and non-judgmental way. Finally, Peplau (1991) explains that the last phase is known as the termination phase. For this phase to be successful the nurse and patient must have passed through the orientation and working phase successfully. In the termination phase, the nurse teaches the patient how to manage their symptoms and recovery on their own. All phases must be successful in order to have positive outcomes for the patient.

Summary

Peplau (1991) stated that the nursing process is educative and therapeutic when nurse and patient come to know and respect each other. As discussed previously, behavioral health patients can be violent, aggressive, or unpredictable. This can make them unaware of the environment or how their unpredictable actions are perceived. The nurse must also realize his or her own feelings and anxiety related to the care of the behavioral health patient. The nurse may not realize the tone of voice, body language, or facial expression he or she is conveying to the patient. This can disrupt the phases the relationship of the nurse and patient must go through to be successful. Senn (2013) states that it is essential for the emergency nurse to communicate proactively with the patients and their families utilizing empathy, assertiveness, and active listening (p.33). The nurse must clear his or her mind of past experiences or stigmas associated with the behavioral health patient and utilize empathy with the patient. ED nurses are accustomed to dealing with the physical crisis of patient but sometimes lack the knowledge to handle the mental crisis of a patient. By utilizing Peplau's Theory of Interpersonal Relationships the nurse can create a positive interaction with the behavioral health patient by trying to understand the patient's crisis.

CHAPTER II

Literature Review

This literature review was conducted by searching Google Scholar, CINAHL, and ERIC. The search criteria included keywords: mental illness, barriers, stigma, attitudes, Peplau, and emergency department. The literature was narrowed down for peer reviewed articles between 2010 and 2020. The literature was reviewed and criteria for inclusion included mental health patient interactions with psychiatric and emergency department nurses.

Personal professional experiences have identified many barriers exist for mental health patients seeking treatment. Bramberg et al. (2018) conducted a study to explore the experiences and views of patients, relatives, and clinicians regarding individual and organizational factors which facilitate or hinder access to somatic healthcare for persons with severe mental illness (SMI). SMI was defined in this study as schizophrenia, bipolar disorder, and psychosis. The researchers gathered qualitative data from SMI patients, their relatives, and clinicians who worked in primary and specialized health care in Sweden. A total of 14 patients, 15 relatives, and 21 clinicians were interviewed face to face. The interview guides were developed from the Consolidated Framework for Implementation Research (CFIR) guide. Inclusion criteria for participants were as follows: ongoing contact with psychiatric out-patient care, psychiatric diagnosis of bipolar disorder type I or II, psychosis, or schizophrenia. Exclusion criteria was as follows: in-patient psychiatric care during the previous 12 months and ongoing investigation of patient's complaints by the patient's advisory committee. Individual barriers that were identified in the study were self-stigmatization, patient's cognitive

disabilities, and the clinicians' lack of knowledge of mental illness. Patients reported previous experience in seeking treatment left them with the impression that their mental illness diagnosis was used as a framework for their symptoms and the perceived tendencies of clinicians to see their psychiatric diagnosis first. One patient reported believing they would receive worse treatment due their psychiatric diagnosis. One relative reported feeling the patient had been labeled. Clinicians reported they may have underestimated a patient's symptoms because of difficulty communicating during medical history interview. The clinicians also found difficulty in understanding the mental health patients' descriptions of symptoms. Clinicians stated they had insufficient psychiatric training and expertise. Organizational level barriers were the primary care system and lack of cooperation between departments within the healthcare system. Both patients and clinicians identified continuity as an opportunity to build a patient-clinician relationship based on a trusting alliance. Bramberg et al. (2018) described the need for ongoing education for medical professionals regarding SMI patients.

Certain stigmas or stereotypes can affect how a person is treated. Frey et al. (2016) conducted a study to examine the stigma experienced by individuals with previous suicidal behavior from treatment providers and individuals in the persons' social and family network. Frey et al. (2016) defined stigma as "poorly justified knowledge structures that lead to discrimination" (p.95). The researchers distributed an online survey to people using listservs maintained by the American Association of Suicidology to identify stigmatizing experiences of persons experiencing suicidal behaviors. The participants had to be 18 years of age and experienced suicidal ideation or had attempted suicide. Listserv also sent the link through suicide support groups such as Suicide

Anonymous and the Suicide Prevention Resource Center. A total of 156 participants took the survey, between the ages of 18 and 77. Seventy-nine percent were female and 90% were Caucasian. The participants were asked if they encountered or experienced stigma from mental health providers, non-mental health providers, and social networks following their suicide attempt. The most common stigmatizing experiences occurred with the emergency department personnel and clergy/ministers. The researchers stated levels of perceived public stigma and self-stigma were measured by using two subscales from the Individual-Level Abortion Stigma Scale, and depression symptoms were measured by the 9-item Patient Health Questionnaire. Frey et al. (2016) stated that the prevalence of reported stigma from non-mental health providers was substantially higher than the prevalence of reported stigma from mental health providers. ($p<.001$) (p. 99). Frey et al. (2016) also stated that the prevalence of reported social network stigma was substantially higher than the prevalence of reported mental health provider stigma ($p<.001$) (p. 99). Since social network members and non-mental health providers are often the first sources of contact for people experiencing suicidal behavior, researchers identified the need for prevention training to focus on recognizing personal bias, on the etiology of mental illness and suicidal behavior, and on specific strategies for combatting observed stigma. The significant findings from this study suggested that stigma source could be in an important factor in suicide prevention.

Vandewalle et al. (2019) conducted a study to understand the core elements of how nurses in psychiatric hospitals make contact with patients experiencing suicidal ideation. The researchers used a qualitative approach and interviewed 19 nurses from four psychiatric hospitals who cared for suicidal patients in the last year. The nurses' ages

ranged from 22 to 61 years and had worked between four months and 39 years. All participants had a degree in psychiatric nursing. All interviews were conducted by asking, "How do you interact with patients experiencing suicidal ideation". A narrative report and conceptual scheme were developed for each interview to identify preliminary concepts while maintaining a holistic understanding of the participant's experiences. Preliminary concepts and memos were discussed and cross-checked between the researchers to elaborate concepts and relations between concepts. The criteria of Lincoln and Guba (1985) were applied to establish the trustworthiness of the study. Two core elements were described by the researchers: Nurses make contact with patients experiencing suicidal ideation so that they "create conditions for open and genuine communication" while maintaining a focus on "developing an accurate and meaningful picture of patients" (Vandewalle et al. 2019, p.2867). The finding also indicated that nurses put emphasis in the contacts with the patient based on whether the approach is guided by checking and controlling suicide risk or by acknowledging and connecting with the patient. According to Vandewalle et al. (2019) four different themes emerged from the study: creating conditions for open and genuine communication, creating avenues to patients experiencing suicidal ideation, creating a safe atmosphere to talk about suicidality, and developing an accurate and meaningful picture of patients. Nurses in this study perceived that patients do not disclose suicidal ideation due to feeling unsafe or unready and this creates a challenge. The shame the patients feel creates a barrier to communication. The authors concluded that recognizing and discussing suicide may reduce suicidal ideation and is a critical component of suicide prevention. Vandewalle et al. (2019) stated nurses' capacity to develop an accurate and meaningful picture of

patients is supported by elements such as listening and talking to patients, being alert, using intuitive senses, respecting the emotions of the patients and developing a trusting bond. (pg. 2874) The findings inform guidelines and educational programs aimed at improving connections with patients and as a foundation for talking and listening to patients and for getting to know them as unique individuals.

Patients have their own views of the care they receive when seeking help. Wise-Harris et al. (2017), explored the experiences of people who have mental health illnesses and who are substance abusers and frequently use the emergency department for treatment. The Coordinated Access to Care from Hospital Emergency Departments (CATCH-ED) study was a randomized controlled trial of a brief case management intervention for frequent users with mental health and addiction challenges. The study consisted of 166 quantitative interviews and 20 qualitative interviews from adults with five or more emergency department (ED) visits in the past year to one of six participating hospitals. Participants were randomized to the intervention or Treatment as Usual (TAU) and followed for 12 months. The participants met with a researcher at baseline and every 3 months. Descriptive statistics were used to summarize baseline self-reported data and ED use over the previous 6 months. Twenty participants were invited to participate in in-depth qualitative interviews. The median age for participants was 44.5 years and 51% were male. There was a median of six ED visits with a median of 3 days in the hospital. Sixty-eight percent of participants reported three or more comorbid chronic health conditions. Wise-Harris et al. (2017) states frequent ED users' perspectives revealed largely negative experiences of ED care including perceived stigma, discrimination, and unsympathetic care. The participants identified their health issues as life-threatening and

that frequent ED use was unavoidable due to acute crisis, pain, and injury. Participants stated that ED visits were necessary due to lack of alternative, accessible destinations, and poor family support systems. Participants complained that local crisis centers and crisis resources such as phone line and mobile crisis teams often turn them away. Wise-Harris et al. (2017) stated service providers in the community, including physicians, therapists, social workers, and the local crisis center, were seen as sanctioning, and in some cases, ‘‘forcing’’ these individuals to go to the ED by calling police or ambulance or by accompanying them to hospital. (p.408). Findings revealed a “mismatch” between the patients concerns and the staff’s response. The researchers expressed a need for training to sensitize hospital staff to factors impacting frequent use, patient experiences, and the importance of referral to timely, appropriate aftercare. Wise-Harris et al. (2017) concluded that institutions need to address staff burnout and compassion fatigue by investing in training for staff to promote compassionate and non-stigmatizing care. The limitations to the study were identified as a small sample size of 20 qualitative interviews from one community and the lack of perspectives from hospital staff.

Hamilton et al. (2016) conducted a study in England to better understand mental health service users’ experiences of stigma and discrimination in different settings and to bridge the gap between discrimination and the behavior associated with the discrimination. The researchers defined stigma as the devaluing of particular social identities or characteristics, including labelling, stereotyping, loss of status, and discrimination. Using a sample from the 2013 Viewpoint Survey, researchers evaluated the impact of Time to Change Anti-stigma Program. The DISC-12 interview asked participants whether they have been treated unfairly in the last year in a range of many

different contexts. Of the 9,599 who were invited to participate, 985 agreed to telephone interviews. Fifty interviews were chosen for analysis based on experiences with discrimination and examples. A coding pattern of nine themes was established: mistreatment, social distance, stereotyping, organizational decisions, lack of understanding or support, overprotectiveness, dismissiveness, the role of self, and positive experiences. Five life areas were identified as having the most reported discrimination: welfare benefits, mental health care, physical health care, family, and making and keeping friends. Welfare benefits participants reported that the system and those who work for it do not have an adequate understanding of mental health and the needs and vulnerabilities of those with mental illness were not considered (Hamilton et al., 2016). Furthermore, mental health professionals described a lack of support from the system and the individuals within the system. Findings revealed distress caused by lack of help in a crisis and lack of access to treatment. Patients described rudeness, dismissiveness, and professionals not listening or believing them. Patients reported a lack of family understanding, dismissiveness, support and a lack of understanding, support, and distancing from friends. This study identifies the need for anti-stigma interventions and the need to help people understand and support those who have mental illness.

MacNeela et al. (2012) studied attitudes towards caring for psychiatric patients and nurses' choice of psychosocial strategies. The researchers used a multimethod design to study medical surgical nurses in general hospitals. This design consisted of a think-aloud decision-making task and critical incident interview. The critical incident interview focused on psychiatric patients who had a physical health problem. Thirteen nurses were asked to think aloud while completing a problem-solving task based on a simulated

patient. Three nurses had less than 5 years of experience and the others had greater than 10 years of experience. The simulated patient in the think aloud task was a 25-year-old male transferred to a medical-surgical ward due to respiratory issues from a psychiatric unit. The nurses were asked to assess the patient's needs and identify priorities to taking over the patient's care. The patient was admitted to the psychiatric unit for anxiety and difficulty coping. He was noted to have been agitated, smoking, and missing IV antibiotics. All nurses described the patient as having anxiety in their responses. MacNeela et al. (2012) states references to the patient's anxiety conveyed an informal, everyday sense of the term rather than a psychiatric disorder. (p. 205). Difficulties in breathing were referred to as shortness of breath and rapid breathing. The two attitudes themes were risk (n = 7) and vulnerability (n = 5). One nurse expressed both attitudes. The psychosocial interventions were reassurance (n = 9), encouragement (n = 7), and structured engagement (n = 5). Furthermore, MacNeela et al. (2012) stated the most directive category of psychosocial care, structured engagement, was closely linked to a risk-oriented attitude. (p. 209). Improved practitioner knowledge of psychiatric conditions and psychosocial responses to hospitalization are key to caring for psychiatric patients (MacNeela et al., 2012). The researchers also suggested development of therapeutic communication skills through high-fidelity case simulation.

Workplace violence is a high-risk issue for nurses. (Llor-Esteban et al., 2017) Llor-Esteban et al. (2017) conducted a study to analyze hostile user statements against nursing professionals of mental health services and emergency units in health service hospitals and determine the frequency of exposure to the different violent user behaviors. The study was conducted with a sample of 518 nursing professionals and axillary staff

from four hospital services in Murcia, Spain: mental health, emergency units, medical hospitalization, and maternal-child units. This was a total of four hospitals out of nine. Six hundred and twenty questionnaires were sent out with a response rate of 83.55. Four validated instruments were used: Ad hoc questionnaire of sociodemographic and work variables, Healthcare-workers Aggressive Behavior scale-users (HABS-U), Maslach Burnout inventory- General Survey (MBI-GS), General Health questionnaire (GHQ-28), and Overall Job Satisfaction Scale (OJS) (Llor-Esteban et al., 2017). Males reported greater exposure to physical violence than the females, $t = 3.16$, $df = 507$, $p < .05$, $d = 0.632$, and age was significantly negatively correlated, $r = -.146$, $p < .01$. (Llor-Estaban et al., 2017). Healthcare experience was related to lower risk of suffering verbal violence ($r = -.09$, $p < .05$). It is observed that anger because of assistance delay is more frequent in Emergency Units than in the other services studied, $F = 32.69$, $df = 515$, $p < .001$, $\eta 2 = .690$, and also angry grimaces or disdainful looks, $F = 19.34$, $df = 514$), $p < .001$, $\eta 2 = .692$. (Llor-Estaban et al. 2017, p.36) The patient raising his or her voice is more frequent in Emergency Units and Mental Health, $F = 30.19$, $df = 512$, $p < .001$, $\eta 2 = .715$, as well as insulting, $F = 24.72$, $df = 511$, $p < .001$, $\eta 2 = .729$, displaying a defiant attitude or gesticulating violently, $F = 19.29$, $df = 513$, $p < .001$, $\eta 2 = .691$, and threatening to attack the staff, $F = 20.59$, $df = 509$, $p < .001$, $\eta 2 = .702$." (Llor-Etsaban et al. 2017) More intense anger, breaking doors, windows, walls, $F = 18.93$, $df = 514$, $p < .001$, $\eta 2 = .799$, is also more frequent in this group. (Llor-Estaban et al. 2017) The researchers concluded that exposure to violent situations can provoke diverse psychological consequences in health professional such as: decreased job satisfaction, burnout symptoms, and psychological distress. The limitations to the study were the design which limits some

relations among variables and the events were based on what the participants recalled and could not be exact. The overall violence healthcare workers experienced was more nonviolent than violent, and the nonviolent was more typical in emergency departments. The researchers expressed the need for more training in areas such as communication and conflict management.

In another study to gain insight about ED nurse experiences caring for mental health clients in the ED, Marynowski-Traczyk and Broadbent (2011) conducted a hermeneutic study of six RNs. The interviewer asked each RN, what are your experiences in caring for clients with a mental illness in the ED? What factors affect your ability to care for a client with a mental illness? How do you feel the environment within the ED has impacted your experiences in caring for clients with a mental illness? and What are your experiences in caring for acutely unwell clients with a mental illness? (Marynowski-Traczyk & Broadbent, 2011). The interviews were audiotaped and transcribed to text then checked by a research supervisor for credibility. Three themes emerge from the data: Time: a causative force, environment: surrounding influences and understanding the client's personal journey. Qualitative data from this study elucidated that ED nurses perceived clients with a mental illness to have a considerable impact on the flow within the ED and upon the work demands placed on them. (Marynowski-Traczyk & Broadbent, 2011, p. 177). Time was also noted to be detrimental to the mental health patient in the ED. The researchers acknowledged the mental health patient is best managed in an environment that is quiet, low stimulus, and calming. The researchers concluded that if the ED is to be the main point of entry to mental health care, then it must be redesigned to meet the needs of this client group.

Conclusion

The research shows there is a negative stigma surrounding the behavioral health patient and that there is a lack of mental health education provided to nurses for the proper care of this patient population in the ED. Education related to stigmas associated with the behavioral health patient can break down the barriers nurses and patients feel while receiving care in the Emergency Department. Patient's felt stigmatized by ED staff due to their frequent visits or mental health and/or addictions. (Wise-Harris et al., 2017). These users also described ED personnel as "nasty, rude, smug, sarcastic, not always caring and pretty cold like they don't care". (Wise-Harris et. al., 2017) Research has shown that patients describe professionals as being rude, dismissive and do not listen or believe them (Hamilton et al., 2016) Nurses view the interaction with mental health patients differently and may not realize they are being rude or uncaring. Marynowski-Traczyk and Broadbent (2011) quoted a nurse stating "with mental health there is a time factor, I know that out in triage that I don't have the time and that's what I know they need. I find it frustrating that you don't have time, it's just a big rush if it's busy". (pg. 175) Research also shows nurses lack the education needed to have therapeutic communication and properly care for the behavioral health patient. Wise-Harris et al. (2017) expressed the need for training to help staff to promote compassionate and non-stigmatizing care. Education related to compassion, communication, and anti-stigma could help decrease anxiety and misinterpretation from the nurse yielding a better relationship between the ED nurse and the behavioral health patient.

CHAPTER III

Needs Assessment

Target Population and Setting

The target population for this project was the ED nurse. The aim of the project was to address the relationship between the emergency department nurse and the behavioral health patient, and to change the behavior and actions of the ED nurse for better patient outcomes. The setting for this relationship was the emergency department in which the behavioral health patient presents seeking help and treatment.

Sponsors and Stakeholders

The sponsors and stakeholders for this project were the emergency department nurses, emergency department managers, the emergency department director and assistant vice president (AVP), and the director of nursing. With approval from the managers, the director and AVP the project will be taken to the educational committee for review and approval.

SWOT Analysis

Figure 1

SWOT Analysis

	Strengths	Weaknesses	Opportunities	Threats
Product/ Service Offering	Nationally recognized and proven training		To increase compassion among nurses caring for behavioral health patients	
Brand/ Marketing	One-time class associated with one-time cost	In class provider training of 15 hours		

Staff/ HR		Self-paced online courses	Specialized teammates to help educate and promote the change	Staff reluctance or resistance to training
Finance	No cost for training material The program would be paid for through the education budget instead of the operational budget		Show the need for more money in the educational budget	Time consuming increasing cost Continuing education for effectiveness of training
Operations/ Management		Lack of time allotted for proper learning environment		Lack of support for training from management
Market			Potential to increase patient satisfaction scores	

Can any of your strengths help with improving your weaknesses or combating your threats? If so, please describe how below.
The nationally recognized and proven effectiveness of the training as well as the zero-cost associated with training materials would be a positive selling point to management to incorporate the training in the department.
Based on the information above, what are your immediate goals/next steps?
The next steps would be to present the educational materials and a cost and benefit analysis to the management team and educational team for approval.
Based on the information above, what are your long-term goals/next steps?
Long term goals for this project are to implement this educational program into all Emergency departments (ED) so that ED nurses can provide care to behavioral patients without stigma and to increase patient satisfaction scores.

Available Resources

The available resources for this project were the National Alliance on Mental Health, Charlotte, NC division, Bonnie Cook MSN, CNML nurse manager for behavioral health services and Donna Sandifer MSN facility nurse educator.

Desired and Expected Outcomes

The desired outcomes for this project were to identify self-awareness and recognition of personal bias toward patients with mental health issues, decrease stigma associated with the care of the behavioral health patient, improve therapeutic communication, increase patient satisfaction, and diminish compassion fatigue among ED nurses. It was expected that patient satisfaction will increase showing an improvement in compassionate care and provide better patient outcomes.

Team Members

The team members for this educational project were emergency department nurse managers and educators, behavioral health nurse manager, director of nursing, Assistant Vice President for patient care services, and the project manager (you). Team members will be responsible for education of teammates and resources for information after the educational project has been initiated.

Cost and Benefit Analysis

The cost of this project was the hourly rate of pay for nurses during the initial viewing of the 47-minute video. The starting hourly rate for registered nurses with Atrium health is $27.00/hour. This rate was used to calculate and estimate the daily cost associated with the time associated with watching the video and completing the ProQOL survey. If a department has 30 nurses who watch the video, the total cost for the viewing the video with an estimated hourly rate of $27/hour, would be $810. The cost of the video is a one-time fee of $10 from the National Alliance on Mental Illness (NAMI). The NAMI offers all materials free to healthcare workers. There is no cost associated with using the ProQOL 5 survey as a measuring tool.

The benefits of the video would be to provide education that will result in a better understanding of self-views of patients with behavioral health issues as well as recognition and understanding of the patient's needs, decrease stigma associated with the behavioral health patient, and provide more compassion and understanding to this group of patients. Studies have shown that anti stigma training improved attitudes towards those with substance abuse disorders and improved clinical skills for those who work with those who have these disorders (Livingston et al., 2011, pg. 46). Knaak et al. (2017) states that for many healthcare providers, it is only through the experience of receiving anti-stigma training that they become aware of the subtle and unintended ways certain beliefs and behaviors may have been contributing to stigmatizing experiences among their patients (pg. 112). By decreasing stigma and improving attitudes associated with the behavioral health patient this author hopes to improve patient satisfaction.

CHAPTER IV

Project Design

The goal of this project was to decrease stigma associated with the behavioral health patient therefore improving patient outcomes and decrease compassion fatigue. By decreasing the stigma associated with the behavioral health patient this researcher hoped to improve communication and improve the relationship between the ED nurse and the behavioral health patient. Knaak et al. (2017) states that people with lived experience of a mental illness commonly report feeling devalued, dismissed, and dehumanized by many of the health professionals with whom they come into contact. (pg. 111). This project will help nurses identify and decrease behavioral health patient stigma so that those with mental illness feel less dehumanized and are provided compassionate care. A secondary outcome will be to improve patient satisfaction scores by providing patients with more compassionate care.

Objectives

The objectives of this project were as follows: (1) increase awareness of stigma towards behavioral health patients by educating nurses on the stigma associated with mental illness, (2) provide the ED nurse a better understanding of what the behavioral health patient is going through by educating them on what a person with mental illness is going through, (3) provide the ED nurse with the tools to develop therapeutic communication by educating on communication styles used by mental health professionals, and (4) to see an improvement on compassion fatigue stress and burnout on the ProQOL by providing resources to ED nurses that they can use when they feel stigma may get in the way of proving compassionate care. By giving the ED nurse these tools,

this researcher hopes the ED nurse will be able to provide more compassionate care to the behavioral health patient, yield better patient outcomes and improve the relationship between the ED nurse and the behavioral health patient. By the end of this project the ED nurse will have a better understanding of stigma, how to decrease the stigma, develop therapeutic communication and have a better understanding of what the behavioral health patient is going through. Increased knowledge provides awareness of issues and an opportunity to improve professional behaviors. ED nurses who have more knowledge about mental health issues and management strategies will have greater confidence in their abilities. This will lead to an increase in positive outcomes for the patient and the nurse.

Plan and Material Development

This project is an educational project with a pre and post electronic educational survey as well as a pre and post evaluation of patient satisfaction scores. The educational project consists of an anti-stigma video provided by the National Alliance on Mental Health (NAMI) in which the participants would be required to view as part of as part of educational requirements for the year. The video, "Competent caring: When mental illness becomes and traumatic event", is 47 minutes long and consists of scenarios performed ineffectively and effectively as well as discussions throughout the DVD. (NAMI, 2020) Before the participants view the video, the Professional Quality of Life Scale (ProQOL) will be administered electronically and anonymously. The ProQOL scale is a free tool that measures compassion satisfaction and compassion fatigue. According to Heritage et al. (2018) the ProQol is a measure intended to provide practitioners and researchers with an indication of a caring professional's compassion satisfaction, burnout,

and secondary traumatic stress. The validity of the instrument can be measured by the Rasch measurement and has theoretical validity-based advantages and practical advantages (Hertiage et al. 2018). The survey is in electronic format and is a self-reported tool. The participants will have 30 days to watch the video. At the end of the video participants will be asked to complete an attestation statement that they have viewed the video and understand the material. This video was created by a NAMI educator and is provided at a onetime charge of $10. The course objectives of the video are as follows: understanding of the realities of having a mental health condition, increased compassion for the vulnerabilities people face when seeking care, recognition of your critical role in the individual and family journey towards recovery, and empowered view of the lasting impact your care makes (NAMI, 2020). Six months after the participants have watched the video, they will be asked to take the electronic ProQOL survey again to see if the video changed their perception of compassion satisfaction and compassion burnout when caring for behavioral health patients.

The overall project should take 7 months to complete. The participants will be given 30 days to complete the initial ProQOL and to watch the video. Six months after the completion of the video the researcher will administer the ProQOL again to look for change and improvements on self-reported compassion fatigue and burnout. Next the researcher will evaluate patient satisfaction scores from the Press Ganey national patient satisfaction survey at the beginning of the project and 6 months post education to see if the scores increased in relation to the educational video and educational project. Patient satisfaction surveys will be kept anonymous and free from patient's personal information.

Budget

The overall cost of the project includes the time associated with watching the 47-minute video and the cost associated with the video itself, $10. The average starting wage for nurses at Atrium Health is $27.00/hour. If 30 nurses watch the 47-minute video an average cost of the viewing the video is $810. The total cost of the educational project is projected to be $820.

Evaluation Plan

The educational project aims to use de-identified surveys with the ProQol and de-identify all patient satisfaction survey scores. The ProQol will be administered electronically before the educational video, the participants will be asked to watch the educational video and patient satisfaction scores will be reviewed. Six months following the educational project initiation, the ProQOL will be administered again electronically and de-identified. Patient satisfaction scores will also be reviewed retrospectively for 30 days prior to and six months after implementation of the educational training intervention in order to evaluate for changes in satisfaction. Data will be analyzed and reported to the stakeholders and the emergency department administrative team.

CHAPTER V

Introduction

This project hopes to decrease the negative mental health stigma among nurses in the emergency department in order to provide better nurse and patient outcomes. All patients have the potential to be experiencing a mental health issue despite being treated for a non-mental health concern. According to the World Health Organization (2001) one in four people in the world will be affected by mental or neurological disorders at some point in their lives. Around 450 million people currently suffer from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide. (pg. 1) Despite the limitations to this project, this project manager aims to decrease stigma and improve therapeutic relationships so that all patients can have better patient outcomes.

Dissemination

This project will be presented to the emergency department managers and director for approval. The material will be presented in a virtual video to discuss the benefits of incorporating the training video into annual competency training for emergency department nurses. The managers and director will receive a written proposal of the budget, the objectives and benefits of the training video. An explanation of goals such as decreasing stigma and increasing patient satisfaction scores will also be included. The virtual video will include an explanation of how the survey will be presented electronically and de-identified as well as how this author will gather patient satisfaction scores pre and post education. The video will also explain the material in the video and the benefits to the department. Upon completion of the project, an additional presentation

will be offered for stakeholders, ED managers, and director. The final presentation will include data analysis to describe changes in compassion fatigue and patient satisfactions after the intervention is completed. Additional poster presentations at local or regional conferences may occur.

Limitations

This project faces several limitations. The COVID-19 pandemic diminished the ability to meet face to face. Participants would have greater benefit from an intervention that included face to face interactions and role play to identify potentially positive and negative interactions with patients. Participants would also benefit from in person discussion of personal feeling associated with mental health stigma. The online option using a video and virtual survey will limit the opportunity for participant feedback. The limited face to face interaction also limits the project manager's ability to make a case for the educational project. With a virtual presentation the author lacks the ability to interact with the stakeholders. The personal one on one interactions with stakeholders could be a key point in getting approval for the project because face to face meetings are more personal. The time constraints for this project is also a limiting factor. With the increase in mental illness due to the COVID-19 pandemic it is essential this education is presenting quickly. According to Czeilser et al. (2020), elevated levels of adverse mental health conditions, substance use, and suicidal ideation were reported by adults in the United States in June 2020. The prevalence of symptoms of anxiety disorder was approximately three times those reported in the second quarter of 2019 (25.5% versus 8.1%), and prevalence of depressive disorder was approximately four times that reported in the second quarter of 2019 (24.3% versus 6.5%) (*2*). (pg. 1053) It is important for

nurses to understand the mental health crisis during these times and to make changes for patient outcomes.

Impact for Nursing and Recommendations

This project has the potential to have a profound impact on nursing because it could improve knowledge, skills, and confidence of all nurses decreasing the amount of compassion fatigue in the profession and improving mental health patient outcomes. With the increase in mental illness and the current COVID-19 pandemic the need for nurses to understand and communicate effectively with those who have mental illness is essential. According to the Center for Disease Control (2020), fear and anxiety about a new disease and what could happen can be overwhelming and cause strong emotions in adults and children. Public health actions, such as social distancing, can make people feel isolated and lonely and can increase stress and anxiety (pg. 1). It is the authors belief this training should be implemented in all areas of nursing not just the emergency department because all patients have the potential to have an emotional reaction to their conditions and the pandemic such as anxiety, depression and stress. According the World Health Organization (2019) determinants of mental health and mental disorders include not only individual attributes such as the ability to manage one's thoughts, emotions, behaviors and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, standards of living, working conditions, and community support (pg. 1). This statement indicates all patients from all walks of life have the potential for having a mental illness. It is imperative that nurses understand the stigma and their personal feelings associated with mental illness so that all patients can benefit from better patient outcomes. It is this authors

recommendation that all nurses have access to the video provided by NAMI to educate on mental health stigma, proper ways to communicate with those experiencing a mental illness and to be able to understand the feelings of those who have a mental illness.

Conclusion

Mental illness is becoming more and more prevalent especially with the COVID-19 pandemic. It is important for the ED nurse, among other healthcare professionals, to recognize personal feelings about mental health stigma and to understand the potential for non-mental health patients to have a mental illness. It is also important for ED nurses to understand the power of the therapeutic relationship between nurse and patient in terms of patient satisfaction and nursing job satisfaction. Nurses who learn to work with mental health patient's more effectively may experience less violent episodes with a patient.

Despite the limitations due to COVID-19, this author feels this project is important and timely. It is important for nurses to identify and move past the stigma to provide better patient outcomes. Implementing this training in all areas of nursing has the potential to increase patient satisfaction and provide better patient care.

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Appendix A

Patient Satisfaction Survey

Atrium Health

EMERGENCY DEPARTMENT SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND QUESTIONS

1. Time of day you arrived: (**select one response only**)
   - ○ 7:01 am - 11:00 am
   - ○ 11:01 am - 3:00 pm
   - ○ 3:01 pm - 7:00 pm
   - ○ 7:01 pm - 11:00 pm
   - ○ 11:01 pm - 3:00 am
   - ○ 3:01 am - 7:00 am

2. Time spent in the Emergency Department:
   ☐☐ hours ☐☐ minutes

3. Who is filling out this survey?
   - ○ Patient
   - ○ Parent
   - ○ Family
   - ○ Friend
   - ○ Other _____ (specify)

4. Did a Department Representative check on your comfort, safety, and satisfaction during your visit to this facility? ..... ○ Yes ○ No

INSTRUCTIONS: Please rate the *Emergency Department services* you received *from our facility*. Select the response that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely. Example: ●

ARRIVAL	very poor 1	poor 2	fair 3	good 4	very good 5
1. Comfort of the waiting area	○	○	○	○	○
2. Waiting time before you were brought to the treatment area	○	○	○	○	○

Comments (describe good or bad experience):_____

NURSES	very poor 1	poor 2	fair 3	good 4	very good 5
1. Courtesy of the nurses	○	○	○	○	○
2. How well the nurses took the time to listen to you	○	○	○	○	○
3. Nurses' attention to your needs	○	○	○	○	○
4. Nurses' responses to your questions/concerns	○	○	○	○	○

this section continued on next page...

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NURSES (...continued)	very poor 1	poor 2	fair 3	good 4	very good 5
5. Nurses' concern for your privacy	○	○	○	○	○

Comments (describe good or bad experience):_____

DOCTORS	very poor 1	poor 2	fair 3	good 4	very good 5
1. Courtesy of the doctors	○	○	○	○	○
2. How well the doctors took the time to listen to you	○	○	○	○	○
3. How well the doctors included you in decisions about your treatment	○	○	○	○	○
4. Doctors' concern to keep you informed about your treatment	○	○	○	○	○
5. Doctors' concern for your comfort while treating you	○	○	○	○	○

Comments (describe good or bad experience):_____

OVERALL ASSESSMENT	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well the staff cared about you as a person	○	○	○	○	○
2. How well the staff worked together to care for you	○	○	○	○	○
3. Overall rating of care received during your visit	○	○	○	○	○
4. Likelihood of your recommending our Emergency Department to others	○	○	○	○	○
5. Safety and security felt in the Emergency Room/Department	○	○	○	○	○
6. Degree to which staff respected your family's cultural, racial/ethnic, or religious/ spiritual needs	○	○	○	○	○
7. Degree to which the staff members talked with you using words and terms you could understand	○	○	○	○	○
8. Overall cleanliness of ER/ED	○	○	○	○	○

Comments (describe good or bad experience):_____

Patient's Name: (optional)_____

Telephone Number: (optional)_____

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Appendix B

ProQOL Survey

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____

Total: ____

The sum of my Compassion Satisfaction questions is	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____

Total: ____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____

Total: ____

The sum of my Secondary Trauma questions is	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High