Nurses As Psychiatric Consultants in a General Hospital Emergency Room

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ABSTRACT: Psychiatric nurses' experience in milieu therapy, home treatment, community aftercare, and psychotherapy can be the basis for new roles in mental health. This study used psychiatric nurses as consultants to general physicians in a general hospital emergency room. Psychiatric nurses successfully managed 66% of the psychiatric referrals in the emergency room and required only telephone consultation in a majority of the remaining cases to develop and implement a satisfactory treatment plan. The resistance to using nurses in this new role seems a result of anxiety generated in the emergency room staff and physicians. Sensitivity to these discomforts reduces “undermining” behavior and provides the opportunity for new roles to develop, be defined, and be accepted.

The expansion of the nurses' role is an area of interest for nurses and other professionals. Nurses have become more active in hospital therapeutic community settings (Jones, 1968), have taken primary patient care responsibilities in community aftercare (Coleman, 1967), have become key professionals in home treatment programs (Pasamanick, 1967; Greenblatt, 1963), and have become individual and group psychotherapists (Armstrong & Rouslin, 1963). In addition they have maintained their professional roles in hospital and community settings.

During the past year a program to utilize the skills of psychiatric nurses for consultation in the emergency room of a university affiliated general hospital was developed and implemented. Nursing personnel in the department of psychiatry were interested in developing a program that would use psychiatric nurses to evaluate and assess patients who came to a general hospital emergency room and were judged in need of psychiatric consultation. This was undertaken to expand the nurse's role within the psychiatric team concept.

A survey of the literature indicates that consultative roles for psychiatric nurses in emergency rooms of general hospitals have not been developed. This paper discusses first the assessments and decisions made by psychiatric nurses by comparing these decisions to ones made during the same time period by psychiatric resident physicians and psychiatrists. It then addresses some of the problems encountered in developing and implementing the program.

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PATIENT CARE

The setting for the project was the emergency room of a 100-bed university general hospital serving a black and Puerto Rican urban underprivileged population in a northeastern metropolitan area. The program did not go beyond a planning and proposal conceptualization for approximately 2 years because of the reluctance of medical faculty to transfer psychiatric emergency room consultation responsibilities to the psychiatric nurse. The change was precipitated by an acute shortage of psychiatric residents and psychiatrists to provide consultation in the emergency room. Illness, vacations, and attendance of a large number of faculty at a professional meeting provided a crisis in which the nursing section of the department of psychiatry saw the opportunity to volunteer their services. Their objective was to involve nurses more directly and centrally in the initial assessment of candidates for emergency psychiatric services. The program innovation which was proposed and accepted was that psychiatric nurses, who had adequate psychiatric experience and expertise, would function as consultants to the emergency room during the daytime hours.

Patients were initially assessed by the nonpsychiatric physician staffing the emergency room. He made the determination whether a psychiatric consultation was indicated. The two psychiatric nurses who provided consultation were also team leaders on an inpatient unit. They offered consultation to the emergency room weekdays from 8:00 A.M. to 4:30 P.M. The psychiatric consultations for the remaining hours of the day and night were covered by psychiatrists who were residents in training, and on occasion by psychiatrists who were members of the university faculty.

METHOD

The mechanics of the program were that when the emergency room called to request a psychiatric consultation, one of the nurses would respond. She would interview the patient, any family, and the physician who requested the consultation; and where necessary she would obtain a psychiatric consultation from a psychiatric nurse clinician or psychiatrist. A psychiatric nurse clinician and a psychiatrist were available to discuss the case over the phone or, on request, to see the patient. She would then formulate her findings and offer them to the referring physician. The physician who had requested the consultation had the prerogative of accepting or rejecting the nurse's evaluation. For this reason the nurses presented their findings and conclusions to the physicians in the emergency room as recommendations for which the general physician had to provide approval before any action was undertaken. These recommendations were usually accepted. After the recommendations were approved, the psychiatric nurses assumed the major responsibility for implementing the decision—for example, arrangements for an outpatient referral and appointment, day-care referral, admission to the psychiatric unit and so forth.

Subjects

The sample, which consisted of 199 patients who came to the emergency room during a 5-month period of time, was divided into two groups—psychiatric nurse (PN) and nonpsychiatric nurse (NPN). The patients in both groups lived in close proximity to the facility. Eighty-four percent of the PN and 77% of the NPN populations lived in the city of Hartford, in which the hospital was located. The average age for the PN group was 35.5 and in the NPN group 33.3. The sex distribution of patients in both groups were similar—47 men and 53 women for the PN group, and 43 men and 56 females for the NPN group. The two groups were also very similar on marital status. Schizophrenia was the primary diagnosis for 36% of the PN sample and 27% of the NPN sample.