Meeting the Needs of the Behavioral Health Patient in the Acute Care Setting

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Some of the most difficult diseases to understand and treat are mental illnesses or behavioral health (BH) issues. Recent cutbacks in mental health care have left many undiagnosed and undertreated. Mental illness can include disorders that affect mood, thinking, and behavior. Examples of mental illness include depression, anxiety, bipolar disorders, schizophrenia, and addictive behaviors. The range and types of signs and symptoms can vary greatly. When patients with signs and symptoms are admitted to the hospital setting, they may be admitted to a special behavioral health unit, or if they also have a medical problem, they can be admitted to a medical surgical unit. Approximately 69% of adults with behavioral health conditions also have a medical condition, and 29% of adults with a medical condition also have behavioral health concern.

Prevalence of Mental Illness in the US

In 2012, there was an estimated 9.6 million adults age 18 or older with a serious mental illness in the US. This represents 4.1% of all US adults. Also in 2012, there were estimated 43.7 million adults ages 18 or older in the U.S. with some degree or form of mental illness. This represents 18.6% of all US adults. These figures do not include those persons diagnosed with drug or alcohol addiction.

Mental disorders are also common among children in the US. The difficulty lies with those children experiencing a seriously debilitating mental illness. According to the National Institutes of Health, just over 20% of children at some point during their lives will have had a seriously debilitating mental disorder.

The Agency for Healthcare Research and Quality (AHRQ) tracks the costs associated with behavioral health and the costs are tallied from the Medical Expenditure Panel Survey (MEPS). This survey and its database provide information on the total expenditures for mental health services, the number of Americans who have paid for mental health services, and the average cost for each person who received mental health services.

Among all Americans, 36.2 million people paid for mental health services totaling $57.5 billion in 2006. These are the most current figures available. This means the average expenditure per person was $1,591 for the year 2006.

Within this group, 4.6 million children received mental health services totaling $8.9 billion. The average expenditure per child was higher than that for the average adult at $1,931. While it is difficult to put these costs into perspective, mental health continues to be costly in the US. In 2006, more people paid expenses for care related to mental disorders than any other medical condition except for asthma.

Persons with mental health disorders are admitted and treated in a variety of settings. This includes acute care general hospitals, freestanding psychiatric hospitals, long-term and acute care and skilled nursing facilities.
pneumonia (VAP) or to avoid respiratory complications resulting from having the bed flat while a patient receives tube feeding.

The behavioral health unit typically does not have a fully electrical medical bed. It is feared that a traditional bed would have too many removable parts and too many ligature points. Currently there are medical beds designed for this environment. The headboard and footboards are bolted onto the frame, the cords are removable, and the bed can be mounted to the floor. These features reduce injury to patients and staff (See Wagner interview, insert).

There are several populations that may benefit from this type of specialty bed. This includes those persons with delirium, dementia, Parkinson’s or Alzheimer’s, and those with substance abuse withdrawal. These populations may benefit from specialty beds that have built-in safety features. Features may include removable electric cords to prevent strangulation, permanent headboards and footboards, and less ligature points. In addition, the newest low beds on the market can be lowered to their lowest position and locked. Being able to lock out the controls prevents patients from raising the bed; this design feature is imperative for those persons at risk for a fall. While not all falls can be prevented, lowering the bed reduces the severity of the injury when a fall does occur.

This type of specialty bed can be one part of a comprehensive program to prevent falls with injury. As previously mentioned, other medical conditions that aren’t behavioral health concerns also benefit from a fully electrical medical bed. These include patients with Alzheimer’s and Parkinson’s who are admitted to the geriatric unit or memory unit. These patients may have problems with standing or walking, or impaired balance and coordination. It is these older patients or those with respiratory issues who may have difficulty breathing on a flat bed. These patients benefit from having their head elevated as needed.

Delirium

Patients with delirium may be at harm to themselves or others. Delirium is a serious disturbance in a person’s mental abilities that results in a decreased awareness of one’s environment and confused thinking. The onset of delirium is usually sudden, often within hours or a few days. This may occur after being admitted to the hospital. Factors for risk can include chronic illness, various medications such as anesthesia, infection surgery, or drug or alcohol abuse or withdrawal.

Sometimes patients who use alcohol and drugs are admitted to the hospital. The hospital may not receive this important information. These patients will withdraw from the alcohol or drugs and may react violently during the withdrawal process. They may also experience delirium. Symptoms may include but are not limited to hallucinations, restlessness, agitation, irritability or combative behavior, disturbed sleep habits, and extreme emotions such as fear, anxiety, anger or depression.

These patients may be admitted to a specialty unit to undergo withdrawal care. It is at this time that they may benefit from having a bed that does not have any removable parts. It is also critically important to remove all electrical cords that may be used to harm themselves or others.

Restraints: A Refresher

Restraints in a medical setting are items that limit a patient’s movement. Restraints can help keep a person from getting hurt or doing harm to others, including their caregivers.

Restraints may be used to keep a person in proper position and prevent movement or falling during surgery or while on a stretcher. Restraints can also be used to control or prevent harmful behavior. They are used as a last resort. There are many types of restraints.

Types of restraints can include:

- Belts, vests, jackets, and mitts for the patient’s hands
- Devices that prevent people from being able to move their elbows, knees, wrists, and ankles

Other ways to restrain a patient include:

- A caregiver holding a patient in a way that restricts the person’s movement
- Patients being given medicines against their will to restrict their movement
- Placing a patient in a room alone, from which the person is not free to leave

Sometimes hospital patients who are confused need restraints so that they do not:

- Scratch their skin
- Remove catheters and tubes that give them medicine and fluids
- Get out of bed, fall, and hurt themselves
- Harm other people
The Origin of the Behavioral Health Bed
with John Wagner

John Wagner, RN, MA, BC, is the Director of Clinical Services for Behavioral Health, Department of Nursing, University of Iowa Hospitals and Clinics in Iowa City, Iowa.

XW: How long has your facility been using the new behavioral health bed?

JW: I took over in 2010 and the unit had 88 beds. Most of these beds were 26 years old; they were hand-cranked and could be raised and lowered by patients, so given the risks associated with the behavioral health (BH) patient, these beds were very unsafe for this population. However, regardless of lack of safety, there were no real options for a long time for the BH patient population. In 2010, we began to meet with Sizewise Corporation to discuss working together on a bed made specifically for the BH patient. We partnered, and following that meeting, for 11 months we tested an existing ICU bed and then, with Sizewise, went through various beta versions until we had a bed that worked for this population.

XW: What were the components of the beta versions that helped eventually shape the behavioral health bed design?

JW: We looked at all components that would affect the ability to give patients functionality without increasing risk. So we studied things like wire storage—enclosing them versus tying them down, and we didn’t want them to hang because then the patient could use that for electrocution. We looked at lockout options such as key codes. Codes were the way many other companies were locking patients out of bed adjustment, but this was ineffective as patients would inevitably find out the code and share it with other patients. We looked at bed height, bed frame design, and other design aspects of the bed in terms of safety, and vulnerability to self-harm behavior. We also looked at design as it pertains to biohazards and cleaning, hygiene and sanitation. We looked at whether the bed was designed, as many are today, with the overall care of the patient in mind—we wanted the bed to meet the comorbid medical conditions and illnesses of the BH patient, including asthma, COPD, and GERD. The bed also needed a Trendelenburg position component, to treat specific conditions that are particular to an aging population. For example, a patient with COPD would be on a flat bed and we would have to put blocks underneath to raise the head, but blocks can be used as a weapon. Partnering with the manufacturer enabled the design engineers to draw upon our knowledge and experience working with BH patients for 30 years, and it gave us the ability to identify what we believe is needed in a BH bed.

XW: How many patients have been placed on the product? How long has it been in use?

JW: We have 58 of these beds on our adult unit. Our units are usually at capacity, so these beds are in use all of the time. We have had the beds for almost four years.

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**XW: How has this product changed how you give care? What are the benefits to using a fully electrical bed in this care setting?**

JW: The fact that we now have a bed that is designed for the BH patient that also encompasses the design aspects that most medical beds now include means we have marked improvement in the overall patient care experience. Patients can use a bed that is safe, with minimal ligature points. The bed can be lowered to the floor and locked in place. The electrical cords can be completely removed on some models and the bed can be safely locked out to patient access. The mattress is completely sealed so patients cannot reach the foam. For the elderly or those with breathing problems, the head of the bed can be raised to facilitate lung expansion. Staff can raise the bed to provide care, preventing back strain.

**XW: Any changes or upgrades since the initial prototype?**

JW: The bed went through several changes as the staff tested it. The bed now includes:

- an optional scale to weigh the patient
- an optional bed alarm
- one central, universal lockout
- a removable short electrical cord
- filled in molded side rails
- a bolted headboard
- tied down and secure wiring location
- minimal ligature points.

**XW: Can we expect a follow-up to your original article?**

JW: Yes, we are now working on a five-hospital study and are in the process of collecting data, which has shown great results thus far.

**XW: Can you see any other areas of care using this product?**

JW: Yes. This bed would benefit any patient who could hurt him or herself on a bed either by intent or confusion; this can extend to dementia units, psychiatric units, units that care for patients who have overdosed, and VA hospitals, etc. Every ICU should have one. For those patients who are suicidal even though the ICU is high visibility, there’s no active way of preventing suicide and this bed greatly cuts down on that risk.

**XW: What would you tell other facilities considering the use of the BH bed?**

JW: It greatly improves patient care on several levels, cuts down on the risks associated with care of the BH patient, enables staff to better care for their patients by meeting the basic medical needs of a growing population, and provides the patient with functionality without sacrificing safety.
Fall Prevention

A few words about falls. There are many risk factors associated with falls. See Xtrawise (14.1).

There are many groups of people at risk for falling, including the elderly, those with gait problems, and those with low blood pressure, impaired cognition, poor judgment, impulsiveness, and impaired vision.

The hospital can be an unfamiliar environment, and getting in and out of bed becomes a challenge, especially at night.

How Are BH Patients’ Needs Met in the Hospital Setting?

The focus of this article is the care of behavioral health patients in acute and long-term acute care settings. See the previous article on this topic (Xtrawise 14.1).7 There are many patients who have a behavioral health problem as well as a medical problem. Patients with these two types of diagnoses are often left to fall through the cracks of the health care system. If a patient is admitted to a medical surgical unit, his or her behavioral health condition often goes overlooked and untreated, and the necessary medications are not ordered in a timely manner. This leads to further stress and anxiety for the patient as well as the staff. Poor communication and inadequate training means neither the medical-surgical unit nor the behavioral health unit is equipped to deal with conditions with which they may be unfamiliar. For example, those admitted to the behavioral health unit may find that their comorbid medical conditions may not be fully understood by the nursing staff.

It is the complex patient who requires mental health services and medical care that is vulnerable. Traditionally, the mental health unit or behavioral health unit may not be able to manage the patient’s mental health needs as well as the medical component of their care. The problem with the traditional medical model is the separation of the mind and body, treating each as if it is a separate unit. What can be a challenge for nurses is the ability to properly care for a person with acute medical needs in the behavioral health unit and vice versa. (Please see Xtrawise 14.1 for more on this topic.) So while increasingly there is an expectation that all of the patients’ needs should be met, when there is not appropriate communication and staff integration between units, neither unit staff is equipped or trained to manage both sets of needs.8 The medical unit does not have the trained professionals to deal with the complex mental health patient. The result can be a lack of skilled care for the behavioral health needs of the patient. For example, patients with suicidal tendencies may be overmedicated to keep them safe.

Many of these patients require specialized care and equipment while in the acute care and long-term acute care setting. This may include private rooms, memory units, or hospital beds designed to promote safety of both the patients and staff.

One of the ways to do this is to ensure access to a safe environment.

What Does “Safe Environment” Mean?

A safe environment is an environment in which the patient can expect the least amount of complications. This includes the avoidance of “never events” or medical injuries that are sustained while in the hospital. Providing the necessary equipment to keep the mental health patient and the staff safe is a major step in ensuring access to a safe environment and reducing or avoiding never events.

A safe environment in the behavioral health unit involves certain equipment design features that promote safety.9 This includes, for example, furniture that cannot be moved, covered wall outlets, and screening for dangerous objects. Another example of such equipment is a fully electrical medical bed.

Never events include things like pressure ulcers, falls, and infections. It may be necessary to raise the head of the hospital bed to prevent ventilator-acquired
Dementia

While dementia is not a specific disease, it is an overall term that describes a wide range of symptoms associated with a decline in memory and/or other mental skills. This diminished mental capacity is severe enough to reduce a person's ability to perform his or her everyday activities. Alzheimer's accounts for 60 to 80 percent of cases of dementia. Closely related is vascular dementia, which occurs after a stroke.

These conditions place patients at risk for confusion, and according to John Wagner (see insert), having a fully electrical medical bed in the memory unit may promote increased safety and ease of care that not only is beneficial for the patient, but also for the caregiver. Having a hospital bed with a low feature can also be helpful with patients who have difficulty getting out of bed.

While Alzheimer's disease is a form of dementia, certain behaviors in this population may lead patients to be admitted to a geriatric or memory unit. At the same time, the medical or surgical unit will often see those patients who undergo a surgical procedure or have a medical problem be treated. These patients may be stable at home, but when admitted to a different environment, they experience an exacerbation of their symptoms. All precautions need to be taken to prevent falls and keep patients safe. Specialty equipment such as electrical medical beds may be helpful to meet the goals of care.

Conclusion

Patients who are admitted to the hospital need complex care. This includes care of those with medical conditions as well as behavioral concerns. These patients present not only with multiple medical comorbidities, but with mental health concerns as well that have their own critical care needs associated with them. The prepared unit understands the needs of the complex patient and adapts accordingly. This includes having the correct equipment available to meet mental health patient care needs as well as general medical needs.

About The Author

Erica Thibault is a Clinical Manager at Sizewise, and is a registered nurse, a Certified Wound Ostomy Nurse (CWON) and a Nursing Research PhD candidate specializing in pressure ulcer prevention. She is a member of the Wound, Ostomy and Continence Nurses Society, the World Council of Enterostomal Therapists and the Sigma Tau International Honor Society for Nurses. Erica has published a number of articles, posters and presentations. Currently she focuses on the design and development of clinical research and programs that will advance the knowledge and meet the needs of the facilities, care providers and patients Sizewise serves.

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