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Nurses' conceptions regarding to the use of psychiatric emergency protocols in mobile pre-hospital care

Concepções dos enfermeiros frente à utilização de protocolos de urgência psiquiátrica no atendimento pré-hospitalar móvel

Concepciones de las enfermeras sobre el uso de protocolos de emergencia psiquiátrica en la atención prehospitalaria móvil

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ABSTRACT
Objective: to ascertain nurses' conceptions regarding the use of psychiatric emergency protocols in mobile pre-hospital care. **Methods:** in this qualitative, descriptive exploratory study of nurses in a Mobile Emergency Care Service, data were collected through semi-structured interviews and submitted to content analysis. **Results:** two categories were listed: Psychiatric emergency care protocols and their use in the pre-hospital care service; and Factors that influence emergency care and psychiatric emergency. The protocols are at odds with the tenets of psychiatric reform and frame its applicability as a factor that interferes with management of persons in crisis, thus serving to perpetuate the ideological social action of physical restraint. **Final considerations:** the study showed the context of nurses' practice in psychiatric emergencies and showed that nurses of the Mobile Emergency Care Service are not properly equipped to work in psychiatric emergencies.
Descriptors: Emergency Nursing; Psychiatric Nursing; Emergencies; Crisis Intervention; Protocols.

RESUMO
Objetivo: conhecer as concepções do enfermeiro frente à utilização de protocolos de urgência psiquiátrica no atendimento pré-hospitalar móvel. **Métodos:** estudo qualitativo, descritivo exploratório, com enfermeiros do Serviço de Atendimento Móvel de Urgência. Os dados foram coletados por meio de entrevista semiestruturada e submetidos à análise de conteúdo. **Resultados:** foram elencadas duas categorias: Protocolos de atendimento de urgência psiquiátrica e seu emprego no serviço de atendimento pré-hospitalar; e Fatores que influenciam o atendimento de urgência e emergência psiquiátrica. Os protocolos se direcionam contra os preceitos da reforma psiquiátrica e colocam sua aplicabilidade como fator de interferência no manejo da pessoa em crise, dando continuidade à ação ideológica social da contenção física. **Considerações finais:** o estudo mostrou o contexto da prática dos enfermeiros nas urgências psiquiátricas e evidenciou que os enfermeiros do Serviço de Atendimento Móvel de Urgência não estão devidamente instrumentalizados para atuarem nas urgências/emergências psiquiátricas.
Descritores: Enfermagem em Emergência; Enfermagem Psiquiátrica; Intervenção na Crise; Emergência; Protocolos.

RESUMEN
Objetivo: conocer las concepciones de las enfermeras sobre el uso de protocolos de emergencia psiquiátrica en la atención prehospitalaria móvil. **Métodos:** en este estudio cualitativo, descriptivo, exploratorio de enfermeras en un Servicio Móvil de Atención de Emergencias, los datos fueron recolectados a través de entrevistas semiestructuradas y sometidos a análisis de contenido. **Resultados:** se enumeraron dos categorías: protocolos de atención de urgencias psiquiátricas y su uso en el servicio de atención prehospitalaria; y Factores que influyen en la atención de emergencia y la emergencia psiquiátrica. Los protocolos están en desacuerdo con los principios de la reforma psiquiátrica y enmarcan su aplicabilidad como un factor que interfiere con el manejo de las personas en crisis, sirviendo así para perpetuar la acción social ideológica de la restricción física. **Considerciones finales:** el estudio mostró el contexto de la práctica de las enfermeras en emergencias psiquiátricas y mostró que las enfermeras del Servicio Móvil de Atención de Emergencias no están debidamente equipadas para trabajar en emergencias psiquiátricas.
Descriptores: Enfermería de Urgencia; Enfermería Psiquiátrica; Intervención en la Crisis (Psiquiatría); Urgencias Médicas; Protocolos.

INTRODUCTION

The need to care for a victim refers to the urgency and emergency service, which requires swiftness and a qualified staff. In this context, prehospital care (PHC) corresponds to any and all actions directly or indirectly taken outside the hospital environment, using available means and methods, which can vary from medical orientation to sending a vehicle to the occurrence site, aiming at maintaining life and minimizing complications[1,2].

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Assistance to psychiatric urgencies has been the technical competence of urgent services since 2003, and the Mobile Emergency Care Service (SAMU) is responsible for providing psychiatric care and articulating the flow of mental health care, referring it to the most appropriate service[3]. During care provision, SAMU professionals must base their conduct on protocols that define the team's skills in four items: recognizing the severity signs of psychiatric pathologies in an urgent situation at the scene of the occurrence; describing the signs observed in patients to the regulating physician; recognizing the need to engage other actors in the care for psychiatric urgencies when it involves the PHC team's safety, and adopting measures for managing aggressive, psychotic and suicidal patients[4].

SAMU serves more than 150 million Brazilians through its Regulation Centers, which are spread across the national territory, and it annually performs more than 13 million urgent and emergency calls[1]. That is the reason why it is important to understand the time-dependence relationship of a PHC service from the team's view, as it is trained to deal with incidents in which the time to arrive at the urgency site is a primary factor for maintaining life. In psychiatric urgencies, this relationship is different, since it allows the team to call for other support teams, as determined by Ordinance 2048/2002[4,5].

The legislation identifies an acute mental health crisis as a psychiatric urgency, under the responsibility of SAMU, the psychosocial care network, the police and fire departments[4].

Thus, in a psychiatric urgency, it is necessary to see the person in crisis from the context in which he/she is. A crisis is considered to be the moment when an individual manifests his/her extreme anguish and suffering, which may lead to loss of contact with the external reality, turning to his/her internal reality, with shifts in thinking, sensoperception, orientation, memory, mood , among others. Among the changes in thinking, delusions are common and, in sensoperception, hallucinations. Such manifestation is considered as a psychotic outbreak, a concept used to characterize the psychiatric urgencies described in Ordinance 2048/2002, which can be found in psychopathologies, such as depression, suicide attempts, schizophrenia, use and abuse of psychoactive substances, organic brain syndromes, among others[2,6].

As members of the mobile emergency care team, nurses can be included in the different moments of care provision, ensuring that it is based on a qualified technical view, scientific knowledge and efficiency. Due to the plurality of urgent situations, dimensioned by protocols with numerous variables, it is up to nurses to make a difference, based on their experience which, in association with scientific knowledge, will produce expertise that can qualify nursing work[7].

Thus, in addition to knowing the protocols for urgent and emergency psychiatric care, nurses' performance in the mobile PHC requires skills, such as clinical reasoning for decision making, physical and psychic ability to deal with stressful situations, ability to work as a team and ability to perform interventions promptly[8].

Therefore, the objective was to learn about nurses' conceptions regarding the use of protocols in psychiatric urgencies in the mobile prehospital environment.

METHOD

Qualitative, descriptive and exploratory study, conducted at a SAMU base in the municipality of Rio Grande, Rio Grande do Sul, Brazil.

The service was founded in 2009, based on the guidelines provided by Ordinance 2048/20024, and it has nine nurses who work in a Basic Support Unit (BSU) and in an Advanced Support Unit (ASU). Before the interview, the professionals were instructed on the purpose of the study and signed an Informed Consent Form (ICF).

Data were collected from September to October 2016 by a semi-structured interview individually conducted by the researchers at the SAMU base, in a previously booked room. The interviews contained open questions that contemplated the objective of the study and were recorded for later transcription.

The data were analyzed by Thematic Content Analysis[9], which consists of a set of communication analysis techniques, where the researcher builds knowledge from the participants' discourse, aiming, in addition to obtaining the meanings of the discourses, to apprehend the message that is implicit[9]. For data analysis, the transcripts were carefully read, returning to the study objective. The material was explored and, subsequently, the categories were established, grouping the material by similarities, listing the relevant, significant and specific aspects, according to the theme. Finally, the data were analyzed based on the literature.

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The study was submitted to the institution's Ethics Committee for Health Research and approved according to Report no. 150/2015, dated 10/02/2015. In order to ensure the participants' anonymity, the statements were identified with the letter "N" (Nurse), followed by the interview number.

RESULTS

All the nine nurses on the team participated in the study, two of whom were males and seven females. They had graduated between 1999 and 2009 and were from 31 to 51 years old. All of them had been working at the PHC service for more than three years, and five professionals had previously worked in in-hospital psychiatric care.

From the data analysis, two categories emerged: *Urgent psychiatric care protocols and their use in the prehospital care service* and *Factors that influence urgent and emergency psychiatric care*, which are described below.

Urgent psychiatric care protocols and their use in the prehospital care service

Considering that the prehospital service operates based on protocols and that those related to care provision for a psychiatric crisis are not in line with the new mental health care policies, nurses' performance is conditioned to observing the situation involving the person in crisis, as well as the protocols used in daily practice, prioritizing physical signs and symptoms, as observed in the statements below:

> *Procedures vary according to the type of urgency the patient is in, ranging from verbal management to mechanical or chemical restraint (N8).*
>
> *The procedures performed are verbal management, checking vital signs, medication administration, when possible and when indicated by the regulating physician. Most of the times, the patient is taken to the referral institution, which is the psychiatric hospital (N4).*
>
> *Generally, verbal management; drug interventions and mechanical restraint are not often used. The patient is always very nervous, which does not mean that he will be aggressive and/or agitated towards the team, but you never know, do you? (N3).*

It is also evident that some cases require more time for care provision, as verbal management requires availability, especially when there is resistance from the patient and/or his/her family:

> *Our procedure regarding care provision will largely depend on the symptoms shown. In many cases, the patient has disorders arising mainly from the use and abuse of substances and, then, he is more reticent to verbal management (N1).*

When providing care, most of the times the team considers that the patient will assault them and, therefore, they understand that there is a need to follow other protocols, such as physical restraint.

> *Verbal management is performed. If the team, together with the physician, either the regulator or the assistant, deem physical and/or mechanical restraint pertinent, that procedure is performed (N2).*
>
> *Calls are screened by medical regulation, and when there is a need or risk of violence against the team, support from the Military Brigade is immediately requested (N6).*
>
> *I try verbal management, and when I am unsuccessful, I contact medical regulation. Then, some of them recommend that we use medication and mechanical restraint (N6).*
>
> *When verbal management is unsuccessful, we have the support from the Military Brigade, and physical restraint is used if the patient poses risk for himself or others. (N7).*

The statements confirm that the protocols for psychiatric emergency care need to be revised, in accordance with Law no. 10.216, dated April 6, 2001, regarding the Psychiatric Reform, which implements new care provision forms for people with mental disorders, moving from the biomedical model to the psychosocial model, including embracement and therapeutic communication as essential to gain the patient's confidence and reduce his/her anxiety.

Factors that influence urgent and emergency psychiatric care

According to the nurses' perception, there are differences between the calls for psychiatric emergency care:

> *What usually gets our attention is the reason for service requests, which are more often due to family member's anxiety than specifically to the patient's psychic condition, it is obvious that each situation gives us with a different perception, a different approach; it depends on the case (N1).*
>
> *I realize that the situations that we attend to are different, I mean they are peculiar and generate feelings of doubt about how to approach the victim in a way that we can control him, the patient, the person who*

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> *requested the service, so that everything can occur calmly until they become unafraid or less anguish is generated. We have to behave as the scene presents itself (N4).*

Likewise, it is noted that the feelings that the request causes in nurses differ, according to each case:

> *When we receive a call due to a psychotic break, we always feel a little insecure (N5).*
>
> *When we are called we always consider the worst hypothesis: aggressiveness and risk of violence. I am apprehensive about the occurrence and how to proceed, I try to remain calm, get information from family members and people in the community to really know what has happened, to know about the patient's history, use of medication and about the reason for the crisis (N6).*

Regarding qualification for care provision, professionals feel unprepared and insecure:

> *I don't feel prepared for psychiatric urgencies, as each case is different and the situation is always unexpected (N6).*
>
> *I often feel helpless and unprepared in the face of such an event. When the service is requested, society or the patient's family want results in removing the individual, either by consensus or through physical measures, thus violating essential freedom rights (N2).*

Multidisciplinary action is understood to be essential in order to provide adequate care to the patient and his/her family's needs. For nurses, the person in crisis always poses a risk to the team and, therefore, mechanical or chemical restraint is necessary, as it is the recommendation given by central regulation, according to the information provided by the person making the request, who states that there is imminent aggressiveness. Often, due to distorted perceptions, expressed through inadequate communication, the crisis is considered something serious, which requires support from other professionals, even before verifying the real situation:

> *Most cases have a lot to do with the family's anxiety, not always associated with the patient's desire for hospitalization or care. (...) The family usually requests assistance in situations in which the patient does not show psychiatric symptoms that would indicate hospitalization (N1).*
>
> *As instructed by the medical regulation center, the team often only travels for assistance with the support of a Military Brigade vehicle, as it understands that there is a risk for the team (N2).*
>
> *Yes, the team only moves with support from the Military Brigade in order to prevent aggression, mainly because I work the night shift (N5).*
>
> *In these situations, the health care team works in partnership with a security team, that is, the Military Brigade (N9).*

The first contact by the prehospital team with the people involved in the psychiatric crisis is important and decisive if it is supported by the analysis of the situation, after a verbal approach focused on the team and other people' safety. Even without specific training or qualification in mental health, nurses must have the ability to perform verbal management of the patient, seeking to have his/her confidence, calm him/her down and offer security, in the sense that everyone is willing to help him/her to improve so that he/she can be well. If possible, the nurse should also request his/her collaboration in decision-making and avoid physical restraint, which, if necessary, should be done without violence.

> *Yes, some patients become very aggressive and, several times, try to attack the professionals. I've been beaten without gravity, with kicks and hair pulling (N8).*
>
> *The team needs to wait for the direct intervention by the Military Brigade to contain or intimidate the patient, that's the only way to manage him (N3).*

The form of intervention performed by nurses shows that they are usually unable to assess the complexity of the patient's psychopathology and, therefore, they make decisions based on the requester's report, without considering the flexibility that the protocols should have by taking into account the particularity of each situation. Therefore, there is the need to always count on police intervention, as the police provide security to nurses. The lack of skill in psychiatric emergencies usually leads to this type of intervention, when the professional should prioritize the understanding of the patient's behavior and appropriate management so that he/she accepts the actions that need to be taken, without fear or violence.

> *What PHC professionals lack is theoretical accumulation, which is routinely discussed by fellow mental health professionals. However, it seems to me that mental health care colleagues lack the experience lived by the PHC teams, with regard to the dynamics and reality of the management of patients in crisis. As long as we continue to work in a segregated way, as regards the discussion, conceptions, procedures and actions, system users will continue to suffer, as these are services on the same care provision network that work in a different and independent way; nevertheless, they act on the same individual (N2).*

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DISCUSSION

The national intervention protocols for SAMU were designed from the analysis of national and international application experiences aimed at effectively promoting the reduction of probable traumatic situations to the victim at the site of occurrence of the factor originating the call. These protocols are analyzed from the perspective of professional practice of the different categories involved in care provision, and their fundamental basis is updated periodically[10].

The results in this study showed that nurses usually seek to perform the verbal approach, based on what the protocol establishes as a "lucid interval", which comprises the stage of certain mental illnesses in which the symptoms disappear, giving the impression that the patient in crisis has returned to being an individual who remains balanced and, therefore, management through more cautious observation is not necessary, nor is it expected that a more aggressive attitude towards the health team will occur[11].

The protocol that refers to verbal management in psychiatric urgencies, as a primary condition, is similar to the others, which standardize the systematization of care provision in stages. However, in a psychiatric emergency, it is necessary for the team to perceive the person as a unique individual and consider the care provision scenario, which makes systematization difficult, as each situation involves different factors that trigger the conflict caused in the person with a mental disorder[12].

Often, a psychiatric urgency requires a more comprehensive approach and therapeutic communication. Therapeutic communication is a singular type of communication used by health professionals to support, inform, educate and train people in the transition processes from health to illness and/or in adapting to difficulties[13].

The situation determined by verbal management imposes a time demand that is a not according to the care provision standards for other SAMU occurrences in which response time is recommended. In the case of psychiatric occurrences, actions take a longer time, thus compromising the protocol bases of agility in care provision, with resolvability based on effective care[14].

Still in the context of care provision, authors point out that the greatest challenge to the team in urgent psychiatric care is to know how to act in the face of the unexpected, as professionals rarely know the type of care that will be needed, the characteristics of the site of the occurrence or the factors that may interfere with their action. In these cases, fear emerges as a strong feeling that can often mobilize professionals and is an integral part of the stigma related to the psychiatric crisis, which has happened since the nurses received their professional training[15].

Decisions regarding the physical restraint of a patient in crisis should be made as a last alternative, after attempts to calm the patient down and establish a relationship of trust, through therapeutic communication. Currently, the legislation establishes that a person with a mental disorder has the right to "be treated in a therapeutic environment by the least invasive means possible"[16,17]. Being an invasive intervention, physical restraint should be avoided as much as possible and when performed it requires specific techniques that will not agitate or hurt the patient. As a result, it is essential that nurses receive training to deal with psychiatric crises through scientific knowledge about mental disorders[18,19].

Although many institutions use institutional and service protocols as tools to achieve their goals, the decision to use restraint should not be based on service protocols which, despite establishing parameters for addressing a situation, are not definitive in their applicability and, therefore, must be adjusted to the singularity of each occurrence[8,10,20,21].

The protocols serve as a description of the best professional practice to be followed in each moment and situation, from the perspective of the nurse who works in the event in order to protect the patient in crisis and the health team. The nurse should never forget to review and maintain the verbal intervention, which includes explaining what is being done in order to establish trust and a sense of security for everyone involved in the process[10,13,14,18,19].

The study shows that nurses' feelings in the face of a psychiatric urgency are directly associated with the type of management that should be performed with the individual in crisis or with the person who requested assistance. It is also noticed that the nurses in the study, who were qualified in specific urgency and emergency training with an emphasis on clinical and trauma cases, find it difficult to work in the psychiatric emergency due to the lack of theoretical-practical training to solve the particularities involved in the crises caused by mental disorders. Insecurity is even greater when more time is needed to conclude the occurrence due to the fact that the professional has mastered the rules of clinical and traumatic occurrences, but does not have sufficient knowledge or mastery to perform in urgent psychiatric care[14,22].

The results also show that when following the recommendations of the protocols in psychiatric urgency, the nurse finds a gap in the interpretation of Ordinance 2048/2002, related to the need for support from other actors at the site

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of the occurrence, as a way to maintain safety and the physical integrity of the team and of the person in crisis. The decision must be made based on the recognition of the severity signs of psychiatric pathologies in urgent situations and at the occurrence site, and the nurse must describe what is being observed in the patient being cared for to the regulating physician[4].

The need to call other professionals for urgent psychiatric care occurs when risk to the safety of PHC teams is identified, that is, people with an aggressive behavior, at risk for themselves and for others, as in the management of psychotic and suicidal patients. However, behaviors can only be analyzed at the site where care will be provided, since the information from the person requesting the service is always centered on the need for hospitalization of the person in crisis, and that may not be the most appropriate attitude to be taken[14].

The perception of the possibility of aggression may be related to nurses' academic education, since they do not understand the relevance of therapeutic communication to perform verbal management. Such situation may also be related to the lack of specific training to provide urgent psychiatric care[14,23].

However, thoughts and interventions end up being traditional and conservative, thus opposing to principles and guidelines of the new Mental Health Policy, as they maintain a relationship of subordination and threat to people with mental disorders, who are more likely to be victims of violent acts than to commit them[17,24].

FINAL CONSIDERATIONS

The results in this study show that SAMU nurses do not feel adequately equipped to work in psychiatric urgencies/emergencies, and that there is a gap with regard to technical and scientific knowledge focused on the biopsychosocial model, as well as the absence of motivation by nurses working in PHC to seek such training.

Brazilian studies on this topic are few, which may indicate a lack of interest in this area of knowledge and a lack of concern among researchers to learn about the real needs of nurses working at SAMU.

It is considered that this study has achieved the objective proposed and that it has provided a view of the daily practice of nurses working in psychiatric urgencies, thus contributing to the development of future research that can expand the knowledge in this specific field and provide more humanized and appropriate care to the needs of this population. The need to include continuous training and specialized support in this field in accordance with the new mental health policies for nurses working at SAMU was also evident.

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