

ORIGINAL ARTICLE

Nurses and Assistant Medical Officers' Competency in Managing Clients Presenting with Psychiatric Disorders in The Emergency Department

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ABSTRACT

Introduction: General Hospital's Emergency Departments (ED) have become focal points for individuals presenting with mental health problems seeking help. However, frontline ED nurses and Assistant Medical Officers (AMOs) often lack the skills and competency to effectively triage and manage clients presenting with a myriad of psychiatric issues. The objective of the study is to assess ED nurses & AMOs' s perceived competency and associated factors in providing care for clients presenting with psychiatric concerns. **Methods:** This study is a quantitative, cross-sectional survey design. One hundred and forty-six ED nurses & AMOs were recruited from two tertiary general hospitals in Kota Kinabalu by random sampling. A validated tool ($\alpha = 0.92$), the Behavior Health Competency Care (BHCC) questionnaire was used to measure psychiatric care competency among participants. Data analyses used descriptive and inferential statistics to identify the association of respondent's work setting, designation, age, years of work experience, qualification with competency scores. **Findings:** low total mean score of 2.52(SD 0.68) was found in perceived psychiatric competency among ED nurses & AMOs. Other findings indicate, low perceived competence in risk assessment and poor ability to provide intervention for clients presenting with acute psychiatric conditions. **Conclusion:** This study found major gaps in psychiatric care competency among ED nurses & AMOs. As ED's of general hospitals continue to be a focal point for clients with psychiatric disorders seeking help, competency shortfall among frontline ED nurses & AMOs, will negatively affect the quality of psychiatric care delivery and needs to be addressed.

Keywords: Nurses and assistant medical officers, competency psychiatric emergency triage

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INTRODUCTION

Decentralization of psychiatric services in the 1990s had turned emergency department (ED) of general hospitals to become the frontline service and initial point of contact for patients seeking help with psychiatric concerns (1). Hospital-based surveys (2,3) report that among clients attending the emergency department for a variety of reasons, 4% - 10% of the clients present with mental health problems or psychiatric issues. Malaysian hospital-based studies (4) indicate that among mental health patients seen in EDs, 60-70% of them present with psychiatric crisis or emergencies that warrants urgent attention. Typical psychiatric emergencies presentations in ED settings include drug-induced agitated behaviour, suicide attempts, or acute psychotic episodes (4,5). Mental health crisis or psychiatric emergencies are

serious disturbances of behaviour that requires urgent triage and intervention. In government-run hospitals' EDs, nurses & AMOs who perform frontline primary triage, face tremendous difficulties in managing complex psychiatric emergencies (6). Triage and managing ED clients presenting with a spectrum of psychiatric issues requires a high degree of discerning skills and critical evaluative competency.

Competency is the integration of knowledge, skills, attitude, and judgment in the delivery of patient care (7). Psychiatric competency of Nurses & AMOs in ED settings is governed by the professional standards of practice-guide by the Ministry of Health Malaysia (8). To date, there have been no local studies evaluating the psychiatric competency of ED allied health staff within non-psychiatric settings. Psychiatric competency skills include expertise in de-escalation techniques to subdue hostility or agitation, skills in the rapid administration of tranquillizing injections, technical skills in using physical restraint to secure disturbed or violent patients, competency to triage and code severity and the ability to accurately assess any underlying co-morbid critical

medical conditions (9).

A preliminary qualitative study (6) which explored the experience of nurses & AMOs in caring for psychiatric clients from two local hospitals, revealed the following major barriers influencing care delivery: i) lack of specialized knowledge to differentiate the complex psychiatric presentations ii) lack of dedicated psychiatric-specific triage -screening tools for risk assessment of psychiatric emergencies and suicidal crisis iii) stigma and fear of and lack of soft skills to confidently manage disturbed or violent cases iv) inadequacy of resources such as security back up and limited access to emergency psychiatric medications. Poorly or inadequately triaged psychiatric patients can have serious implications. Distressed patients may become frustrated with the long waiting time and be left untreated (10). Untreated psychiatric emergencies pose an elevated risk for the client and others, as the patient in crisis may become suicidal, homicidal or escalate and become aggressive or violent. Additionally, patients with psychiatric symptoms presenting with critical co-morbid medical conditions risk being overlooked by ED triage staff (11). Hughes et al. (12) assert that it is imperative that frontline nurses and AMOs in primary care setting have adequate knowledge, as well as the soft-skills necessary for patients presenting with mental health problems. Exemplary practice development initiatives indicate that an add-on psychiatric training for ED nurses and frontline staff on psychiatric emergencies significantly improves patient outcomes in accuracy of triage, reduced waiting time and timeliness of intervention (13). However, designing pragmatic add-on psychiatric training for ED service personnel requires a careful need-analysis study to identify specific competency deficits and tailor relevant remedial training.

Currently, there is no baseline needs -analysis study among nurses and assistant medical officers in Malaysian ED settings regarding competency in caring for clients presenting with psychiatric problems and thus, warrants the need for such a study. The objective of the study is to assess nurses & AMOs 's perceived competency and associated factors in providing care for clients presenting with psychiatric crisis in the emergency department of general hospitals.

MATERIALS AND METHODS

This study is a quantitative, cross-sectional survey design, using a structured questionnaire to objectively evaluate the level of perceived competence in psychiatric triage, among emergency- department nurses & AMOs. This study was conducted in two tertiary-level hospitals located within the metropolitan district of Kota Kinabalu in the state of Sabah Malaysia. The study population involved emergency department nurses & AMOs from the two tertiary level general hospital i) Queen Elizabeth 1 (QE1) and ii) Queen Elizabeth II (QEII).

Both these hospitals are similar in characteristics in terms of patient- load, manpower capacity and have a resident psychiatrist overseeing psychiatric services. The reason for selecting the two hospitals in this study is to facilitate a second -follow-up study to test a prospective competency education intervention, which the two hospitals could serve as the experimental- control- arm.

The Ethics committee of University Malaysia Sabah (JKetika 2/16(1), and Ministry of Health Malaysia (NMRR 16-596-29873) approved the study protocol. Ethical clearance to conduct this study was also obtained from the hospital -level research ethical committee of QE1 & QEII. Informed consent was also obtained from respondents prior to their participation in the study. Respondents were reassured of confidentiality and briefed regarding their right to withdraw from the study at any juncture without repercussion.

A total of 146 nurses and assistant medical officers (nurses n=50, assistant medical officers n=96) were selected by random sampling. Random selection was generated using Microsoft Excel based on the full list of all eligible participants from the above mentioned two hospital's EDs, having fulfilled the following inclusion criteria: i) is either, a registered nurse or registered assistant medical officer ii) works full time in the ED department of either QE1 or QEII hospital. Nurses & AMOs with previous post-basic training in psychiatry were excluded, as the primary intent of the study was to assess the competency gap of generalist nurses and AMOs with no psychiatric training.

The Behavior Health Competency Care (BHCC) (14) questionnaire was used to measure health personnel's perceived competency in providing psychiatric care. The psychometric properties of this tool have been well established, with reported overall internal consistency coefficient of 0.92 (14). The BHCC has four domains or subscales of perceived competency: i) assessment (nine items, $\alpha = 0.91$), ii) hands-on or intervention (eight items, $\alpha = 0.90$), iii) recommendation of psychotropic medications (two items, $\alpha = 0.78$), iv) utilizing resources (four items, $\alpha = 0.92$).

As the BHCC tool was benchmarked from studies in the United States and has not been utilized in any study in Malaysia, the tool was piloted within the local context to ascertain its reliability. A pilot study with 22 nurses & AMOs, selected from the ED of a hospital not involved in the study, found reliability coefficient Cronbach's alpha = 0.86. Forward translation into the Malay language was done and certified by the Malay language experts from UMS Humanities Faculty. The backward translation from the Malay version to English was retested with a group of 24 respondents with an overall internal consistency of 0.84. The face and content validity were reviewed by two experts and no modifications were made. The final BHCC questionnaire for respondents was presented in a

dual, English – Malay language version.

The BHCC questionnaire consisted of two parts: a series of background questions and clinical variables which measured the respondents' perceived competency. Background questions of the BHCC captured data on demographic characteristics such as hospital setting, designation, age, years of working experience and highest qualification attained. The BHCC instrument consists of 23 questions or items on self-perceived competency where each item used a 5-point Likert-type scale ranging from 1 to 5 (strongly disagree =1 point, to strongly agree = 5 points). The higher the BHCC score, the higher is a respondent's perceived behavioural healthcare competency.

Data collection for this study commenced in September 2017. Initially, the researcher met with the ED physician-in-charge and the allied health manager of both hospitals mentioned above to brief the purpose of study and request participation of all staff under their jurisdiction. After permission had been granted, information regarding the study, its eligibility criteria were circulated via the social media group through the ED allied health manager. To accommodate varying work shift, and leave of absence among potential eligible participants, data collection at the site was done by the principal researcher over a span of five consecutive days. Data collected was cleaned, coded, and analyzed using Statistical Package for Social Sciences version 22.0. Descriptive statistics were used for demographic variables and mean scores were calculated from the response in each BHCC Likert-scale item. Inferential statistics identified the correlation of factors. Pearson's correlation analyzed respondent's age, years of work-experience with competency scores, One-way ANOVA analyzed association of respondent's qualification (diploma, post basic emergency care and degree) with perceived competency scores and t-test identified association of respondent's hospital setting (QE1 and QEII) and designation (nurse and assistant medical officers) with competency scores. An odds ratio with a 95% confidence interval was used to identify the strength of the associated factors, significant at $p \leq 0.05$.

RESULTS

Sample characteristics

Over the time allotted, 146 (N) nurses & AMOs from the Emergency Department of Queen Elizabeth Hospital 1 (n=78, 53.4%) and Queen Elizabeth II hospital (n=68, 46.6 %) completed the survey (Table I). Among respondents, 34.2 % (n=50) were nurses and 65.8% (n=96) were assistant medical officers. The average age of respondents was 36.4 years (SD 34.2). By qualification, among the 146 ED nurses & AMOs, 69.9 % (n=102) had a basic diploma, 24.7% (n=36) had post-basic training in emergency -care and 5.5 % (n=8) had degree qualifications. In terms of number of years of work- experience, nurses & AMOs in this study had a

mean of 12.4 years (SD 12.2) of work tenure.

Table I: Participant characteristics, hospital, gender, age, education & work experience

Variable	n (%)
Hospital	
Queen Elizabeth Hospital I Emergency Department (QE I)	78(53.4)
Queen Elizabeth Hospital 2 Emergency Department (QE II)	68(46.6)
Gender	
Male	81(55.5)
Female	65(44.5)
Age	
	36.4 years (SD 34.2)
18 - 30	56(38.4)
31-50	68(46.6)
51-60	22(15.1)
Allied - Health Designation	
Assistant Medical officers	96(65.8)
Registered Nurse	50(34.2)
Highest level of education	
Diploma	102(69.9)
Post -Basic Emergency Care	36(24.7)
Degree	8(5.5)
Years of work experience	
	12.4 years (SD 12.2)
1-5 years	32(21.9)
6 -10 years	24(16.4)
11 - 20 years	68(46.6)
>21 years	22(15.1)

Table II: Behavior health care competency (BHCC) subscale scores by hospital setting.

BHCC- Subscale	All N=146		Hospital QE I n=78		Hospital QE II n=68	
	M	SD	M	SD	M	SD
Assessment	2.53	0.66	2.55	0.66	2.50	0.67
Practice/intervention	2.32	0.75	2.31	0.74	2.34	0.76
competency						
Recommend psychotropics	2.01	0.61	2.00	0.60	2.01	0.62
Resource adequacy	3.21	0.72	3.20	0.75	3.21	0.69
TOTAL	2.52	0.68	2.52	0.69	2.52	0.68

No significant difference in means scores of all subscales between Hospital QE1 and QEII, p-value= 0.49

Psychiatric competency

The BHCC mean total score was 2.52 (SD 0.68) for the entire sample (Table II), indicating an overall low perceived competency among emergency department nurses & AMOs. Total mean scores of the four BHCC subscales rated by all (N=146) nurses & AMOs from both

QE I and QE II hospital, ranked from highest to the lowest were: i) competence to manage resource adequately mean 3.21 (SD 0.72), ii) competence in assessment mean 2.53 (SD 0.66) iii) competence in hands-on practice/ intervention competency mean score of 2.32 (SD 0.75), and competence to recommend psychotropics mean 2.01 (SD 0.61). Compared by hospital setting, between personnel from the two hospitals in this study, QE I and QE II, showed no significant differences in competency scores across all four BHCC subscale (p-value= 0.49).

Table III: Behavior health care competency subscale scores by age and years-of work -experience

	Pearson's correlation	
	Age in years	Number of years of work-Experience
Assessment	0.253**	0.243**
Practice /Intervention	0.130	0.150
Recommend	0.243**	0.255**
Psychotropics		
Resource Adequacy	0.253**	0.253**
Total Competence	0.253**	0.253**

** . significant at the 0.05 level (2-tailed).

Association of behavior health care competency (BHCC) subscale scores with demographic variables

Table III reports the correlation of selected demographic variables with BHCC total and subscales scores. Pearson’s correlation indicate that the respondent’s age and years of work- experience were positively correlated with competency in assessment and ability in recommending psychotropics (p-value < 0.05). However, t-test analysis comparing nurses and AMOs found no difference in BHCC total or subscale scores among the two groups of allied health personnel (Table IV).

Table V reports findings of one-way ANOVA analysis, comparing nurses and AMO’s qualification i.e. basic diploma, post basic emergency care and with BHCC competency scores, which showed qualification of nurses and AMOs had no significant difference in BHCC total or subscale competency scores.

Table: IV: Difference in behavior health care competency subscale scores between nurses and assistant medical officers

	t-test		
	Mean Difference	Std. Error Difference	Sig. (2-tailed)
Assessment	-.05056	.04528	.266
Practice /intervention	-.00839	.06306	.894
Recommend psychotropics	-.05042	.09901	.611
Resource adequacy	.04135	.06477	.524

No significant difference between nurses and AMOs BHCC subscale scores p=0.49

Table V: Comparison of behavior health care competency (BHCC) subscale scores by respondent’ qualification

Dependent Variable	(I) Qualification	(J) Qualification	Mean Difference (I-J)	Std. Error	Sig.
Assessment	Diploma (102)	Post basic in Emergency &Trauma Degree	-.00763	.05072	.989
	Post basic in Emergency &Trauma	Degree	.00163 .00926	.09606 .10226	1.000 .996
Practice / Intervention	Diploma	Post basic in Emergency &Trauma Degree	-.15748	.06887	.077
	Post basic in Emergency &Trauma	Degree	.08732 .24479	.13043 .13885	.800 .215
Recommend Psychotropics	Diploma	Post basic in Emergency &Trauma Degree	-.18791	.10927	.231
	Post basic in Emergency &Trauma	Degree	-.17402 .01389	.20696 .22032	.703 .998
Resource Adequacy	Diploma	Post basic in Emergency &Trauma Degree	.04739	.07192	.805
	Post basic in Emergency &Trauma	Degree	.16544 .11806	.13622 .14501	.480 .718

No significant difference in mean BHCC scores among respondents with basic diploma, post-basic emergency or degree qualifications.

DISCUSSION

This is the first known needs-analysis study in Malaysian government-run hospitals to evaluate the perceived competency among ED nurses & AMOs in caring for clients presenting with a psychiatric crisis. The overall findings of this study indicate that nurses & AMOs working in the emergency department in two major tertiary- level government hospitals, QE I and QE II had low perceived competency to manage clients presenting with psychiatric problems. By comparison, the overall mean competency score of 2.52 among 149 nurses and AMOs in this study is markedly lower than a similar study in the United States by Rutledge et al (15), using the same BHCC tool involving 840 nurses, which reported a moderate mean score of 3.44 (15). However, the psychiatric competency deficits found in this study are not unusual, as numerous other studies have well documented similar competency shortfalls among non-psychiatric health care staff when managing clients with psychiatric issues (6,16, 17 and 18). Consensus from the literature indicates several factors shaping the competency of health care personnel and their subsequent quality of care delivery for clients presenting with psychiatric problems. These factors included: lack of time (19); health -care personnel attitudes (20); knowledge and experience (14); client’s disposition or presenting behaviour (21); the degree of system support; ease of access and adequacy of resources (22). Comparison of staff competency among hospital QE and QE II found no significant difference in competency scores by ED nurse and AMOs in the two hospitals. Respondents from the two hospitals have a similar demographic profile, both having a mix of senior and

junior staff with a varying degree of nursing experience and therefore did not differ much in their experiential competency.

This study suggests a strong perception among nurses & AMOs that performing primary triage for clients presenting with psychiatric issues in the ED is time-consuming when compared to triaging a non-psychiatric or medical case (mean score 2.7). A similar predicament is echoed in studies by Harrison & Zohhadi (21) and White (17), where health care personnel lament that primary clerking of clients with underlying psychiatric issues is an arduous task. In the context of this study, it is possible that the notion that psychiatric patients are tedious to assess stems from the lack of expertise or the unavailability of a designated assessment protocol to gauge the severity of the presenting psychiatric psychopathology (19). Another relevant deficit found in this study among ED nurses and AMOs is the perceived low competency (mean score of 1.94) in their ability to assess and identify common psychiatric illness such as depression, schizophrenia, or bipolar disorder. In comparison, in a similar study by Rutledge et al (15), nurses reported much higher competency for the same item (mean 3.52), which indicates a marked gap for potential improvement in assessment competency among ED nurses and AMOs in this study. The knowledge deficit in this study is probably due to lapse in retention of psychiatric clinical knowledge acquired during training or failure of in-service nurses and AMOs to undergo refresher psychiatric training (6). The implication of frontline ED personnel with such knowledge deficits poses a devastating risk with the potential for patients with mental health problems to be mis-triaged. In a similar context, the risk of diagnostic -overshadowing has been well documented in the literature, where psychiatric clients presenting with a genuine medical emergency, may inadvertently risk misdiagnosed by health care personnel (10). Another pertinent finding from this study indicates, a low perceived competency (mean score of 2.1) among ED nurses & AMOs in risk assessment of self-harm or suicidal behaviour and other dangerous behaviour. By comparison, Rutledge et al (15) in their study, found nurses had a much better competency in suicide risk assessment (mean score 3.6). The probable reason for the poor competency in risk assessment stems from the fact that nurses and AMOs in both hospitals in this study rely on conventional medical -surgical triage-risk assessment tool, which is inadequate for assessing risk among clients presenting with a psychiatric crisis. The issue is also prevalent in other Malaysian hospitals as well, where there is no designated tool or protocol for primary triage of patients presenting with psychiatric emergencies (22). Clients presenting with self-harm and suicide behavior in ED settings triaged using generic tools could lead to wrong diagnosis or suicide risk not accurately assessed (23). It is imperative that frontline ED health personnel are well versed and competent in suicide risk assessment or trained to use suicide risk

screening tool (24). Currier et al. (25), in their quasi-pre-post intervention study among nurses, found that poor pre-study knowledge and confidence in self-harm risk assessment, significantly improved after education using a suicide risk screening tool. Likewise, evidence from several action research studies attests that the use of suicide screening protocols in primary care, improves detection, timeliness of intervention and improves prognostic outcomes for vulnerable clients with self-harm tendencies. Recent development in emergency care indicates an array of evidence-based interventions that can be effectively used to triage psychiatric patients in EDs. Among these, is the Australian Mental Health Triage tool (26), which was found to be a robust and reliable tool to triage psychiatric emergencies. Within the local context, there are numerous evidence-based specific suicide risk assessment tools which can be benchmarked to improve nurses and AMO's competency in suicide risk assessment (25).

Another critical finding reported among ED nurses & AMOs in this study is the low level of perceived competency on hands-on skills to manage clients experiencing psychotic hallucinations (mean score 2.0) or resolve conflicts or defuse impending violence using de-escalation techniques (mean score 1.98). In comparison, Rutledge et al (15) reported moderate competency in managing psychoses (mean score 3.04) and ability in using de-escalation to resolve conflicts (mean 3.11) among nurses in the United States using a similar rating instrument. The reason for the apparent higher competency in Rutledge et al's study (15), is probably due to the accreditation requirement in the United States, where all frontline health personnel are mandated to be trained to manage violence and assaultive behaviour. Within the local context, this finding may be an indication of the hospital's human-resource management overseeing in addressing staff's continuous skill-development needs, where rightfully all frontline ED personnel should be trained in de-escalation techniques and conflict management. Inevitably, ED personnel who lack skills and confidence in managing conflicts will encounter difficulties in triaging disruptive clients. Pich et al. (27) reported similar findings, where non-psychiatric-trained health care personnel report being unprepared or fearful when confronted to manage clients with acute crises or conflict. Recurrent themes from narrative studies among ED personnel found that besides lack of skills, health personnel's fear of unpredictability of the mentally ill patient is a major barrier in managing conflicts with a psychiatric client (13). However, in the context of the duty of care, irrespective of the client's presenting demeanour, the establishment of rapport and trust is an essential competency in the provision of nursing care (28). Add-on psychiatric competency education has shown to alter health personnel's fear to a more receptive stance towards people with psychiatric illness (13). Similarly, Payne et al. (29) in their study, found the level of confidence to

engage with mental health clients, increased among nurses and paramedic staff who received mental health training. Findings in this study also suggest there is poor perceived competency among ED nurses and AMOs to recommend psychiatric medications to the physician during impending emergencies. These low competency findings did not differ much from Rutledge et al.'s study (15) where nurses also report low competency scores (mean 2.5) on the similar item regarding recommending psychotropics. It is probable that in ED settings, nurses and AMOs experience of ED-based-physicians prescribing neuroleptic tranquillizing agents may be rare and therefore poor recall due to unfamiliarity. Fair working knowledge of common psychotropic medications is a necessity among ED personnel. In critical situations, when the use of de-escalation technique fails, patients experiencing acute agitation or violence may need rapid tranquillizing medication to subdue dangerous behaviour (30). Thus, in ED settings, when a patient presents with acute psychoses or violent outburst, inept drug knowledge among nurses & AMOs, delays decision making on the choice of psychiatric medication for such dire emergencies and risk further escalating the patient's crisis. A positive finding from this study is the moderate agreement in perceived competency by ED nurses & AMOs, on their ability to readily access back-up resources when faced with a client with unmanageable psychiatric issues. The context of the respondent's work setting could have influenced this finding, as both hospitals in this study are established tertiary level hospitals with adequate resources such as a back-up resident psychiatrist, robust security service, ED set-up with a designated room for managing psychiatric cases, and has one-stop crises centre within the ED. However, findings of by Giandinoto & Edward (31) did not concur with the results of this study and found health personnel perceived lack of confidence and felt vulnerable when confronted with a difficult client due to inadequate access to resources. In this study, several demographic variables were analyzed for association with competency scores. For instance, the respondent's demographic factor of age and years of work-experience, positively correlated with BHCC subscale scores in assessment and ability to recommend psychotropic medications. In the context of this study, the probable reason for the positive correlation is simply because years of service tally in tandem with experience, and thus senior staff with extensive years of service would report being more competent. In both hospital QE1 and QE II ED settings, frontline primary triaging is carried out both by nurse and AMOs. Both nurses and AMOs, although differing by designation, undergo a similar three-year training curriculum except that AMOs have added training in diagnostic skills to manage minor ailments. Technically, AMOs should be better skilled in assessment compared to nurses, however, in this study, comparison of competency scores between nurse and AMOs did not differ significantly. The probable reason

for this is that AMOs may be skill-trained to assess routine psychiatric cases but are unlikely to possess a high degree of skills to manage complex psychiatric crises. Another demographic factor considered in this study was the respondent's qualification against competency scores. Findings indicate that BHCC competency scores between respondents with basic a diploma, post-basic emergency or degree qualification, did not differ. The reason for this is that the post-basic emergency training curricular does not include psychiatric emergency, focusing only on neurological emergencies. Likewise, respondents with degree qualification in this study are generalist with management skills and are not exposed to specific skills for managing psychiatric patients.

The use of the BHCC instrument in this study has been useful as a needs assessment tool to identify specific deficits in psychiatric competency among nurses and AMOs working in ED settings of general hospitals. In the context of gaps found in this study, the following competency gaps need be tailored into the proposed refresher training: i) recognition of psychiatry emergencies ii) primary risk assessment and triage of psychiatric emergencies iii) managing conflicts and de-escalation iv) psychotropic medications and rapid tranquilization. The proposed refresher training can be made available to ED departments, as part of their continuous professional development program, delivered through a variety of methods, such as problem-based learning, role play, mock-violence de-escalation demonstrations, video feedback on interview session, or via online learning. Recommendations for future research include the viability of using the BHCC tool in a pre-post designed intervention study, to evaluate the impact of refresher training intervention among ED nurses & AMOs.

Study limitations

The study focused on two hospitals of similar characteristics, and thus limits comparison. Respondent's competency evaluated in this study used the BHCC instrument, which is a self-reported questionnaire open to bias.

CONCLUSION

This study served as a need assessment survey and found major gaps in psychiatric care competency among ED nurses & AMOs. As ED's of general hospitals continue to be a focal point for clients with psychiatric disorders seeking help, competency shortfall among frontline ED nurses & AMOs, will negatively affect the quality of psychiatric care delivery and needs to be addressed.

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