Hospital Staff Nurse Perceptions of Competency to Care for Patients With Psychiatric or Behavioral Health Concerns

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Disruptive behaviors are common among hospitalized patients with psychiatric and substance abuse behaviors. Nurses working on nonpsychiatric units, however, may lack competencies to care for patients with such behaviors. A survey was developed and administered to 844 nurses across three hospital settings that revealed a lack of nurse confidence to intervene in situations that require de-escalation techniques and crisis communication. This study provides direction for further research and interventions in hospital settings with similar professional development needs.

Professional development educators and nurse researchers at three Catholic hospitals perceived potential knowledge and competence deficits among nonpsychiatric mental health nurses who care for patients with concurrent psychiatric and medical illnesses or patients with behavioral health concerns. They believed that it was important to examine nurse perceptions of their competencies to assess, provide needed interventions, recommend the need for medications, and use needed resources to provide safe and effective care for such patients.

Mental Illness and Behavioral Issues in Hospitalized Adults

The prevalence of mental illness in the United States is high, with approximately 20% of adults living with a psychiatric diagnosis (National Institute of Mental Health, 2010). Psychiatric disorders are common among hospitalized patients. They are more frequently diagnosed in patients with chronic medical conditions who require hospitalization and experience consistently higher rates of coexisting conditions (de Hert et al., 2009; Faglioni & Goracci, 2009; Loi & Chiu, 2011) than patients without psychiatric/mental health conditions (Leucht, Burkard, Henderson, Maj, & Sartorius, 2007).

Patients with psychiatric disorders, when admitted to an acute care facility, have higher than normal acuity levels (Zolnierek, 2009) and subsequently experience an increased risk of adverse outcomes related to prolonged length of stay, risk of rehospitalization, and increased hospitalization costs (Sayers et al., 2007). Patients with psychiatric emergencies such as neuroleptic malignant syndrome, serotonin syndrome, and psychiatric medication overdose are commonly cared for in intensive care units (Sevransky, Bienvenu, Neufeld, & Needham, 2012). Joint replacement patients with dementia were found to face high rates of complications such as slow progress in physical therapy, pulling out intravenous or indwelling urinary catheters, and falling out of bed; they also were likely to display aggression toward staff (Ritter & Harty, 2004).

Equally problematic is that hospitalized patients without preexisting psychiatric disorders may experience anxiety and apprehension that result in disruptive behaviors (Nadler-Moodie, 2010; Nadler-Moodie & Gold, 2005). Patients admitted to nonpsychiatric settings may be at risk for displaying aggressive, disruptive, or noisy behaviors and verbal aggression. Risk factors for these behaviors include a diagnosis of dementia, admission from a dependent living environment (e.g., skilled nursing facility); dual psychiatric/substance abuse diagnoses; a history of traumatic brain injury, especially in younger persons, or stroke; and chronic renal failure (Baguley, Cooper, & Felmingham, 2006; Chan,
NURSING ROLE

On medical–surgical and critical care hospital units, common psychiatric problems include psychosis, substance abuse and withdrawal, delirium, anxiety, aggression, bipolar disorder, personality disorders, and suicidal behavior or ideation (Nadler-Moodie, 2010). Care delivery challenges for nurses include differentiating psychiatric symptoms from medical conditions; this requires attending to symptoms of the psychiatric disorder itself (Palmu, Suominen, Vuola, & Isometsa, 2010), problems confounded by medical conditions (Kelley, Siegler, & Reid, 2008; Zieschang et al., 2010), and preventable adverse events stemming from possible patient–staff communication problems (Bartlett, Blais, Tamblyn, Clermont, & MacGibbon, 2008). These challenges can result in nurse perception of care processes for such patients as stressful, uncomfortable, unrewarding, and difficult (Zolnierek & Clingerman, 2012).

Women’s health nurses may also encounter patients with psychiatric diagnoses. Although 12-month prevalence rates for psychiatric disorders in past-year pregnant women were lower than for nonpregnant women, data from the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions indicates that 12-month prevalence of psychiatric disorders ranged from 0.4% (any psychotic disorders) to 14.6% (any substance use disorder) among past-year pregnant women (Vesga-Lopez et al., 2008). Data from the same survey indicate that the overall prevalence of a major depressive episode during pregnancy was 12.4% and that major depression during and after pregnancy was strongly correlated with other psychiatric disorders (Le Strat, Dubertret, & Le Foll, 2011).

Assessment and Intervention Competencies

Nonpsychiatric nurses need to assess psychiatric symptoms accompanying patients’ presenting medical diagnoses as well as review patients’ medical records for associated risks and discuss risk concerns of family members (Nadler-Moodie, 2010). Psychiatric-mental health nurses are trained to assess patients for predictors of escalating behavior (Mackay, Paterson, & Cassells, 2005) and have experience accessing needed treatment and resources before negative outcomes or adverse events. Similarly, nonpsychiatric nurses in acute care settings who are trained in early assessment of disruptive or inappropriate behaviors perceive that they are prepared to intervene more effectively (Rutledge, Wickman, Drake, Winokur, & Loucks, 2012).

For example, psychiatric nurses have specialized training and experience to manage disruptive behaviors including aggression, agitation, and psychotic episodes. Strategies used to maintain the patient care environment include use of a nonjudgmental, soft, calm voice and slow pace when speaking and maintaining a calm activity level (Bernstein & Saladino, 2007). Such intervention competencies in both psychiatric and nonpsychiatric settings decrease the likelihood that communication and environmental stimuli will lead to patient outbursts or unpredictable behaviors.

Resource Adequacy

Several practice models identify the need for resources to assure competent behavioral health care. In a systematic review of hospitalized medical–surgical patients with psychiatric comorbidity, use of liaison services improved patient and nurse satisfaction but did not improve patient outcomes or cost savings (Zolnierek, 2009). Enhanced service models are also offered in emergency departments (EDs), ED-based psychiatric emergency services (Woo, Chan, Ghobrial, & Sevilla, 2007), ED-based advanced practice nurses (Wand & Fischer, 2006), and on-call nurse liaisons (Wand, 2004). The Behavioral Emergency Response Team, a psychiatric evaluation team, has successfully tried using psychiatric nurses to assist staff nurses working in nonpsychiatric settings (Loucks, Rutledge, Hatch, & Morrison, 2010). Team members provided onsite assessment, evaluation, and disposition for patients experiencing psychiatric emergencies, placed patients on “involuntary psychiatric” holds when needed, and provided disposition to appropriate treatment facilities.

Psychotropics

When de-escalation techniques are ineffective, patients experiencing acute agitation and loss of self-control may need rapid tranquilization to decrease dangerous behavior and allow treatment of the underlying psychiatric condition (Schleifer, 2011). Hospital nurses need to coordinate care effectively with physicians to identify and recommend needed medications. Medications commonly used to reduce agitation include lorazepam (alone or in combination with haloperidol) and atypical antipsychotics (olanzapine, risperidone, ziprasidone). Nurses also must be familiar with the needed route of administration because some drugs are only available orally, some can be given intramuscularly, and haloperidol (lactate form only) is available for both intramuscular and intravenous use (Nadler-Moodie, 2010).

STUDY PURPOSE

The purpose of this multi-site study was to describe hospital staff nurses’ perceptions of their behavioral healthcare competencies. Professional development educators and researchers at each of the study hospitals considered that study findings would serve as a needs assessment before initiating hospital and/or unit-specific educational interventions.

METHOD

This study was conducted after receiving institutional review board approval from each study hospital. Participation
in the survey was deemed to reflect informed consent. Results were reported in aggregate within and across settings.

Sample
A convenience sample of nurses from three community hospitals participated. Registered nurses eligible to participate included direct care providers who were not employed in a psychiatric or chemical dependency setting at the time of the survey. Nurses in management, nurses working in psychiatric or behavioral health services, traveling nurses, and nurses from outside registries were excluded. The three community hospitals were part of the same Catholic healthcare system located in a large southern California county.

Survey
The survey consisted of two parts, a series of demographic questions and the Behavioral Health Care Competency (BHCC) survey. Demographic items included employer and work setting (e.g., emergency services), gender, education obtained, years worked in nursing and hours worked per week, number of nonbasic life support or advanced certicate in life support certifications, psychiatric or chemical dependency experience (yes/no), management of assaultive behavior training (yes/no), and having a history of violence with a psychiatric patient (yes/no).

The BHCC instrument was designed to measure hospital nurses’ perceptions of their individual behavioral healthcare competencies (Rutledge et al., 2012). The BHCC assesses four primary nurse competencies: assessment, interventions, ability to recommend psychotropics, and adequacy of resources. It had adequate content and construct validity (Rutledge et al., 2012). The BHCC consists of 23 items that use a 5-point Likert-type scale requiring responses from strongly disagree (1) to strongly agree (5). It contains four subscales, which indicated adequate internal consistency for a newly developed instrument (alpha coefficients): assessment (nine items, α = .91), practice/intervention competency (eight items, α = .90), recommendation of psychotropics (two items, α = .78), and resource adequacy (four items, α = .78). The total BHCC had an internal consistency coefficient of .92. The higher the BHCC score, the higher is a respondent’s perceived behavioral healthcare competency.

Procedures
The survey was entered into Survey Monkey (Menlo Park, CA) to allow online delivery. Survey Monkey uses Secure Sockets Layer encryption, keeping links and survey pages secure during transmission from the hospital account to respondents and then back into the account; this helped assure participant confidentiality.

Survey administration procedures varied slightly across the three hospitals. At one hospital, nurses were invited to participate by nurse educators during skills days; they completed surveys on portable laptop computers that were moved from unit to unit over a 5-week period. At the other two hospitals, nurses were sent—via their hospital addresses—electronic mail invitations that included a study explanation. An icon placed on one hospital’s intranet provided nurses another point of access for participation. At staff meetings, nurse managers informed nurses of survey availability and encouraged completion. In one hospital, nurse educators and members of the nursing research council visited units during the study period to remind staff nurses of the survey. At the second and third hospitals, the instrument was “live” for the 3 weeks.

All three hospitals used an incentive (total value of $100 or less per hospital) to encourage nurse participation. Nurses who participated voluntarily entered into a drawing for these hospital-specific incentives. For example, nurses at one hospital were able to participate in a drawing for movie tickets if they printed out a survey completion form, signed it, and placed it in a box on the units.

Data Analysis
Descriptive statistics were used to describe the sample and responses to individual items and subscale/total scores. One-way analyses of variances established whether subscale and total BHCC scores were different by work setting; when a significant F value was found, post hoc Tukey’s test established which mean scores were significantly different from each other. Significance level was set at .05.

RESULTS
Sample
Over the time allotted, 844 nurses completed at least part of the survey. Response rates ranged from 23% to 41% for the three hospitals. Nurses were predominately women (90%); 54% had a baccalaureate or higher degree in nursing. They worked in multiple hospital areas: critical care (n = 136, 16%), ED (n = 120, 14%), medical/surgical units including oncology (n = 229, 27%), surgical services including postanesthesia units (n = 57, 7%), telemetry units (n = 63, 8%), women’s services (n = 92, 11%), short-stay areas (n = 32, 4%), procedural areas (n = 30, 4%), and other areas (n = 75, 9%). In general, nurses were experienced, averaging 16.2 years of work in nursing (range, 1–50). They worked, on average, 36.1 hours per week (range, 8–80). Few nurses had psychiatric (n = 44, 5%) or chemical-dependency (n = 29, 3%) work experience, whereas 34% (n = 282) reported having management of assaultive behavior training, and 20% (n = 169) reported having experienced at least one incident of violence involving a psychiatric patient.

BHCC Results
The mean BHCC total score was 3.45 for the total sample, indicating moderate perceived competency in caring for
behavioral health patients. A one-way analysis of variance determined no significant differences in mean BHCC scores by hospital on perceived nurse competency, \( F(2, 790) = 2.200, p = .11 \). Therefore, reported results include nurses from all hospitals. Total sample average subscale scores, from highest to lowest, were resource adequacy \((M = 3.75, SD = .67)\), assessment \((M = 3.64, SD = .64)\), practice/intervention competency \((M = 2.61, SD = .96)\), and recommend psychotropics \((M = 2.61, SD = .67)\). Thus, hospital staff nurses reported moderately strong perceptions that they had or knew when to access resources to care for behavioral health patients in their work units and moderately strong perceptions that they could appropriately assess patients with behavioral health needs. Nurses reported less strong perceptions that they could deliver competent care or recommend psychotropic drugs to other providers for patients who may need them.

Total BHCC score and all subscales differed significantly according to work setting of staff nurse participants (see Table 1). For each subscale, nurses from EDs scored significantly higher than did nurses in all other settings. For assessment, practice/intervention competency, and recommendation of psychotropics, nurses from women’s services settings scored significantly lower than other nurses. For resource adequacy, nurses from two areas, surgical services and short stay, scored significantly lower than nurses from all other areas.

Table 2 reports the individual item scores for the total sample (there were varying numbers of nurses responding to each item, but those responding came from the 834 who indicated their work setting). The table also shows, by subscale, scores from nurses from the groups who scored significantly higher or lower than the other groups.

For assessment, nurses had moderately strong agreement that they could assess patients with psychiatric and behavioral health issues. They scored highest on ability to recognize signs/symptoms of alcohol withdrawal and behaviors indicating alcohol or drug abuse; they scored lowest on being able to distinguish between dementia and delirium. On average, emergency nurses scored from 0.5 to a full point higher than nurses from women’s services on individual assessment items.

For practice/intervention competency, average individual items indicated moderate perceived care competency. Nurses scored highest on perceived ability to maintain therapeutic relationships with patients who have psychiatric symptoms and lowest on being able to address hallucinations. With the exception of being able to plan more time for patients with psychiatric issues and maintenance of a therapeutic relationship, nurses from women’s health scored over 1 point lower than did emergency nurses on individual items related to care giving.

On average, nurses in the study were moderately low in their confidence to recommend the use of psychotropics to

### Table 1

<table>
<thead>
<tr>
<th>Work Setting</th>
<th>Assessment</th>
<th>Practice/Intervention competency</th>
<th>Recommend psychotropics</th>
<th>Resource adequacy</th>
<th>Total score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>3.64</td>
<td>3.29</td>
<td>3.75</td>
<td>3.67</td>
<td>3.45</td>
</tr>
<tr>
<td>Med/Surg, Oncology</td>
<td>3.73</td>
<td>3.38</td>
<td>3.64</td>
<td>3.64</td>
<td>3.51</td>
</tr>
<tr>
<td>Other</td>
<td>3.45</td>
<td>3.16</td>
<td>3.71</td>
<td>3.70</td>
<td>3.45</td>
</tr>
<tr>
<td>Procedural Areas</td>
<td>3.02</td>
<td>2.70</td>
<td>3.54</td>
<td>3.67</td>
<td>3.02</td>
</tr>
<tr>
<td>Short Stay</td>
<td>3.17</td>
<td>2.71</td>
<td>3.68</td>
<td>3.71</td>
<td>3.17</td>
</tr>
<tr>
<td>Surgical Svcs: PACU</td>
<td>3.38</td>
<td>2.16</td>
<td>3.40</td>
<td>3.71</td>
<td>3.38</td>
</tr>
<tr>
<td>Women’s Svcs</td>
<td>3.17</td>
<td>1.83</td>
<td>3.40</td>
<td>3.71</td>
<td>3.17</td>
</tr>
<tr>
<td>ED</td>
<td>3.52</td>
<td>2.16</td>
<td>3.40</td>
<td>3.71</td>
<td>3.52</td>
</tr>
<tr>
<td>Other</td>
<td>3.18</td>
<td>1.83</td>
<td>3.40</td>
<td>3.71</td>
<td>3.18</td>
</tr>
</tbody>
</table>

Note: Svcs = services; PACU = postanesthesia care unit; Med = medical; Surg = Surgical. Subscale scores on a scale of 1 = strongly disagree to 5 = strongly agree.

For all subscales, \( p < .0001 \). Significant lower scores, Tukey post hoc analysis. Significant higher scores, Tukey post hoc analysis.
<table>
<thead>
<tr>
<th>TABLE 2 Behavioral Healthcare Competency Survey Individual Item Scores: For Total Group and Select Work Settings (Highest, Lowest)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td>I can assess patients for potential psychiatric problems.</td>
</tr>
<tr>
<td>3.55</td>
</tr>
<tr>
<td>I identify signs and symptoms of common psychiatric conditions (e.g., depression, schizophrenia, bipolar disorder).</td>
</tr>
<tr>
<td>3.68</td>
</tr>
<tr>
<td>I can identify common neuroleptic, tranquilizers, and antidepressant medications used with psychiatric patients.</td>
</tr>
<tr>
<td>3.54</td>
</tr>
<tr>
<td>I am able to assess patients for risk of suicide (suicidality).</td>
</tr>
<tr>
<td>3.60</td>
</tr>
<tr>
<td>I recognize behaviors that indicate a patient may have alcohol or drug abuse problems.</td>
</tr>
<tr>
<td>3.90</td>
</tr>
<tr>
<td>I can recognize signs and symptoms of alcohol withdrawal.</td>
</tr>
<tr>
<td>3.90</td>
</tr>
<tr>
<td>I can recognize signs and symptoms of drug withdrawal.</td>
</tr>
<tr>
<td>3.76</td>
</tr>
<tr>
<td>I can distinguish between dementia and delirium.</td>
</tr>
<tr>
<td>3.23</td>
</tr>
<tr>
<td>I can recognize the warning signs in patients whose behavior may escalate to aggression or dangerous behaviors.</td>
</tr>
<tr>
<td>3.61</td>
</tr>
<tr>
<td><strong>Practice/intervention competency</strong></td>
</tr>
<tr>
<td>I can initiate appropriate nursing interventions for common psychiatric issues such as depression, bipolar disorder, and psychosis.</td>
</tr>
<tr>
<td>3.24</td>
</tr>
<tr>
<td>I can effectively interact with patients who have mental health problems.</td>
</tr>
<tr>
<td>3.27</td>
</tr>
<tr>
<td>I am able to maintain a safe environment for patients on my unit who have psychiatric conditions.</td>
</tr>
<tr>
<td>3.48</td>
</tr>
<tr>
<td>I can effectively manage conflicts caused by patients who have mental problems.</td>
</tr>
<tr>
<td>3.14</td>
</tr>
<tr>
<td>I can effectively intervene with a patient having hallucinations.</td>
</tr>
<tr>
<td>3.04</td>
</tr>
<tr>
<td>I am able to use de-escalation techniques and crisis communication to avert aggressive behaviors.</td>
</tr>
<tr>
<td>3.11</td>
</tr>
<tr>
<td>I plan for more time to take care of patients with psychiatric issues compared with my other patients.</td>
</tr>
<tr>
<td>3.35</td>
</tr>
</tbody>
</table>
physicians. Emergency nurses were moderately confident, and women’s health nurses were somewhat confident.

Average individual item scores for resource adequacy indicated moderately strong confidence that nurses knew when to and could access hospital and outside resources needed to care for patients with psychiatric issues. Emergency nurses indicated strong perceptions of resource adequacy, whereas nurses from surgical services and short-stay areas had less confidence, particularly related to help and hospital resources being available.

**DISCUSSION**
This is the first known study to describe nonpsychiatric hospital staff nurse perceptions of competency to care for patients with psychiatric disorders or behavioral health needs using a valid and reliable instrument. Findings support variability among nurses in different work settings in terms of their perceived competencies to care for behavioral health patients from assessment through accessing resources. Despite moderately strong perceptions of adequate available resources, hospital nurses were more confident in their ability to assess patients in their areas for psychiatric/behavioral health needs than in initiating interventions or acting in situations that may require de-escalation techniques or crisis communication. Nurses were least confident in their skills to recommend psychotropic medications to physicians. Findings point to implications for staff professional development needs.

Differential responses across subscales show that, although nurses in the sample have confidence with the first phase of the nursing process to assess patients across settings and perceive their access to resources related to caring for patients with behavioral health needs is good, they are less confident in their ability to intervene appropriately and particularly to recommend psychotropic medications when appropriate. After assessing and recognizing a behavioral

**TABLE 2**

<table>
<thead>
<tr>
<th></th>
<th>All, N = 834</th>
<th>Emergency Care, n = 120</th>
<th>Women’s Svcs, n = 92</th>
<th>Surgical Svcs: PACU, n = 57</th>
<th>Short Stay, n = 32</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am able to maintain a therapeutic relationship with most patients on my unit who have psychiatric issues.</td>
<td>3.61</td>
<td>3.82</td>
<td>3.46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommend psychotropics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am confident that I can recommend use of psychotropic drugs to physicians for appropriate patients.</td>
<td>2.65</td>
<td>3.53</td>
<td>1.97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I recommend psychotropic drugs to physicians for psychiatric patients.</td>
<td>2.56</td>
<td>3.27</td>
<td>1.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource adequacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know when to ask for outside help (e.g., physician, psychiatric nurse, other) for a patient with psychiatric issues or dangerous behaviors.</td>
<td>3.88</td>
<td>4.21</td>
<td></td>
<td>3.67</td>
<td>3.83</td>
</tr>
<tr>
<td>I call for outside resources (e.g., physician, psychiatric nurse, other) when I recognize a patient’s behaviors are escalating beyond my capabilities.</td>
<td>3.96</td>
<td>4.25</td>
<td></td>
<td>3.74</td>
<td>3.77</td>
</tr>
<tr>
<td>I am confident that help is available to me when I need assistance with patients who have comorbid behavioral or psychiatric issues.</td>
<td>3.59</td>
<td>3.91</td>
<td></td>
<td>3.31</td>
<td>3.43</td>
</tr>
<tr>
<td>Hospital resources are available to me when I need assistance with behavioral health, psychiatric issues, or substance abuse issues.</td>
<td>3.56</td>
<td>3.70</td>
<td></td>
<td>3.43</td>
<td>3.37</td>
</tr>
</tbody>
</table>

*Note.* Subscale scores are on a scale of 1 = strongly disagree to 5 = strongly agree. Svcs = services; PACU = postanesthesia care unit.
health problem, these nonpsychiatric nurses perceive the need for additional education in intervening and recommending psychiatric medications for this patient population. These findings reinforce the need for hospital education departments to ensure that nurses have sufficient knowledge and training in the areas of psychiatric nursing interventions and psychopharmacology for patients hospitalized in nonpsychiatric settings. Statistics for readmission rates, prolonged length of stay, and costs for this patient population (Abrams, Vaughan-Sarrazin, & Van der Weg, 2011; Katschnig, 2011; Reese et al., 2011) underline the financial repercussions associated with not paying attention to this problem in today’s pay-for-performance environment.

Nurses from different work settings have differing perceptions related to their capacity to care for patients with behavioral health issues. Emergency care nurses probably have the highest exposure to psychiatric emergencies because of the nature of their work environment and patient load. Between 5% and 13% of patients admitted to EDs have a psychiatric or chemical abuse problem (Owens, Mutter, & Stocks, 2010; Shafiei, Gaynor, & Farrell, 2011). According to California Health and Safety Code 1257.8, nurses who work in EDs must have training in management of assaultive behavior. Prior research showed that nurses (emergency and other), who have such training, had significantly higher scores on the BHCC than those who did not (Rutledge et al., 2012).

Surprisingly, nurses from women’s services showed relatively low scores on three of the four subscales. Prevalence rates for psychiatric illnesses (Le Strat et al., 2011; Vesga-Lopez et al., 2008) indicate that women’s health nurses may be encountering patients with psychiatric disorders. However, according to study findings, these nurses may not perceive themselves competent in assessing and providing care for such patients. Educational needs of nurses in women’s health related to psychiatric patients need to be addressed.

As a result of study findings, all of the involved hospitals have sponsored separate educational offerings for nurses within the health system related to care of patients with behavioral health issues with plans to resurvey nurses for changes in perceived competencies. The third hospital has hired a mental health nursing/education consultant to assist with development of educational programs.

**Implications for Nursing Professional Development Specialists and Research**

Use of instruments like the BHCC scale could allow professional development specialists and managers in hospitals to do a needs assessment of behavioral health competencies in nonpsychiatric nurses. Results from such assessments could be used to tailor educational programs to meet the needs of the nursing workforce. It is essential that nonpsychiatric nurses receive specialized training and experience to assess, care for, and intervene with patients who have behavioral health conditions and to manage disruptive behaviors from such patients. This training can be provided in conjunction with a hospital’s education department through a variety of methods such as simulation training with mock scenarios, violence de-escalation workshops, conferences, and online resources.

Recommendations for future research include evaluating the competencies of nurses in different settings, including non-Catholic hospitals and community-based settings. The BHCC could be used as a pretest and posttest evaluation in conjunction with an educational intervention designed to increase competencies in caring for patients exhibiting disruptive behaviors.

**CONCLUSIONS**

Findings from this study indicate that nurses lack confidence in their abilities to implement treatment options, de-escalate aggressive behavior, and recommend psychotropic medications that are necessary to provide a healing and trusting therapeutic environment for patients. As hospitals continue to experience an increase in individuals with psychiatric disorders being admitted to medical–surgical and other work units for complex health issues, educational programs are needed to provide nurses with effective skills/tools for managing these challenging patients.

**References**


