Published Online: 2025 May 6 **Research Article**

The Quality of Nursing Care and Some Related Factors in the Emergency Department of a Psychiatric Teaching Hospital: A Cross-sectional Study

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Received: 24 November, 2024; **Revised:** 19 April, 2025; **Accepted:** 23 April, 2025

Abstract

Background: Understanding the various aspects of nursing care quality in psychiatric emergencies across different contexts facilitates the achievement of optimal care for patients with acute mental conditions.

Objectives: This study aimed to assess the quality of nursing care (QNC) and related factors in the emergency department of a psychiatric teaching hospital in Iran.

Methods: This cross-sectional study was conducted in the emergency department of a psychiatric teaching hospital affiliated with Zanjan University of Medical Sciences (ZUMS) in Iran between July 6 and December 29, 2021. Data from 200 psychiatric patients were gathered using demographic and clinical characteristics questionnaires, along with the Quality of Psychiatric Emergency Nursing Care Scale (QPsychENCS). To analyze the collected data, the 24th version of SPSS was utilized. The significance level was considered to be less than 0.05 for all variables.

Results: According to the results, patients had a mean age of 36.83 ± 12.35 years and a mean psychiatric illness duration of 12.18 ± 9.47 years. The majority were male (74.5%), single (50.5%), unemployed (47.7%), and had a primary education (53%). The findings from the observation of patients showed that the total QNC and its subscales — except for the implementation of the discharge plan — were 97.5% and 95 - 96.5% desirable, respectively. The patient discharge plan implementation met desirable quality standards for only 49% of patients. Data analysis revealed that factors related to QNC included sex, occupation, emotions, and causes of patients' hospitalization, along with patients' admission times based on nurses' shifts ($P < 0.05$).

Conclusions: It is suggested that, in order to provide high-quality care in the psychiatric emergency department, factors related to QNC should be carefully considered in addition to institutionalizing continuous care programs through an appropriate discharge plan.

Keywords: Quality of Health Care, Psychiatric Emergency Services, Nurses

1. Background

Investigating and enhancing the quality of nursing care (QNC) in healthcare systems is crucial. Patient care quality focuses on delivering effective care that meets patients' needs for optimal health benefits (1-3). Nurses, as key members of the healthcare team, provide the majority of patient treatment, greatly improving service quality. Their timely interventions in the emergency department and strong communication with both patients and healthcare team members underscore their crucial role in ensuring high care quality (4-7).

Psychiatric emergency services must provide quick access to short-term assessment and treatment for patients facing mental health crises or at risk of rapid deterioration that may require hospitalization. However, there is a lack of understanding regarding the best strategies to organize these services to improve care quality for this population (8, 9). These patients have various psychiatric conditions such as depression,

How to Cite: Rasouli M, Ramezani-Badr F, Amini K. The Quality of Nursing Care and Some Related Factors in the Emergency Department of a Psychiatric Teaching Hospital: A Cross-sectional Study. J Nurs Midwifery Sci. 2025; 12 (2): e158051. https://doi.org/10.5812/jnms-158051.

anxiety disorders, bipolar disorder, eating disorders, schizophrenia, and substance abuse disorders. According to an estimate by the World Health Organization in 2019, the prevalence of psychiatric disorders was one in eight people worldwide. In other words, 970 million people were living with a mental disorder, of which anxiety and depressive disorders were the most common (10). In Iran, a systematic review and meta-analysis by Taheri et al. reported a 31.03% prevalence of psychiatric disorders. This study revealed a rising trend in mental disorders in Iran (11).

The significant prevalence of patients with mental disorders and the crucial role of nurses in the psychiatric emergency department, as the front line of care for these patients, indicate that QNC should be evaluated using appropriate and valid methods. While most of these studies address patient satisfaction and quality of care through self-report surveys from the perspectives of patients and nurses, other methods — such as observation — have been used less frequently to investigate the quality of nursing practices in the workplace (12-17). Studies on psychiatric emergency departments primarily focus on patient satisfaction with care rather than directly assessing the QNC (13, 14, 16, 17). Although patient satisfaction with nursing care is an important predictor of care quality (5), the studies on patient satisfaction and care quality in Iran and globally have produced favorable and almost favorable results. However, a notable finding was the significant variation in quality across different care areas, including the triage process, patient communication, collaboration on psychiatrists' orders, and discharge planning (12-14, 16-19). Despite some studies showing patients' satisfaction with QNC, the complex care needs of those in psychiatric emergency departments and the critical nature of their conditions highlight the necessity for high-quality care (14, 16, 20).

Studies on nursing care quality and patient satisfaction show that efforts to improve care have not yet succeeded. Factors such as rising costs, inadequate facilities, insufficient immediate mental health support, a shortage of specialized psychiatric nurses, and limited educational programs in undergraduate nursing negatively affect the quality of patient care (15, 20-24). It is worth noting that most nurses in Iranian psychiatric hospitals hold a bachelor's degree in nursing (22). A lack of understanding of care quality and its influencing factors can adversely affect patient outcomes, safety, and treatment adherence, particularly in psychiatric emergency departments (13, 16, 17, 19). Optimizing psychiatric emergency care necessitates identifying and addressing environmental and contextual factors that could compromise a patient's stability and prognosis (23, 25, 26). An inappropriate physical environment in the emergency department, insufficient skills and knowledge among healthcare staff, negative attitudes towards patients with mental disorders, poor patient interactions, and inadequate inter-professional communication can compromise the quality and efficiency of care (27).

Key contributors to QNC in this setting include timely interventions, effective therapeutic communication, patient safety, confidentiality, patient satisfaction, risk assessments, insurance considerations, team dynamics, and continuity of care. Developing a quality assurance system for psychiatric emergencies requires a continuous understanding of individual and systemic factors shaped by contextual and cultural influences that affect care quality (15, 23, 28). Addressing these factors can improve the quality of acute psychiatric care and patient satisfaction (15), but the contextual, organizational, professional, and cultural influences on nursing care quality in these emergencies remain poorly understood.

2. Objectives

The present study aimed to assess the QNC and identify the socio-demographic and clinical factors of patients that influence care quality in the emergency department of a psychiatric teaching hospital in Iran.

3. Methods

3.1. Study Design, Participants, and Setting

This cross-sectional study was conducted in the outpatient and inpatient emergency departments of a medium-sized psychiatric teaching hospital affiliated with Zanjan University of Medical Sciences (ZUMS) in Iran between July 6 and December 29, 2021. The hospital is a 120-bed, single-specialty public teaching facility. In the outpatient emergency department, patients typically receive temporary treatment lasting between 1 and 4 hours before being discharged. In contrast, the length of stay in the inpatient emergency department varies based on the severity of the patient's condition and the treatment required. Generally, if long-term hospitalization and treatment are necessary, patients may remain in this department for several days or longer until their condition stabilizes.

A convenience sampling method was utilized to include 200 eligible patients in the study. The sample size was calculated using the following formula:

$n = \frac{z^2 P(1-P)}{d^2}$, considering P = 0.51 (29), Z = 1.96, and d = 0.07. Patient inclusion criteria included admission to the outpatient or inpatient psychiatric emergency department and compliance with the necessary conditions to observe nursing care from admission to discharge. These conditions included adherence to patient safety and privacy regulations. Patients requiring nursing care that could not be continuously monitored by researchers were excluded from the study. Nursing care in the psychiatric emergency department was delivered by nurses holding a bachelor of nursing degree (92.9%). The majority of nurses were female (96.4%), and their employment status was temporary (57.1%). The nurses' mean age was 32.25 ± 5.67 years, with a mean of 10 ± 5.96 years of general nursing experience and 4.11 ± 3.68 years specifically in psychiatric emergency work. Additionally, the average nurse-to-patient ratio was 1:10.16 per shift.

3.2. Instrument

We utilized a questionnaire on patients' sociodemographic and clinical characteristics, as well as on the sociodemographic and occupational characteristics of nurses — such as age, gender, educational level, employment status, and nursing work experience — and the Quality of Psychiatric Emergency Nursing Care Scale (QPsychENCS) to gather the required information.

The sociodemographic and clinical characteristics questionnaire for psychiatric emergency department patients includes 12 questions covering age, gender, marital status, level of education, employment status, psychiatric illness history and duration, history of psychiatric hospital admissions, history of referrals to psychiatric emergency departments, admission times according to nurses' shifts, entry method, patient emotions, and admission reasons.

The QPsychENCS is an observation tool adapted specifically for this study from three questionnaires by Schröder et al., Segal et al., and Sale (30-32). This checklist was developed by integrating elements from these instruments — the instrument quality in psychiatric care (31), the quality of psychiatric emergency evaluations (32), and the Quality Patient Care Scale (30) — to cover standard nursing care areas in psychiatric emergencies (33).

After designing the initial version of the QPsychENCS, content and face validity were used to determine the validity of the instrument. Content validity was assessed in both qualitative and quantitative domains. The qualitative content validity of the QPsychENCS was supported by the opinions of 15 experts, including 8 Ph.D. holders in nursing with master's degrees in psychiatric nursing, 4 Ph.D. holders in clinical psychology, and 3 registered nurses with a decade of experience in psychiatric emergency care. After gathering the experts' perspectives, their viewpoints were discussed in a meeting, and appropriate adjustments were implemented. The content validity ratio (CVR) and Content Validity Index (CVI) were used to assess the quantitative content validity of the QPsychENCS. These indicators evaluate the necessity, relevance, simplicity, and clarity of each item. Based on the Lawshe table, with a panel of 15 experts, the minimum acceptable CVR was set at 0.49 or higher (34). In the present study, the mean CVR and CVI were calculated as 0.68 and 0.91, respectively.

The designed checklist consists of 6 subscales and 55 items: Eighteen for triage and patient status assessment, 8 for basic psychiatric nursing care, 14 for nurse-patient and family communication, 5 for intra-and-inter-professional nursing relationships, 6 for managing the emergency department's physical environment, and 4 for the patient discharge program. Each item is scored on a three-point scale: Full implementation earns 2 points, partial implementation earns 1 point, and non-implementation earns 0 points. During nursing care assessments, no points are awarded for unnecessary actions. The QNC overall scores assigned to each patient were recorded in the QPsychENCS, with scores of 80% and above considered desirable and those below 80% deemed undesirable (35).

A backward translation method was used to ensure the accuracy and consistency of the checklist with the items from the three English-language questionnaires utilized. The translation process followed the backward method described by Beaton et al. (36), using two native Persian speakers fluent in English. In the forward translation step, two independent translators translated the three questionnaires from English to Persian. After designing and determining the content and face validity of the final version of the QPsychENCS checklist, the translators retranslated it from Persian to English. Subsequently, a meeting was held with the translators to compare the translated versions with the original English questionnaires, and consensus was reached.

The reliability of the QPsychENCS was determined using inter-rater reliability and Pearson's correlation coefficient. The checklist was completed by two researchers simultaneously for ten patients. The correlation coefficient between the two observers was calculated to be 0.93, indicating satisfactory reliability of the tool.

3.3. Data Collection

After securing the required permits from the University Research and Technology Vice-Chancellor and hospital officials, and establishing participant criteria while adhering to ethical considerations for both participants and nurses, the researchers commenced data collection. To gather the sociodemographic and clinical data of the patients, the researchers obtained necessary information from the patients or their legal guardians, as well as from the patients' files. Two researchers assessed the QNC by observing the nursing care provided to each patient in the psychiatric emergency department from admission to discharge and documenting the required details. After completing the assessment of all checklist items for one patient, the next participant was observed. To minimize the Hawthorne effect and observer bias, the researchers spent additional time with the nurses prior to the main observation phase.

3.4. Data Analysis

To analyze the collected data, SPSS version 24 was utilized. For continuous variables, the mean and standard deviation (SD) were used; for categorical variables, frequency and percentage were reported. To examine the analytical objectives of the study using inferential statistics, the Kolmogorov-Smirnov test was initially applied to determine the normality of the distribution. Based on the results of the Kolmogorov-Smirnov test, parametric tests such as the independent-samples *t*-test and one-way ANOVA were used to compare QNC across categorical variables of patients' sociodemographic and clinical characteristics. The Pearson correlation coefficient was used to assess the relationships of continuous variables, such as patient age and duration of psychiatric illness, with QNC.

For multivariate analysis, multiple linear regression was used to identify the predictor variables for the overall nursing care quality score. Patient sociodemographic and clinical variables were entered into the regression model using a stepwise backward method. Dummy variables were generated for categorical variables. A significance level of less than 0.05 was considered for all variables.

3.5. Ethical Considerations

The study was approved by the ZUMS Ethics Committee (IR.ZUMS.REC.1400.036). Participants were provided with detailed information, both written and oral, regarding the study's objectives, confidentiality, the voluntary nature of participation, and the option to withdraw at any time. Written informed consent was obtained from patients or their legal guardians, as well as from the nurses.

4. Results

Regarding the sociodemographic and clinical characteristics of participants, the mean age of patients was 36.83 ± 12.35 years, and the mean duration of their psychiatric illness was 12.18 ± 9.47 years. Table 1 presents the demographic and clinical characteristics of the study participants.

Observation of nursing care in the psychiatric emergency department revealed that 97.5% of patients received a favorable overall QNC. Except for the discharge plan implementation — which met desirable quality standards for only 49% of patients — the quality of other nursing care subscales was appropriate for 95% - 96.5% of patients (Table 2).

A comparison of the total QNC and its subscales in the psychiatric emergency department, based on patients' sociodemographic and clinical characteristics, revealed that the mean score of the basic psychiatric nursing care quality subscale varied significantly depending on the sex and occupational status of patients ($P < 0.05$). Furthermore, the mean score of the subscale related to interaction and communication between nurses and patients, along with their families, showed a significant difference based on the patients' emotional state ($P < 0.05$) (Table 3). The results of the Pearson correlation test indicated that there was no significant relationship between the total QNC score or its subscales and patients' age or duration of psychiatric illness ($P > 0.05$).

Multiple linear regression analysis revealed that the predictors of total QNC included the cause of hospitalization and patients' admission times based on nurses' shifts. Hospitalization reasons, such as substance abuse and depression ($P = 0.005$), along with night shift admission times ($P = 0.043$), were identified as independent predictors of total QNC (Table 4). This model explains 15.7% of the variation in the total QNC.

5. Discussion

The majority of patients in our study — including males, singles, the unemployed, and those with low income — were consistent with findings from previous studies on psychiatric patients admitted to emergency departments in Africa and India (16, 17, 37). However, our results differed from those reported by Marzola et al. in Italy, Fleury et al. in Canada, Richard-Lepouriel et al. in

Table 1. Sociodemographic and Clinical Characteristics of Patients (N = 200)

Variables	No. (%)
Gender	
Female	51 (25.5)
Male	149 (74.5)
Marital status	
Single	101 (50.5)
Married	99 (49.5)
Level of education	
None	26 (13.1)
Primary	105 (53)
Diploma	48 (24.2)
Bachelors and higher	19 (9.6)
Missing	2
Employment status	
Unemployed	92 (47.7)
Employed	60 (31.1)
Household work	41 (21.2)
Missing	7
History of psychiatric illnesses	
Yes	161 (84.3)
No	30 (15.7)
Missing	9
History of psychiatric hospital admission	
Yes	137 (68.5)
No	63 (31.5)
History of referral to psychiatric emergency department	
Yes	134 (67)
No	66 (33)
Patients' admission time according to nurses' work shifts	
Morning	45 (22.5)
Evening	89 (44.5)
Night	66 (33)
Emergency entry method	
With companion	176 (88)
Ambulance	19 (9.5)
Alone	5 (2.5)
Patient's emotion	
Aggressive	148 (74)
Silent	52 (26)
Cause of admission in psychiatric emergency department	
Aggression and irritability	80 (40)
Suicide	9 (4.5)
Substance abuse	50 (25)
Psychosis	30 (15)
Depression	15 (7.5)
Anxiety disorders	16 (8)

Switzerland, and Faerden et al. in Norway regarding sociodemographic characteristics. In those studies, emergency department patients were primarily female, averaged over 39 years of age, and held university degrees. Nonetheless, both our research and theirs identified common traits such as being unmarried, unemployed, and engaged in low-income professions (13, 14, 38, 39). In our study, the number of visits by male patients was more than twice that of female patients, indicating that contextual and cultural factors significantly influence care-seeking behaviors. Social stigma and the lack of acceptance of mental illness

Table 2. Quality of Nursing Care and Its Subscales in Psychiatric Emergency Department

Variables	No. (%)	Mean ± SD
Triage process and assessment of patient's status		33.74 ± 1.91
Desirable (80% ≤)	190 (95)	
Undesirable (< 80%)	10 (5)	
Basic psychiatric nursing care		15.50 ± 0.88
Desirable (80% ≤)	190 (95)	
Undesirable (< 80%)	10 (5)	
Interaction and communication of nurses with patients and their families		27.5 ± 0.92
Desirable (80% ≤)	193 (96.5)	
Undesirable (< 80%)	7 (3.5)	
Intra-professional and inter-professional relationships in nursing care		9.96 ± 0.21
Desirable (80% ≤)	193 (96.5)	
Undesirable (< 80%)	7 (3.5)	
Emergency department's physical environment management		11.33 ± 0.65
Desirable (80% ≤)	190 (95)	
Undesirable (< 80%)	10 (5)	
Patient's discharge program		6.56 ± 0.89
Desirable (80% ≤)	98 (49)	
Undesirable (< 80%)	102 (51)	
Total QNC		104.59 ± 3.46
Desirable (80% ≤)	195 (97.5)	
Undesirable (< 80%)	5 (2.5)	

Abbreviation: QNC, quality of nursing care.

likely deter women from seeking help more than men (40, 41). Furthermore, most male patients displayed aggressive behavior upon arriving at the psychiatric emergency department, suggesting that they more frequently seek care to prevent harm to themselves or others.

The study indicated that while the overall QNC was desirable, discharge planning requires improvement. Triage and patient assessment — such as waiting time for the first patient-nurse contact and history taking — were considered to be of high quality. Nurses demonstrated effective communication with both patients and their families. Basic psychiatric nursing care, including the prevention of self-harm or harm to others, ensuring adherence to prescribed medications, and managing pharmaceutical complications, was generally of high quality. Intra-and-inter-professional communication was favorable for making informed healthcare decisions. The management of the physical environment, including patient privacy, safety, and environmental health control, was also of desirable quality. The favorable overall QNC observed in most patients in our study can be attributed to several factors, including nurses' experience, patient characteristics, and organizational variables. Nurses' familiarity with patients' sociodemographic and clinical characteristics — gained from prior emergency department visits — significantly enhances the quality of care they provide, in conjunction with their experience in managing such cases. However, the poor quality of discharge plans — including continuity of care and follow-up after discharge — necessitates improved organizational structures and enhanced nurse training for effective implementation. Inadequate discharge programs disrupt care continuity, increase disease recurrence and emergency room visits, exacerbate overcrowding, and further diminish care quality in a vicious cycle (19). Our quality of care findings — except for discharge planning — align with those of Fleury et al., Woldekidan et al., and Happell and Summers, as most patients reported high satisfaction with mental health services in the emergency department. These studies indicated that positive relationships with patients and their families, along with proper access to necessary services, contributed to this satisfaction. Additionally, patients appreciated the professionalism and attitudes of the emergency staff (14, 17, 18). However, in some other studies, approximately 60% of participants were satisfied with the quality of psychiatric nursing care (12, 13, 16). The main sources of patients' dissatisfaction and suggestions for improving the care provided included:

Table 3. Comparison of the Mean Scores Total Quality of Nursing Care in Psychiatric Emergency Department and Its Subscales Based on Patients' Sociodemographic and Clinical Characteristics [a]

Variables	Triage Process and Assessment of Patient's Status	Basic Psychiatric Nursing Care	Interaction and Communication of Nurses with Patients and Their Families	Intra-professional and Inter-professional Relationships in Nursing Care	Emergency Department' Physical Environment Management	Patient's Discharge Program	Total QNC
Gender							
Female	33.98 ± 2.24	15.70 ± 0.68	27.46 ± 1.03	9.98 ± 0.14	11.24 ± 0.62	6.38 ± 0.90	104.74 ± 0.75
Male	33.66 ± 1.8	15.33 ± 0.93	27.50 ± 0.89	9.96 ± 0.23	11.36 ± 0.66	6.62 ± 0.88	104.53 ± 0.38
P-value [b]	0.31	0.049 [c]	0.77	0.56	0.25	0.10	0.71
Employment status							
Unemployed	33.61 ± 1.64	15.37 ± 0.96	27.52 ± 0.73	9.96 ± 0.25	11.32 ± 0.65	6.48 ± 0.99	104.25 ± 0.24
Employed	33.67 ± 2.12	15.48 ± 0.95	27.47 ± 1.06	9.97 ± 0.18	11.40 ± 0.64	6.72 ± 0.78	104.70 ± 0.69
Household work	34.10 ± 2.21	15.78 ± 0.53	27.46 ± 1.12	9.98 ± 0.16	11.24 ± 0.66	6.46 ± 0.81	105.02 ± 0.78
P-value [d]	0.087	0.048 [c]	0.91	0.89	0.48	0.22	0.47
Patient's emotion							
Aggressive	33.84 ± 1.82	15.52 ± 0.90	27.60 ± 0.69	9.97 ± 0.20	11.38 ± 0.58	6.51 ± 0.90	104.82 ± 3.28
Silent	33.57 ± 2.18	15.42 ± 0.84	27.17 ± 1.40	9.94 ± 0.24	11.19 ± 0.81	6.69 ± 0.89	104.00 ± 3.98
P-value [b]	0.41	0.53	0.006 [c]	0.34	0.07	0.21	0.15

Abbreviation: QNC, quality of nursing care.

[a] Values are expressed as mean ± SD.

[b] Independent-samples *t*-test.

[c] P-value < 0.05.

[d] One-Way ANOVA.

Table 4. Best Fitting Multiple Linear Regression Model Predicting the Total Quality of Nursing Care [a]

Factors	Unstandadized Coefficients		Standadized Coefficients	*t*	P	95% CI		Co-linearity Statistics	
	B	Std.Error	B			Lower	Upper	Tolerance	VIF
Constant	97.525	4.044	-	24.113	<0.001	89.924	105.526	-	-
Causes of admission (reference = suicide)									
Depression	3.153	1.112	0.257	2.837	0.005	0.954	5.352	0.784	1.276
Substance abuse	-3.539	1.246	-0.298	-2.841	0.005	-6.003	-1.075	0.584	1.712
Patients' admission time according to nurses' work shifts (reference = morning-night shift)	-1.274	0.623	-0.170	-2.044	0.043	-2.507	-0.041	0.931	1.074

Abbreviation: CI, confidence interval.

[a] R^2 = 0.157; adjusted R^2 = 0.080; F (p) = 2.036 (< 0.02); variables excluded by model: Age, history of psychiatric hospital admission, emergency entry method, marital status, patient's emotion, and education.

Introduction to social services, the physical environment and atmosphere of the emergency department (14, 42), selection of treatments and medications (13), awareness and readiness to meet patients' needs (16), and the triage process and waiting time (18). Motamed et al. found that limited access to patient records, long wait times, and security concerns hindered care in the psychiatric emergency department of an overcrowded teaching hospital in Tehran, Iran. The variable patient volume at this hospital suggests that overcrowding in the psychiatric emergency department significantly undermines care quality (19).

Our study identified gender, patient emotion, employment status, cause of admission, and admission

time as factors associated with QNC. Female patients and housekeepers received higher quality basic psychiatric nursing care in the emergency department. Since all housekeepers in our study were female, gender may be a factor associated with their care quality. Additionally, as nearly all nurses were female, they may have been more likely to devote additional time to female patients, reflecting cultural context (43). This observation highlights the need for further studies to explore the potential influence of gender dynamics on nurse-patient interactions in psychiatric care settings. However, our study also revealed that most patients referred to the psychiatric emergency department were male, underscoring the need to address their specific needs and experiences. In contrast to our findings, other studies did not identify a statistically significant difference in satisfaction with psychiatric care between male and female patients (13, 16, 17, 44). Consistent with the findings of Omoronyia et al., men exhibited significantly greater dissatisfaction (16). The present study revealed that nurses had more favorable interactions and relationships with aggressive patients than with silent patients. In the stressful environment of emergency departments, nurses aim not only to communicate effectively with patients and their families but also to maintain a calm setting and prevent harm. However, it is crucial to recognize that inadequate communication with silent patients may lead to diminished attention to their needs (42).

According to our findings, substance abuse, depression, and the timing of patient admissions during night shifts were independent predictors of total QNC. The negative correlation between patient referrals for substance abuse disorders and total QNC indicates that this factor adversely affects overall care quality. Nurses' negative attitudes toward these patients significantly impact the quality of care provided (45, 46). Based on our results, depression was a positive predictor of total QNC, indicating that care quality was higher for patients with depression. Conversely, Omoronyia et al. found that patients with depression and bipolar affective disorder reported lower satisfaction with nursing care (16). Faerden et al. reported that patients with personality disorders and those who were briefly and involuntarily hospitalized in the emergency department expressed higher dissatisfaction (13). Similarly, Woldekidan et al. observed that unemployed patients with bipolar disorder expressed the least satisfaction with emergency psychiatric care (17). The QNC was lower during night shifts, which emerged as the third predictor of total QNC. This finding suggests that factors such as nurse fatigue, stress, inadequate supervision programs, poor rest facilities, and unfavorable nurse-to-patient ratios may impair nurses' ability to provide optimal care (4, 47).

5.1. Conclusions

Based on the results of our study, social and cultural factors, organizational and professional variables, and the demographic and clinical characteristics of patients — including gender, patient emotions, type of mental illness, and time of hospitalization — may be related to the QNC. Increased attention and strategic planning by decision-makers and health policymakers regarding these factors can enhance care delivery and improve patient outcomes. While our study revealed that the overall quality of psychiatric emergency care was desirable, it also highlighted that the patient discharge program — an essential component of continuing care and treatment — was considered undesirable. The design and implementation of an efficient follow-up system for psychiatric patients' post-emergency discharge appear necessary to mitigate the rising prevalence of psychological disorders. Further research is needed to explore this area in greater depth.

5.2. Limitations

Using convenience sampling to select patients may limit the generalizability of the study results. However, as a strength, we utilized a valid and reliable observational tool — the QPsychENCS — to assess the quality of care. Its use, nonetheless, could potentially influence the behavior of both patients and nurses. To mitigate observer bias, the researcher initially spent several sessions in the research setting during various shifts without collecting data before completing the checklist.

Acknowledgements

The researchers would like to thank all the participants of the Emergency Department of Shahid Beheshti Psychiatric Teaching Hospital who cooperated with us regarding the conduction of this study.

Footnotes

Authors' Contribution: M. R. contributed to idea generation, data collection and analysis, drafted the final report, and edited sections of the manuscript. F. R. provided supervision, participated in idea development, data analysis, and edited multiple sections. K. A. was

involved in data collection, analysis, and drafting and editing portions of the manuscript.

Conflict of Interests Statement: The authors declare no conflict of interest.

Data Availability: The dataset presented in the study is available on request from the corresponding author during submission or after publication.

Ethical Approval: This study is part of an approved research project (ID: A-11-78-16) conducted under the IR.ZUMS.REC.1400.036 code of ethics at Zanjan University of Medical Sciences (ZUMS).

Funding/Support: The present study received no funding/support.

Informed Consent: Participants were given detailed information, both written and oral, regarding the study's objectives, confidentiality, voluntary nature of participation, and the option to withdraw at any point. Patients or their legal guardians and nurses provided written informed consent.

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