Exploring the person-centred care practice patterns of mental health nurses in Newfoundland and Labrador: A mixed methods study

Isler, C. I., Maddigan, J., Burry, R. D., & Gaudine, A. P.

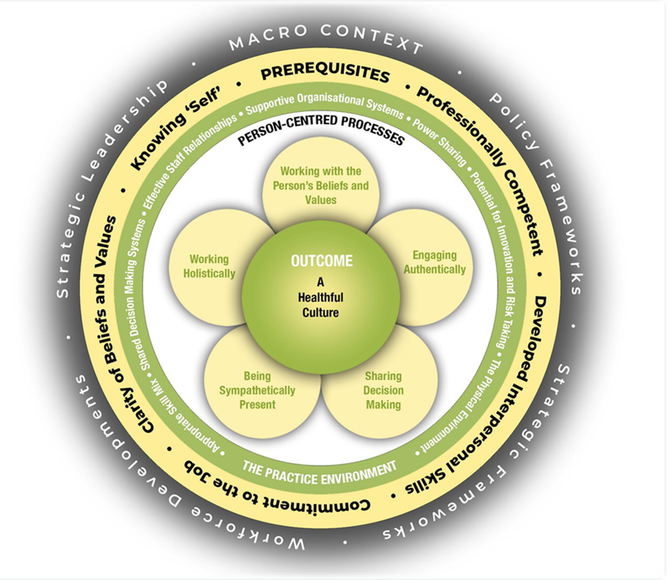
Memorial University of Newfoundland, Faculty of Nursing

INTRODUCTION

Person-centred care (PCC) is the humanizing of healthcare delivery, prioritizing the needs and preferences of individuals and families.[1-3] PCC can result in improved patient satisfaction[4-5] and improved health outcomes such as increased self-efficacy, shorter hospital stays, and better functional performance.[6-9] However, operationalizing PCC can be challenging throughout health systems.[10] Contextual issues in mental health settings such as disempowerment, forms of coercion, and questions about decisional capacity[11-12] can create a particularly challenging environment for PCC to flourish. The landscape of person-centred mental health nursing care in Newfoundland and Labrador (NL) has yet to be mapped. In order to advance person-centred mental health nursing care within the province, more evidence is needed on the PCC practices that currently exist. The purpose of this study is to better understand the prevalence and nature of PCC being delivered by mental health nurses in NL.

FRAMEWORK

The person-centered practice framework[13] was used to guide the design and implementation of the study. As seen below, there are two prerequisites to PCC: 1) key attributes of nurses and 2) environmental characteristics. The person-centred process is the component of the framework that focuses on the patient in their context.[13] Finally, person-centred outcomes demonstrate the expected benefits of effective PCC.



PATIENT PARTNERS

A partnership with The Pottle Centre, a social centre for those living in the community with mental illness, facilitated the formation of an Experience Expert Advisory Group. Seven members of The Pottle Centre met to: 1) clarify and affirm the importance of research questions, 2) review proposed data collection methods, and 3) assist in interpreting data.

RESEARCH QUESTIONS

Research Question: What are the PCC practice patterns exemplified by mental health nurses in NL?

Sub-Questions:

1) What are the self-reported PCC practices of mental health nurses?

2) To what extent is the practice environment associated with the delivery of PCC?

3) What occupational, environmental, and demographic factors predict nurses' delivery of PCC?

4) What are the occupational and demographic factors that predict a PCC environment?

5) What is the nature of the tertiary inpatient care culture as demonstrated by unit observations?

6) What are the PCC perspectives of individuals who have received mental health nursing care in the past year?

METHODS

This study is a concurrent mixed-methods design. The quantitative component is a descriptive cross-sectional design, and the qualitative component uses a nursing methodology, interpretive description.[14]

Quantitative Methods

The quantitative methods addressed research sub-questions one through four. All mental health and addictions (MH&A) registered nurses (RNs) working in NL were invited to participant in an online survey that included: 1) 13 demographic and occupational questions and 2) The Person-Centred Practice Inventory-Staff (PCPI-S).[15] Descriptive and inferential statistics were used to address the four quantitative research questions.

Qualitative Methods

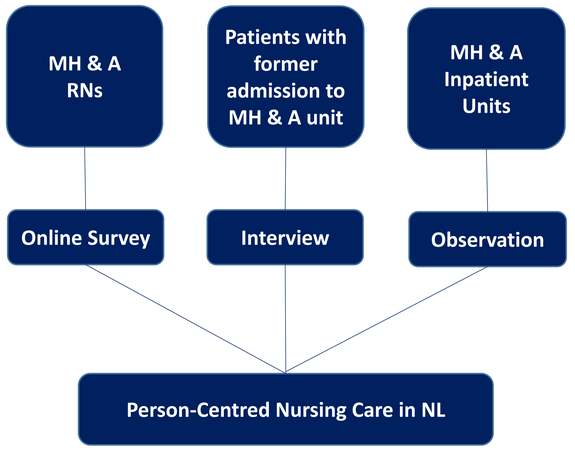
Qualitative data collected during structured inpatient unit observations addressed sub-question five. Three mental health units in Waterford Hospital, St. John's, were used for data collection. Wilson et al. (2020)'s Workplace Culture Critical Analysis Tool Revised (WCCATR)[16] was used to collect qualitative data on the PCC culture of each unit. Data was collected in 2 hours time intervals and each unit was observed for a total of 12 hours. Constant comparative method was used to analyze observational data.

Data collected during patient interviews addressed sub-question six. Individuals who received direct inpatient mental health nursing care in the past year were invited to be interviewed. Eight individuals participated in an interview where their experiences of receiving PCC were explored in-depth. Constant comparative method was used to analyze interview data.

Integration

The Pillar Integration Process (PIP) was chosen as the methodology for the integration phase of the study.[17] PIP is a four-stage technique designed to integrate qualitative and quantitative data using joint display tables (Johnson et al. 2019).[17] For the purpose of this study, an additional step was implemented to further integrate the 17 integrated themes and develop the PCC practice patterns of mental health nurses.

METHODS



RESULTS

Three practice patterns were developed from 17 integrated themes to describe the how nurses conduct and navigate their practice within the mental health care environment locally. These patterns captured the complex interrelatedness of the nursing attributes, the care context within which they work, and the delivery of PCC.

Practice Pattern One: *Mental health nurses maintain a separation from patients and often deliver nursing care from a distance.*

The majority of the care provided on inpatient units did not require the nurse to spend time "with" the person and was task-based. Nurses were competent in assisting patients in moving through the day and were responsive to their physical needs. However, they were less likely to implement interventions or activities that were supportive of the individuals' mental health (e.g. provide programming or other therapeutic activities, spend private one-on-one time with patients to discuss their mental health concerns). Nurses often stayed together in the nursing station and individuals remained on the outside; often, nurses responded to their requests for care from inside the nursing station. Adequate staffing levels and skill mix did not change these practices.

Practice Pattern Two: *Mental health nurses practice in an organizational culture that supports the status quo, which is not person-centred care.*

The evidence indicates that nurses do not facilitate decision-making directly with individuals in their care. Further, many nurses do not have a strong clarity regarding their professional beliefs and values or a strong commitment to the job. However, the evidence also indicates that nurses are working in an organizational cultural that does not promote these personal attributes and no resources were identified that would build nurses' capacity to engage in PCC with individuals. Nurses also demonstrated little capacity to practice innovation and risk taking, which suggests that nurses are working in a risk-adverse environment with reduced autonomy to provide PCC. It was also evident that although nurses were active members of collegial teams, they continue to work in a hierarchical system with little evidence of power sharing.

RESULTS

Practice Pattern Three: *When mental health nurses and individuals co-engage in person-centred moments, the results are inspiring and foster hope*

Although there was scant evidence of shared decision-making in the practices of mental health nurses, findings suggest that nurses did have the professional knowledge and skills to engage therapeutically with individuals and families and co-create trusting relationships. When nurses took the time to get to know and understand their patients, individuals felt accepted and supported.

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CONTACT

Chantille Isler RN PhD Email: v43cihb@mun.ca

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