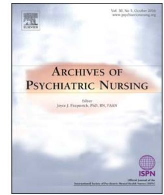
Archives of Psychiatric Nursing 31 (2017) 614–623

Contents lists available at ScienceDirect

Archives of Psychiatric Nursing

journal homepage: www.elsevier.com/locate/apnu



Categorising Patients Mental Illness by Medical Surgical Nurses in the General Hospital Ward: A Focus Group Study

Scott Brunero[a,*], Niels Buus[b], Sandra West[c]

[a] University of Sydney, Australia
[b] Faculty of Nursing and Midwifery, University of Sydney; St. Vincent's Hospital Sydney, St. Vincent's Private Hospital Sydney, Australia
[c] Faculty of Nursing and Midwifery, University of Sydney

A R T I C L E I N F O

KEYWORDS:
Nurse
Medical surgical nurse
Mental illness
Categories
Discourse analysis
Acute care
General hospital
Nursing

A B S T R A C T

AIM: To gain insight into medical surgical nurses' process(es) of categorising mental illness in general hospitals.
BACKGROUND: Categorising patients is a daily social practice that helps medical surgical nurses understand their work and actions. Medical surgical nurses' categorising of mentally ill patients in general hospitals is a means in which they articulate their understanding of mental illness and perform their clinical practice. How medical surgical nurses categorise, and the impact that categorising can have on their work practices is poorly understood.
DESIGN: A focus group study.
METHOD: Focus group discussions ($n = 2$) of medical surgical nurses' understanding and experience of delivering care to patients with mental illness in a general tertiary referral hospital were conducted in November 2014. Discourse analysis was used to analyse the transcribed data to uncover how participants made discursive evaluations and how this related to their daily clinical practice.
RESULTS: The analysis uncovered participant's use of four categories of mentally ill patients: the managed, the unpredictable, the emotional and the dangerous. For participants these categories explained and justified their clinical practice as linked to the challenges and barriers they experienced in providing effective care within the larger healthcare organisation.
CONCLUSION: The language used by medical/surgical reflects the wider discourse of managerialism in healthcare organisations. The recognition of these categories can be used by educators, liaison mental health services and policy makers to reconsider service design and learning opportunities for medical surgical nurses to reduce stigmatisation of patients with mental illness.

INTRODUCTION

With the advent of mainstreaming within the Australian health care sector (AIHW, 2015), patients with mental illness along with those who develop mental illness in association with physical illness have become a significant population in general hospital ward settings (Barnett et al., 2012; Mehnert et al., 2014). As patients with mental illness also have an increased risk of physical health comorbidities and patients with a physical illness an increased risk of mental health comorbidities (AIHW, 2007), it this relationship between illnesses that health services frequently struggle to accommodate (Brenda Happell et al., 2016). Consequently, general hospital wards that have both in function and design largely remained focused on the treatment of physical illnesses. General hospital wards are no longer able to remain separate from the impositions perceived as being associated with the current and potential manifestations of a patient's mental illness and the treatment this requires (Giandinoto & Edward, 2014). The inability to avoid this comorbid relationship between physical and mental illness has resulted in medical surgical nurses (or those who do not see themselves as a mental health nurse) attempting to provide assessment and treatment for both mental and physical illnesses.

Medical surgical nurses are being challenged to provide care to mentally ill patients with; (i) a pre-registration education experience that does not leave them with high confidence levels in providing competent care for mental illness (B Happell & Platania-Phung, 2005); (ii) availability of only minimal assistance through consultation from mental health professionals; and (iii) providing care/working in a setting that has not been purposefully designed (Alexander, Ellis, & Barrett, 2016). The medical surgical nurses' daily struggle to provide care for patients with a mental illness is then further challenged

* Corresponding author.
E-mail addresses: scott.brunero@health.nsw.gov.au (S. Brunero), niels.buus@sydney.edu.au (N. Buus), sandra.west@sydney.edu.au (S. West).

http://dx.doi.org/10.1016/j.apnu.2017.09.003
Received 20 March 2017; Received in revised form 1 August 2017; Accepted 3 September 2017
0883-9417/© 2017 Elsevier Inc. All rights reserved.

by numerous factors that are largely beyond the control of individual nurses. Examples of some of the challenges include; organisational preparedness, available resources, the levels of mental health knowledge of other health care providers (Brunero, Jeon, & Foster, 2012) and issues of stigma that surround mental illness within the general ward settings (Alexander et al., 2016; Sinding et al., 2013).

Medical surgical nurses are also reportedly challenged by the language they perceive to be needed when interacting with patients who have a mental illness (the discourse of mental illness). This leads to the perception of others and reinforcing self-beliefs that they struggle with their communication skills (Alexander et al., 2016; Brunero, Jeon, & Foster, 2015). Medical surgical nurses often also lack the knowledge to use more established psychiatric medical discourses to characterise patients with a mental illness, such as seen in the DSM-IV (American Psychiatric Association, 2013). Categorisation processes can be used by people to make sense of their world, to justify and explain their own and others behaviour, to lay blame, and to mitigate evaluations (Potter & Wetherell, 1987). Categories are therefore frequently used as tools to assist medical surgical nurses in managing these complex patients (Alex, Whitty-Rogers, & Panagopoulos, 2013; Herr et al., 2006; Roberts, 2010; Sands, 2009). Further insight into how medical surgical nurses construct categories relating to patients experiencing mental illness may assist understanding of how categorisation influences clinical practice in general wards.

BACKGROUND

The process of categorising can explain a particular group of people in one way on one occasion but differently in another occasion, according to the attributes of the setting in which the group is observed (Potter & Wetherell, 1987). Categorisation has been explained from a social psychology persepective which sees it as a process for simplifying our perceptions of large groups of people or phenomena (Potter & Wetherell, 1987). Categorisation is seen to be constructed to the goals and tasks required by an individual, group of people or organisation. The process of categorisation can also be understood as having deliberate purposes, frequently to accomplish a social action (Griffiths, 2001). It has also been argued that categorising can lead people toward judgments that align with the views of a dominant group and that it can therefore bias an individual's perspective to the point where differences between categories can be exaggerated (Buus, 2011; Potter & Wetherell, 1987). What is emphasised here is that categorising is not a homogenous process and that each member of a category may have many things in common but also have many differences (McEvoy & Richards, 2007).

While categorisation is part of many everyday practices; little is understood about the impact it has on clinical practice (Aneshensel, Phelan, & Bierman, 2013; Crowe, 2000; Crowe, 2005). Mental health professionals use the terms ‘worried well’ and ‘serious mental illness’ as examples of categories used to describe mental illness (Frances, 2013). In emergency departments those with mental illness are also known to be categorised as ‘the frequent flyer’ or ‘the psych patient,’ but little is understood about the categorisation practices which produce such categories and their functions within professional practices (Aagaard, Aagaard, Aagard, & Buus, 2014, Buus & Hamilton, 2016).

Health professionals use both formal and informal categories to describe clusters of presenting problems that continually occur in health care. In the context of this study, formal categorisation would typically refer to medical diagnostic terms whereas informal categories are likely to be used when patients do not fit nicely into formally established categories. Informal categorising within organisations has been described as allowing health care professionals to gate keep or exclude certain groups of patients according to their perceived demands on the professionals (Griffiths, 2001; Rhodes, 1991). Categorisation can therefore also be understood as a process of either expressing the category implicitly or explicitly. Implicit categorisation is normally done by characterising personal properties without marking them as category bound, or without connecting them to the category name, which has been suggested to often avoid openly pejorative or exclusionary descriptive talk (Griffiths, 2001).Whereas explicit categorising uses the category name with or without descriptions of its properties, and as such be more likely associated with pejorative and exclusionary talk; for example the ‘frequent flyer’ (Graumann & Kallmeyer, 2002; Griffiths, 2001).

Further insight into how general health professionals construct categories relating to those patients experiencing mental illness could explain how categorisation influences clinical practice in general wards.

AIM

To gain insight into medical surgical nurses' process(es) of categorising mental illness in general hospitals.

DESIGN

The need for this study emerged from a broader series of studies into mental healthcare in general hospitals that identified the language or discourse use by general health professionals as worthy of further study (Brunero et al., 2012; Brunero et al., 2015). A focus group study was conducted with medical surgical nurses from two ward areas within an Australian tertiary referral metropolitan hospital to investigate how participants established categories of mental illness and legitimised them in the focus group discussions. Discourses, such as those found in focus groups, are regarded as patterns of ways of representing phenomena in language (Fairclough, 1992; Potter & Wetherell, 1987). Discourse analysis as described by Potter and Wetherell (1987) was therefore used to analyse the textual data. Discourse analysis regards language as a form of social practice and as a means of understanding how we form our experiences and relationship with others. Within the discourse, categories may be formed using our daily language and can be generated in the social interactions we engage in as talk with this language (Onwuegbuzie, Dickinson, Leech, & Zoran, 2009).

SAMPLE/PARTICIPANTS

An invitation to attend one of two focus groups to talk about their experiences of nursing patients with established mental illnesses within general wards was extended to medical surgical nurses working in two separate wards (one surgical and one infectious diseases ward) in a metropolitan tertiary referral hospital in Sydney Australia. Table 2 contains the socio-demographics of the study sample. The sample was made up of four nurses who have been reclassified as clinical nurse specialists, which assumes a higher level of education and experience compared to the remainder of the sample, which should be consider in light of the study findings and any further research generated from this paper. Inclusion criteria for participants were: nurses who had direct patient exposure, and those that described themselves as primarily medical surgical nurses without substantial mental health experience. The term “mental health patient” is used to describe a patient with a primary mental illness in this study.

DATA COLLECTION

The focus groups began with an explanation of the purpose of the discussion. The questions outlined in Table 1 were then used to guide the discussion loosely, but their concrete use was dependent upon the flow of the discussion and what was deemed of priority for the group. Broad questions were used as to allow a ‘natural’ discussion of the phenomena which is typically seen in this methodology (Onwuegbuzie et al., 2009; Potter, 1996). The focus groups lasted for approximately 60 min, were audio recorded and transcribed in detail over several sessions by the authors. There was only one interviewer for the focus

Download English Version:

https://daneshyari.com/en/article/6786883

Download Persian Version:

https://daneshyari.com/article/6786883

Daneshyari.com