

Short Communication

Four Hurdles in the Assignment of Nurses in Residential Psychiatric Care

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Abstract

Nurses are assigned to a patient for his or her entire hospital stay. However, patients' needs change during the period of their recovery. The aptitude of the assigned nurse does not always match these changed needs. The results of a study on nurse aptitudes to care for depressed patients indicate that, as a patient's depressive feelings change, a nurse with an aptitude that supports the patient's current needs should be assigned to care for that patient. This suggestion is at odds with current assignment practices. This paper explores this new way of thinking about nurse assignment in residential psychiatric care and delineates four hurdles to take.

INTRODUCTION

In residential psychiatric care, assignment of nurses is based on the principles of primary nursing [1] and the use of the therapeutic relationship [2]. The former results in an assignment of nurses to each patient for his or her entire hospital stay. The latter results in a process of establishing and maintaining a healing relationship where the focus is on the patient and his or her needs. During their recovery in hospital, patients' needs change because of the change in functioning. Despite this change the nurse assignment remains fixed. The main argument is that establishing a therapeutic relationship is tough and thus can hardly be realized with more than one nurse. Besides knowledge and skills, aptitude is an important component of competence [3]. A study on nurse aptitudes to care for depressed patients [4] indicates that nurses have differing mixes of aptitudes and that some aptitudes are associated with the recovery of different aspects of feelings of depression of the patient. Hence to realize patient centered care, nurse assignment should change, as a patient's needs change.

MATERIALS AND METHODS

The study on assignment of nurses to patients with depression based on aptitude comprises 119 nurses and 122 patients on 14 psychiatric wards of general and psychiatric hospitals in Flanders, a region of Belgium [4]. The main hypothesis is that the assignment of nurses to patients requires management, as there is a positive association between the nurses' aptitudes and the outcome of their care to particular types of patients. Methods used are CatPCA [5]; parametric IRT [6]; nonparametric IRT [7]; correlation and partial association [8]; measure of concordance [9] and ridit analysis [10].

RESULTS AND DISCUSSION

All nurses have aptitude in caring for depressed patients and their aptitude differs individually. The aptitude can be grouped into three levels that are labeled novice, proficient and master based on the overall aptitude to care for depressed patient. The aptitude is further characterized by two other constructs that reflect the *aptitude for maintaining boundaries* and the *aptitude for empowering patients*. Each of these constructs can be typified by attributes of nurse behavior, called a therapeutic style. For maintaining boundaries either the nurse can focus on the patient or can rely on her self-awareness. For empowering patients either the nurse can rely on therapeutic use of self or empowers by establishing rapport. This is in line with findings of Dziopa & Ahern who found three styles that nurses use to develop therapeutic relationships [11]. Change in the patients' depressive feelings occurs along two components of dysfunction: performance impairment and negative attitudes towards self, the former being more biological and the latter more psychological in nature.

While empowering patients by establishing rapport **novice nurses** are associated with improvement in overall change in intensity of depressive feelings and change in performance impairment. While empowering patients by therapeutic use of self, novice nurses are associated with change in type of functioning from performance impairment to negative attitudes towards self.

Proficient nurses are associated with improvement in change in performance impairment while empowering patients by therapeutic use of self. Compared to novice nurses proficient nurses have the same effect on patients but with another therapeutic style for empowering patients.

Master Nurses are associated with improvement in change in negative attitudes towards self while empowering patients by establishing rapport or by maintaining boundaries while being self-aware. These nurses are the only ones who are associated with the improvement of change in negative attitudes towards self or the more psychological component of dysfunction of depressed patients. Remark also that master nurses use the same therapeutic style of novice nurses (empowering patients by establishing rapport), which results in another effect on the depressed patient: change in performance impairment for novice nurses and change in negative attitudes towards self for master nurses.

These results show that the type of dysfunction of the patient can be remedied by a therapeutic style of a nurse with another level of aptitude. To optimize patient centered care it is important to know the type of dysfunction of the patient because this type determines the nurse to be assigned. Therefore a systematic screening of patients' functioning is mandatory. Several self rating scales are available for different psychiatric syndromes. Nursing practice should incorporate systematic use of these scales to monitor patient evolution. This is a first hurdle to take in contemporary psychiatric nursing practice. Psychiatric nurses are educated to know the symptoms and ways to cope with. They are trained to use rating scales in a diagnostic phase but not in a systematic way during hospital stay. Moreover they tend to use rating scales for care providers instead of self rating scales for patients. Haspeslagh & Delesie [12] showed that nurses and patients have an opposing opinion on the depressive feelings of the patients. Hence the nurses assess the depressive feelings differently which questions their ability to join the patients' view and adapt their care accordingly.

Besides knowing the changing needs of the patients during their hospital stay, recognizing and knowing the aptitude of

nurses is also mandatory. (Figure 1) and (Figure 2) show bias in the opinion of the nurses. For the aptitude study [4] each nurse of a team rated her own aptitude and that of all her colleagues based on 14 established criteria [13]. This enables aggregation of their opinions in two ways: (1) from every nurse over all her colleagues (called FROM opinions) and (2) from all colleague nurses over one and the same nurse (called ON opinions). In (Figure 2) a quasi normal distribution of opinions shows up. This corresponds to the expectation that most nurses have rather identical opinions about one nurse's aptitudes besides some that assess more positively/negatively the aptitudes of that specific nurse. In (Figure 1) the distribution is skewed to the higher Wt values, which shows that the concordance in opinion is higher when the opinion of the nurses is aggregated from one specific nurse. This does not correspond to the expectation that the aptitude of the colleagues determines the opinion of the nurse rated by the 14 criteria. Instead the viewpoint of a specific nurse determines more the opinion over the colleagues. This shows the bias in opinion of the nurses based on their own frame of reference [14]. Here is a second hurdle to take in contemporary psychiatric nursing practice. Nurses should be aware that their opinion is biased by their own frame of reference and that they have difficulty to assess the aptitudes of their colleagues. Given the existence of bias in the opinion about their colleagues one can question how to take into account the nurse opinion about the patient?

Psychiatric nurses are trained and educated in establishing and maintaining a therapeutic relationship with patients. This therapeutic relationship is the crux of psychiatric nursing [15]. Along with Peplau's model of interpersonal nursing [16] this therapeutic relationship passes through different phases. Based on the results of the aptitude study [4] one can hypothesize that the trust in the orientation phase is realized more quickly

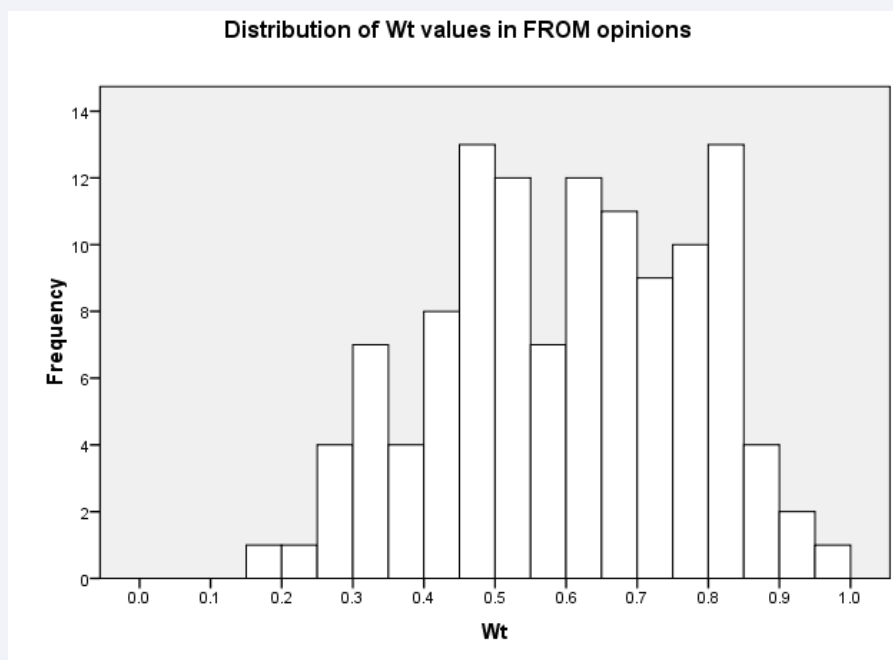


Figure 1 Bias in FROM opinions.

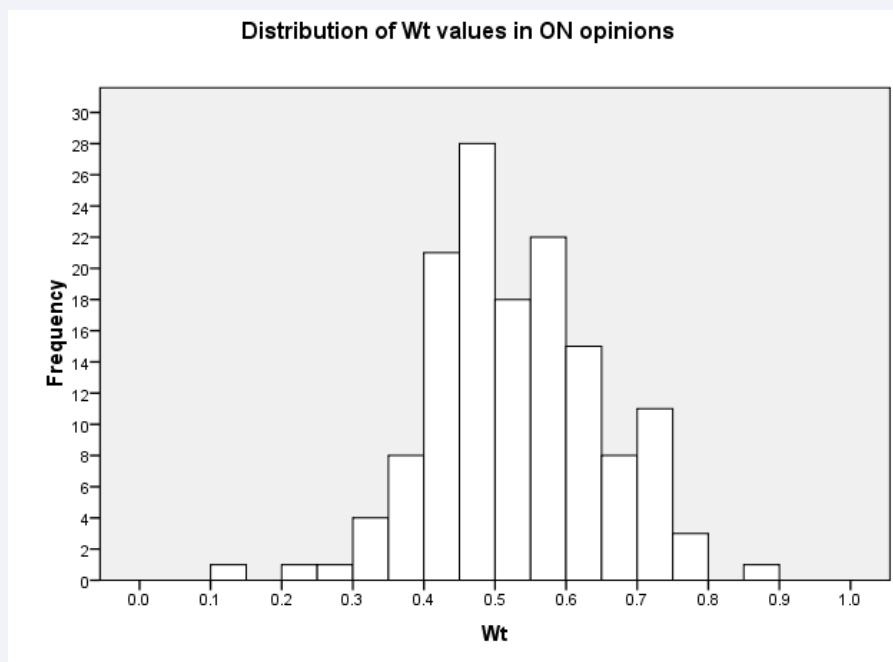


Figure 2 Bias in ON opinions.

by a nurse with a therapeutic style that matches the patient's dysfunction because of the more natural concordance between patient and nurse. Given the quick establishment of trust it is feasible to think that another nurse is capable of establishing a therapeutic relationship with the same patient, a nurse whose aptitude matches the changed needs of the patient during recovery. Moreover, on all psychiatric wards a multidisciplinary team cares for the patients. Other care providers also establish a therapeutic relationship with patients. So the therapeutic relationship is not exclusively the proprietorship of the nurses. This is a third hurdle to take in contemporary psychiatric nursing practice. Along other providers nurses also use the therapeutic relationship. The meta synthesis of Delaney & Johnson [17] found that inpatient psychiatric nurses need to articulate their practice so they can assert for the staffing and resources needed to keep units safe and promote patients' well being, strive toward quality, and promote the development of the specialty. The work of psychiatric nurses is poorly articulated and thus poorly understood. Apart from Delaney & Johnson [17] no studies are available that prove the healing contribution of psychiatric nurses in the recovery of patients suffering from psychiatric disorders.

The assignment pattern in residential psychiatric nursing care is based on the principles underlying primary nursing [1]. One nurse is assigned to one patient during the whole hospital stay of the patient. Patients recover and have changing needs during their recovery. The results of the aptitude study [4] suggest that another nurse with an aptitude that matches the patient's dysfunction at hand should be assigned. This is a fourth hurdle to take in contemporary psychiatric nursing practice. Are psychiatric nurses ready to admit that a changing assignment during hospital stay may enhance patient centered care? Are psychiatric nurses ready to think about new ways of assigning nurses to patients other than on the availability of nurses on a specific day?

CONCLUSION

Assignment of nurses in residential psychiatric care can be optimized in a more patient centered way. A systematic screening of the patients' status with a self rating scale can show the improvement in functioning of the patient during his or her hospital stay. This status is the basis for the assignment of the most apt nurse. This screening should also prevent the nurse to rely solely on her own opinion, which is biased. By relying on her aptitude and therapeutic style the nurse can establish more quickly trust in the therapeutic relationship. Assignment of nurses should be based on the status of the patients and their corresponding needs. This asks for a flexible way of thinking about nurse assignment to act correspondingly in favor of patient-centered care. Such assignment system is a version 2.0.

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REFERENCES

1. Manthey M, Ciske K, Robertson P, Harris I. Primary nursing. *Nurs Forum*. 1970; 9: 64-83.
2. Videbeck SL. *Psychiatric mental health nursing*. Philadelphia: Lippincot Williams & Wilkins. 2004.
3. Nordhaug O. *Human capital in organizations: Competence, training, and learning*. Oslo: Scandinavian University Press. 1993.
4. Haspeslagh M, Eeckloo K, Delesie LB. Aptitude-based assignment of nurses to depressed patients. *J Psychiatr Ment Health Nurs*. 2012; 19: 492-499.
5. Gifi A. *Nonlinear multivariate analysis*. New York: John Wiley & Sons. 1990.

6. Embretson SE, Reise SP. Item response theory for psychologists. Mahwah, N.J.L. Erlbaum Associates; 2000.
7. Mokken RJ. A theory and procedure of scale analysis. New York: Walter De Gruyter/Mouton; 1971.
8. Kendall MG. Rank correlation methods. London: Griffin. 1948.
9. Goodman L, Kruskal W. Measures of association for cross classifications. Journal of the American Statistical Association. 1954; 268: 732-764.
10. Bross IDJ. How to use ridit-analysis. Biometrics. 1958; 18-38.
11. Dziopa F, Ahern K. Three different ways mental health nurses develop quality therapeutic relationships. Issues Ment Health Nurs. 2009; 30: 14-22.
12. Haspesslagh M, Delesie L. Een onderzoek naar (A research for) de ontwikkeling van een informatiesysteem ten (an information system for) behoeve van het beleid. Case-studie over depressies in het algemeen ziekenhuis (general hospital) Sint-Jan te Brugge (at Brugge) [MS Thesis] Katholieke Universiteit (Catholic University) Leuven. 1992.
13. Haspesslagh M, Eeckloo K, Delesie L. Validation of a new concept: Aptitudes of psychiatric nurses caring for depressed patients. Journal of Research in Nursing. 2012; 17: 438-52.
14. Minkowski E. Le temps vécu. Delachaux. 1933.
15. Forchuk C, Metzger McQuiston C, Webb A, Hildegard E. Peplau. Interpersonal nursing theory notes on nursing theories. Newbury Park: Sage. 1993.
16. Peplau H. Interpersonal relations in nursing. New York: G.P. Putnam. 1952.
17. Delaney KR, Johnson ME. Meta synthesis of research on the role of psychiatric inpatient nurses: what is important to staff? J Am Psychiatr Nurses Assoc. 2014; 20: 125-137.

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