Experiences of Medical-Surgical Nurses In Caring for Patients Affected by Mental Illness

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Abstract

More than half of hospital beds in Canada are considered general ward or medical-surgical beds. When individuals affected by mental illness are admitted to hospital for physical health reasons, their average length of stay is twice as long as individuals without a mental comorbidity. Medical-surgical nurses play an important role in destigmatizing mental illness by promoting and providing competent, holistic, and integrated care to all patients they encounter. However, very little research has been conducted on this topic, and existing literature suggests that health-care providers working in non-mental health settings are not equipped with the knowledge and skills to safely care for these complex patients. The aim of this study was two-fold: to explore the experience of medical-surgical nurses in caring for mentally ill patients and to identify shared experiences among those nurses. Hermeneutic phenomenology was used to answer the research question: What is the lived experience of medical-surgical nurses in caring for patients with a mental health diagnosis? Interviews were conducted with 10 participants. Five themes emerged during data analysis: “hope in recovery”, “caring in complexity”, “the nurse-client relationship”, “moral distress”, and “change is needed”. Participants’ experiences were interpreted and discussed within the context of current literature. Study findings contributed to our understanding of the contextual factors that influence the experience of caring for patients with mental illness in medical-surgical settings and revealed barriers to achieving integrated, patient-centred, holistic care. Recommendations and implications for nursing practice and policy are provided.

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Chapter 1: Introduction

Individuals with mental health conditions face significant barriers that are pervasive in society. Their diagnosis exposes them to stigmatization or discrimination on a daily basis (Crisp et al., 2000; Phelan & Link, 1998). Many are denied housing, education, parental rights, and employment (Bonnington & Rose, 2014; Kirby & Keon, 2004). Public stigma impacts their quality of life and can compound unpleasant mental and physical symptoms (United States Departments of Health and Human Services, 1999). Furthermore, there are significant disparities in the physical health of people with mental disorders compared to those without these conditions. Severe mental illness is associated with higher rates of cardiovascular disease, diabetes, obesity, pulmonary disorders, and cancers (De Hert et al., 2011). According to Dai et al. (2020), physical and mental comorbidity is prevalent in Canada and the prevalence of mental disorders is directly proportional to the number of physical disorders.

In Canada, medical-surgical hospital stays for patients with mental illness are associated with increased length of stay and rehospitalizations (Germack et al., 2018; Jansen et al., 2018; Johansen & Sanmartin, 2011). Furthermore, patients often report having unmet care needs related to their mental health (Bagnasco et al., 2019; Johansen & Sanmartin, 2011). Medical-surgical nurses play an important role in destigmatizing mental illness and ensuring the needs of these patients are met by advocating for adequate support and the provision of the right care at the right time. However, the literature suggests that health-care providers working outside of mental health settings are not equipped with the knowledge, skills, or confidence to safely care for these complex patients (Giandinoto & Edward, 2015; Ross & Goldner, 2009).

Research related to the experience of nurses caring for patients with mental illness on medical-surgical units, especially research specific to Canada, is lacking. The purpose of this qualitative research project was to better understand the lived experience of medical-surgical nurses caring for patients with a mental health diagnosis and how these experiences can serve to improve direct patient care for those affected by mental illness.

Research Question

Hermeneutic phenomenology was used to answer the research question: What is the lived experience of medical-surgical nurses in caring for patients with a pre-existing mental health diagnosis?

Gaining insight into the experience of medical-surgical nurses is an important step in the identification of educational and organizational supports that are needed for safe, competent, holistic, and integrated care of medical-surgical patients affected by mental illness. Research findings may provide direction for future areas of study, offer pragmatic strategies to improve care outcomes for patients with severe mental illness, and influence nursing education and practice, as well as organizational policy.

Thesis Overview

In Chapter 1 an introduction to the thesis is provided. In Chapter 2, a review of the literature to identify gaps in knowledge related to the study topic is presented. Definitions for key terms are provided, the prevalence of mental and physical comorbidities is discussed, and the impact on care delivery is explored. The literature review provides context for the study and positions it within the existing literature on the topic.

In Chapter 3, hermeneutic phenomenology, the study's methodology, is described. The research method, including philosophical underpinnings and procedural steps, the researcher's role, and ethical considerations, are summarized.

In Chapter 4, a detailed description of study findings is presented. Themes and subthemes are identified and supported by the rich narrative descriptions given by study participants.

In Chapter 5, the findings, implications for nursing practice and policy, and strengths and limitations of the study are discussed and summarized.

Chapter 2: Literature review

Prior to the preparation of this research proposal, a literature review was conducted to identify research that had been published on this topic. Although some qualitative researchers may debate this step in the research process, reviewing the literature is supported and consistent with the selected methodology for this type of study (Streubert & Carpenter, 2011). The primary goal of a literature review in hermeneutic inquiry is to promote reflection (Smythe & Spence, 2012). A review also ensures that gaps in knowledge are identified, assists the researcher in determining the appropriateness of the selected methodology, and provides rationale and context for the identified problem (Creswell & Poth, 2018). However, the review is neither exhaustive nor conclusive (Smythe & Spence, 2012). Following the completion of the study, the literature review was updated as the researcher became aware of new and additional studies through reflection promoted by study findings and critique from the thesis advisor and committee members.

The literature and knowledge about the topic served as a contextual framework for analysis of the data collected. The databases used for the literature search included CINAHL, PubMed, Health Source, and Google Scholar. The main search terms were *mental illness, medical-surgical units, and nurses.* Other search terms were used in a variety of combinations and included *mental comorbidity, medical-surgical nursing, nurse experience, patient experience, mental illness, continuing education, mental health education, general ward,* and *lived experience*. Advanced search strategies were also employed for *medical-surgical nursing* OR *general hospital nursing* in combination with *mental health* OR *psychiatry* OR *mental comorbidity, mental health* AND *medical-*

surgical nursing AND *education,* and *medical-surgical units* AND *nurse experience* AND *mental illness*. No restrictions on publication dates were used in the literature search.

Only English publications were reviewed. Abstracts from all articles identified in the search were reviewed to determine the most relevant literature. Similarly, references from the selected articles were reviewed to identify additional relevant topics. Most of the selected studies originated in the United States, United Kingdom, Canada, and South Africa.

The review that follows summarizes the main themes identified in the literature: mental illness in medical-surgical settings, the disparities in care for persons affected by mental illness, and progress and gaps in nursing education. In conclusion, implications for research and practice are discussed.

Mental Illness in Medical-Surgical Settings

Comorbidity is defined as the simultaneous occurrence of two or more diseases or medical conditions (Valderas et al., 2009). By extension, physical and mental comorbidity is characterized as the diagnosis of a mental disorder in addition to a medical condition. Mental disorders include psychotic illnesses, mood disorders, substance use disorders, and personality disorders. The relationship between mental and physical illnesses is complex; while comorbidities can be unidirectional or bidirectional, the causes of these relationships are not well established (Smetanin et al., 2011). Patients are admitted to medical-surgical units for treatment of their medical condition, but many have one or more mental comorbidities.

Dai et al. (2020) found that physical and mental comorbidity is prevalent in Canada. According to Zolnierek (2009), 50% of individuals with a mental illness suffered

from an unknown medical condition, and one in five had a medical condition that exacerbates their mental illness. According to Mather et al. (2014), more than half of people (58%) affected by mental illness had a chronic medical comorbidity. There is recent data to suggest that individuals affected by medical conditions with comorbid mental illness relied more heavily on acute care services than individuals without a mental comorbidity (Abernathy et al., 2016). For non-mental health-related admissions in Canada from 2009 to 2010, 16.6% of the hospital days were associated with patients who had a diagnosis of a comorbid mental condition (Johansen & Fines, 2012).

Mental and physical comorbidities impact quality of life, life expectancy, health outcomes, and result in increased use of health services. Notably, this increased use is seen in the frequency and duration of acute care hospital admissions. Across Canada, “the length of stay for hospitalizations with a comorbid diagnosis of a mental condition is twice as long compared with those admitted without one” (Johansen & Fines, 2012, p. 5). In addition, patients with mental illness had an increased risk of suicidal and self-injurious behaviour, which can lead to injuries requiring hospitalization (Bolton et al., 2015).

From these data, it is reasonable to conclude that nurses working in medical-surgical settings interact with patients who have mental illnesses on a regular basis. Moreover, studies have shown that significant disparities exist in the care of individuals affected by mental illness when compared to the general population (Björkenstam et al., 2012; Daumit et al., 2016).

Disparities in Care

When compared to the general population, people with mental illness have faced significant disparities in health-care quality (Pope, 2011). Kirby and Keon (2004) reported that people with mental illness found the Canadian health-care system confusing, under-resourced, and in need of changes that improve the coordination of services. In Canada, hospitalized individuals with a mental comorbidity were more likely to report unmet care needs when compared to individuals without this comorbidity (Johansen & Fines, 2012; Statistics Canada, 2019). Poor communication, lack of involvement in decision making, basic physical care, and emotional support were examples of unmet care needs identified in medical-surgical settings (Bagnasco et al., 2019). In addition, individuals with severe mental illness often delayed seeking medical treatment, resulting in poor health status (Mojtabai et al., 2014).

Patients with mental illness were more likely to experience a 30-day hospital readmission, a common indicator of the quality of care (Germack et al., 2018). Furthermore, the findings from studies examining the quality of health care for persons affected by mental illness suggested that mortality rates and patient safety events were negatively impacted (Björkenstam et al., 2012; Daumit et al., 2016; Hert et al., 2011; Wahlbeck et al., 2011). Several authors have shown that the perception of health-care workers has also contributed to such disparities (Björkenstam et al., 2012; Daumit et al., 2016; Hert et al., 2011; Wahlbeck et al., 2011). Diagnostic overshadowing is one example of how perception impacts the quality of care. Further discussion about mortality rates, patient safety events, diagnostic overshadowing, and the perception of nurses is presented below.

Mortality rates

In a study comparing mortality rates of psychiatric and non-psychiatric patients in Sweden, the rates for psychiatric patients were found to be higher overall, and many deaths could have been prevented with treatment (Björkenstam et al., 2012). In a selective review of clinical data on physical health problems in people with severe mental illness, De Hert et al. (2011) explained that the mortality rate for persons affected by mental illness was two to three times higher than that of the general population which equated to a 30-year difference in life expectancy. While acknowledging the complexity of the relationship between mental illness and mortality rates, the De Hert review clearly demonstrated that inequities in the delivery of health-care service contributed to the difference in mortality rate. These authors stated that individuals with severe mental illness had high rates of obesity, diabetes, and cardiovascular disease, yet were less likely to be screened for metabolic risk factors or to receive the standard of care for diabetes, cardiac medication, and surgical interventions (De Hert et al., 2011). While the disparities in care discussed by De Hert et al. (2011) and Björkenstam et al. (2012) did not specifically mention the contribution of nursing to the health inequities in care delivery, the profession's integral role in the health-care system necessitates a better understanding of caring for patients affected by mental illness across all health-care settings.

Patient Safety Events

A patient safety event is any incident that occurs during hospitalization and has the potential to cause unintended harm (Canadian Patient Safety Institute, 2016). The patient safety literature regarding individuals with mental illness is minimal, yet the

available data consistently demonstrated that patients with mental illness were particularly vulnerable to increased risk of these events when hospitalized for non-psychiatric reasons (Daumit et al., 2016; Khaykin et al., 2010; Mather et al., 2014). In a quantitative study using nationwide inpatient sampling, Khaykin et al. (2010) reported on non-psychiatric hospital discharges across the United States between 2002 and 2007. They found that individuals with a secondary diagnosis of schizophrenia who had been hospitalized for non-psychiatric reasons were more likely to have decubitus ulcers, infections due to medical care, postoperative respiratory failure, sepsis, and pulmonary embolisms when compared to the general population (Khaykin et al., 2010).

Diagnostic Overshadowing

Diagnostic overshadowing is defined as the tendency to relate all problems to a previously diagnosed condition (Neurotrauma Law Nexus, 2018). According to the literature, physical health problems are often attributed to a person's mental illness. Patients with a mental illness were less likely to be diagnosed with medical comorbidities or to receive aspirin, statins, and other important medication to treat medical conditions (Briskman et al., 2012; De Hert et al., 2011). There is evidence to suggest that diagnostic overshadowing impacts nursing care. As an example, in a randomized study published by McDonald et al., 2003, 60 medical-surgical nurses were assigned to one of three groups and asked to make nursing care decisions in response to a presented vignette. The case given to two groups involved a psychotic patient who presented to the emergency department with symptoms of myocardial infarction (MI). The case given to the third (or control) group, was almost identical, except the patient had anxiety that was being managed at home. Nurses assessing the psychotic patient's

condition were less likely to believe that the patient was experiencing an MI and less likely to respond to additional symptoms.

Perception of nurses

Medical-surgical nurses work on general wards and specialized units (e.g., oncology, orthopedic surgery) in acute care hospitals. In Canada, 52% of hospital beds are considered general ward or medical-surgical beds (Canadian Institute for Health Information, 2018). According to the Canadian Association of Medical and Surgical Nurses:

> "Medical and Surgical nurses provide nursing care to adults experiencing complex variations in health. They utilize diverse clinical knowledge and skills to care for multiple acutely ill adults and their families. They are leaders at organizing, prioritizing, and coordinating care, as well as working with interdisciplinary teams. The practice of medical-surgical nursing requires application of evidence-based knowledge and best practice standards to provide quality, safe and ethical care to clients across the continuum of care. (2017, mission section)."

Caring for patients with a severe mental illness in 'non-mental health' settings can be challenging and overwhelming for nurses. In several studies examining the attitudes of health-care providers, and more specifically nurses, patients with mental illness were described as dangerous and unpredictable (Brunero et al., 2017; MacNeela et al., 2012; Ross & Goldner, 2009). This attitude appears consistent with the public's view of individuals with mental illness as reported by several authors (Giandinoto & Edward, 2015; Phelan & Link, 1998; Ross & Goldner, 2009; Wang & Lai, 2008). In a recent Canadian study, 96% of non-psychiatric nurses working in a hospital-based continuing

care setting recognized the importance of attending to the mental health needs of patients; however, only 68% expressed confidence in doing so (Gibson et al., 2015). Conversely, several earlier international studies indicated that the negative attitudes of medical-surgical nurses impacted their ability to care for patients with mental illness (Arnold & Mitchell, 2008; Atkin, Holmes, & Martin, 2005; MacNeela et al., 2012; Mavundla, 2000).

Medical-surgical nurses work in complex, fast-paced environments. Hart et al. (2014) found that while overall confidence in responding to deterioration of physical conditions was high, medical-surgical nurses appeared to feel less confident when faced with a deteriorating mental health event such as a change in mental status. Moreover, supporting mental health was not always viewed as part of the nursing role in medical-surgical settings where the primary focus was meeting the physical care needs of patients (Foye et al., 2020; MacNeela et al., 2012).

Progress and Gaps in Nursing Education

Undergraduate Education

Mental health advocates have long called for more mental health content in undergraduate nursing curricula (Kent-Wilkinson et al., 2016). In 2016, the Canadian Federation of Mental Health Nurses (CFMHN) published its third position paper on the matter that included an important statistic: almost one third of Canadian nursing schools did not include a mental health placement in their curriculum (Kent-Wilkinson et al., 2016). Efforts have been made to address gaps in mental health content in undergraduate nursing education. In 2015, the Canadian Association of Schools of Nursing and the CFMHN collaborated on the expansion of entry-to-practice mental

health and addictions competencies intended to promote the integration of mental health content into undergraduate nursing curricula. In 2017, the Registered Nurses Association of Ontario released a Nurse Educator Mental Health and Addiction Resource to support educators in developing mental health and addiction knowledge and skills amongst nursing students. Finally, the College of Nurses of Ontario (2019) updated entry-to-practice competencies for RNs to include competencies specific to mental health promotion and recovery-oriented practice.

While educators may recognize the value of clinical experience in mental health settings, nursing schools are faced with clinical placement shortages across care settings (Council of Ontario Universities, 2013; Happell et al., 2014). Nurse educators are challenged to find creative and effective ways to include effective, hands-on mental health experience to support students in meeting entry-to-practice mental health and addictions competencies. Kent-Wilkinson et al. (2016) recommended expanding mental health placements to include settings such as senior centres, homeless shelters, and correctional centres. However, Happell and Platania-Phung (2012) found clinical placements in general settings did not adequately prepare students in caring for patients with mental illness. These findings highlight the need for clinical placements in mental health settings to better prepare nursing students for future practice. Role-play, simulation, and activities that facilitate relationship-building with persons with lived mental health experience have also been shown to improve mental health knowledge and reduce mental health stigma amongst nursing students (Gu et al., 2021; Happell et al., 2014; Patterson et al., 2018).

Continuing Education for Medical-Surgical Nurses

The strategies to support medical-surgical nurses who care for patients with mental illness that are identified in the literature are consistent. Training and education are unfailingly recommended for achieving holistic, integrated nursing care for patients with mental illness in medical-surgical settings (Avery et al., 2020; Gibson et al., 2015; MacNeela et al., 2012; McDonald et al., 2003; Reed & Fitzgerald, 2005). Despite this, the strategies related to education, training, and support with the aim of promoting holistic nursing care for mentally ill patients in acute care wards have been described as "more theoretical than pragmatic" (Alexander et al., 2016, p. 268). One study conducted by Gibson et al. (2015) identified short lectures, case studies and increased specialized mental health support as the preferred education strategies for increasing capacity in mental health. However, no studies examining the effectiveness of educational strategies amongst medical-surgical nurses were found.

Implications for research and practice

The current structure of health-care delivery in Canada is fragmented with barriers at three levels—the system, the organization, and the provider. These barriers impact the quality of care offered to patients with a mental illness diagnosis who are hospitalized for medical reasons. Provincial and national mental health strategies highlight the need for improving access to health services, reducing stigma, and promoting education of patients, families, and health-care providers (Mental Health Commission of Canada, 2012; the Ontario Ministry of Health and Long-Term Care, 2011). Nevertheless, current research and knowledge related to the provider experience of caring for patients with a mental illness outside of mental health settings in Canada

are lacking. There is minimal available literature describing nursing care in medical-surgical settings for patients affected by mental illness. The attitudes and knowledge of nurses are emphasized in the literature, as opposed to the social, political, and organizational contexts that may influence this experience. Since no studies were found that investigated the lived experience of nurses in caring for patients with a pre-existing mental health diagnosis in medical-surgical settings in Canada, this study aimed to provide a more complete, contextualized understanding of this area of interest. The knowledge gained from this study can potentially improve medical-surgical nurses' ability to care for patients affected by mental illness. Similarly, the information gained may benefit education, research, and policy within and beyond medical-surgical nursing practice.

Chapter 3: Research Design

In this study, hermeneutic phenomenology (HP) was used to gain a deep understanding into the lived experiences of medical-surgical nurses caring for patients with a mental health diagnosis. Phenomenology is both a research method and a philosophy (Cohen et al., 2000; Streubert & Carpenter, 2011; Creswell & Poth, 2018). HP has been described as a valuable methodology for exploring phenomena that have not been defined, investigated, or adequately contextualized (Creswell & Poth, 2018). The method is considered useful in studying a new topic or a topic that has been studied but requires a new perspective through a different lens (Cohen et al., 2000). As noted earlier, current knowledge related to nursing care for patients affected by mental illness in medical-surgical settings is minimal and emphasizes attitudes and knowledge of nurses. This study attempts to address the meaning of the experience and the context that may influence this experience among nurses. The research method, strategies to ensure trustworthiness, and ethical considerations were consistent with hermeneutic phenomenology and are summarized in this chapter.

Research Method

Philosophical underpinnings

Edmund Husserl (1857–1938), Martin Heidegger (1889–1976), Maurice Merleau-Ponty (1905–1980), and Jean-Paul Sartre (1905–1980) were prominent influencers of phenomenological philosophy (Smith et al., 2009). Husserl established the relevance of understanding the human experience and is recognized as the founder of phenomenology (Klein & Westcott, 1994; Smith et al., 2009). Heidegger, Merleau-Ponty, and Sartre further developed phenomenological philosophies with unique

contributions toward an interpretive perspective “with a focus on understanding the perspectival directedness of our involvement in the lived world – something which is personal to each of us, but which is a property of our relationships to the world and others” (Smith et al., 2009, p. 21). HP research is rooted in the works of these four philosophers and involves careful consideration of the relationship between context and knowledge (Creswell & Poth, 2018; Streubert & Carpenter, 2011).

Another central philosophic underpinning of HP is hermeneutics, the theory of interpretation (Smith et al., 2009). Through interpretation, HP researchers seek to understand the meaning of experiences that “are not always apparent to the participants but can be gleaned from the narratives produced by them” (Lopez & Willis, 2004, p. 728). HP differs from other phenomenological methods in that researchers are not expected to bracket preconceived notions, as the conscious separation of what is known about the phenomenon under study contradicts the prominent assumption in HP that “consciousness is essentially engaged in the world” (LeVasseur, 2003, p. 415). Instead, HP acknowledges the influence and knowledge of the investigator in the research process, which adds richness to the interpretation of data (Lopez & Willis, 2004).

Researcher’s role

Qualitative research is a co-production of knowledge between researcher and participant (Karnieli-Miller et al., 2009). The researcher’s personal, professional, and educational background is considered a valuable aid in guiding research (Lopez & Willis, 2004). The researcher is a registered nurse with a Bachelor of Science in Nursing degree and is currently enrolled in the Master of Psychiatric Nursing program at

Brandon University. The researcher is certified in psychiatric and mental health nursing through the Canadian Nurses Association. Areas of current practice include community mental health crisis nursing and nursing education. The researcher's previous experience includes nursing care in acute care mental health, medicine, hemodialysis, and primary care. In nursing practice, the researcher has encountered many patients who require medical-surgical hospital admissions and has observed certain aspects of care are often neglected or missed. Additionally, the researcher has worked with medical-surgical nurses on various corporate committees and often heard comments such as "I could never work in mental health; I struggle with those patients." These experiences piqued the researcher's interest in the study topic and fueled a passion and curiosity needed to sustain the project. The researcher's nursing practice is recovery oriented. The researcher has no associated conflicts of interest.

Participant selection

Criterion and snowball sampling were used in this study. Criterion sampling is a form of purposive sampling often employed in HP to ensure information-rich cases. It involves selecting participants based on inclusion criteria to ensure they "have experienced the phenomenon and must be able to articulate what it is like to have lived that experience" (Polit & Beck, 2016, p. 499).

Participants were required to meet the following inclusion criteria:

1. Be a registered nurse currently employed on an acute medical/surgical unit
2. Have practiced a minimum of two years in medicine or surgery
3. Fluent in English
4. Have no previous professional mental health experience

5. Have cared for a minimum of one patient in a medical-surgical setting with a co-morbid mental health diagnosis

Initially, the researcher utilized their own professional knowledge and experience to identify three participants that adhered to the identified inclusion criteria. Snowball sampling was employed to identify additional participants. Each participant interviewed was asked to recommend two to three medical-surgical nurses based on their knowledge, practice, and the inclusion criteria. A letter of invitation was emailed to potential participants, asking them to contact the researcher to schedule an interview if interested (Appendix A). Recruitment was ongoing throughout the study and occurred simultaneously with data collection and analysis. The size of the sample was "considered adequate when interpretations are visible and clear, new informants reveal no new findings and meanings from all previous narratives become redundant" (Crist & Tanner, 2003, p. 203). A total of 10 nurses participated. At the time of the interviews, all participants worked in medical or surgical units in Ontario, Canada.

Data generation and treatment

Data generation in HP typically involves at least one interview with each participant to gain a rich description of the participant's experiences (Crist & Tanner, 2003). Information about the lived experience of participants in the study was collected using semi-structured interviews and observations. Interview questions used in the study are outlined in Appendix B. In addition to open-ended questions related to the phenomena of interest, demographic information such as age, gender, highest level of education, years of nursing experience, years of medical-surgical practice, and current area of employment was collected in each interview.

The researcher conducted in-person interviews with participants and recorded observations of body language and vocal intonations or expressions throughout the interviews. Interviews were audio-recorded and transcribed by both the researcher and a transcriptionist based on availability. All interviews transcribed by the transcriptionist were reviewed by the researcher for accuracy. Interviews and observations were analyzed concurrently, alongside the recruitment of participants (Crist & Tanner 2003).

In some studies, follow-up interviews are conducted to provide an opportunity to elaborate on specific issues and to obtain reflections of participants on the researcher's interpretations from previous interviews. This practice, known as member checking (Crist & Tanner, 2003), is a process employed to enhance the trustworthiness of a study (Carlson, 2010). Member checking can include a range of activities such as follow-up interviews, focus groups, and returning full or partial transcribed interviews to participants as a way of ensuring data accuracy (Birt et al., 2016). Follow-up interviews for member checking are a controversial practice. It has been described as incongruent with the philosophical underpinnings of HP because researchers may "guide the participants in the direction they desire" (McConnell-Henry et al., 2011, p. 31). For this reason, only one interview was conducted with each participant. However, member checking was conducted by providing each participant with a copy of their transcribed interview to verify its accuracy.

Data analysis

The process of interpretation in HP is often referred to as the hermeneutic circle. As the name denotes, this process is not linear yet can be generally presented in three stages. Data are examined as a whole, and initial thoughts are conceived (naive

reading), patterns of meaningful connection are identified (structural analysis), and a comprehensive understanding is sought through a reflection of the naive reading and structural analysis (interpretation of the whole) (Streubert & Carpenter, 2011). Overlap of each phase is inevitable as the researcher "strives to uncover and explicate practical understanding of the phenomenon" (Allen & Jensen, 1990, p. 244). The researcher analyzed data following a five-step interpretive process proposed by Crist and Tanner (2003). The circular nature of the interpretive process, which occurred simultaneously with data collection and ongoing recruitment, was important. While the phases of interpretation undertaken are described as a progression, overlaps occurred between phases.

The first stage of interpretation is early focus and lines of inquiry. In this step, the researcher read and re-read whole transcripts from initial interviews. Passages deemed pertinent were highlighted. By becoming acquainted with the data, the research identified areas that required further exploration in subsequent interviews. Through this process, the researcher was also able to identify areas for improvement on their part. For example, a review of initial interviews found that the researcher at times ended topics abruptly and learned to incorporate more reflections and open-ended discussion in the interview process.

As a second step, central concerns and themes for individual participants were identified and summarized through interpretive writing and rewriting. The researcher entered pertinent passages into an Excel spreadsheet and noted initial thoughts and reflections for each passage. As central concerns for each participant emerged, they were included in the spreadsheet. By reviewing the written interpretations of the

individual central concerns, the researcher began to identify shared meanings and themes amongst participants. Crist and Tanner (2003) described this third step in the process as observing the “connections between meanings found within and across stories, or constitutive patterns” (p. 204). Potential themes and shared meaning were reviewed in detail. The researcher used Excel to sort central concerns and themes alphabetically which helped group similar passages and interpretations together for comparison.

In the fourth step, the themes identified through interpretive writing (or final interpretations) were used to clarify and support interpretations of data gathered in final interviews. Pertinent passages from final interviews that supported the previously identified themes were entered into the Excel database. In the fifth and final step, a manuscript of interpretation was completed, and an audit trail was developed. The manuscript of interpretation included a brief summary of each theme and supporting descriptions from the data. The manuscript was discussed in detail with the thesis advisor who helped to refine the language for identified themes. The audit trail included all raw data, data analysis and notes, and instrument information such as interview questions and schedules.

Study Integrity

The researcher selected integrity as the term that guided their efforts to support the scientific adequacy of the study. Watson and Girard (2004) contended that while qualitative research often borrows terms such as rigour and reliability from quantitative methodologies, the term integrity is more congruent with hermeneutic phenomenology. Watson and Girard (2004) reviewed the components of integrity (wholeness, honesty,

and soundness) as they relate to and support the philosophical tenets of interpretation. Each of these aspects of integrity was considered throughout the research process as the researcher endeavoured to ensure the topic was well examined and well explained.

Wholeness

Watson and Girard (2004) consider wholeness in the hermeneutic approach as the researcher's ability to find meaning through the fusion of understanding one's own history and assumptions, dialogue with participants, and consideration of the wider context. The researcher was aware of their role in the research and provided a clear and detailed description in the section on research methods. Additionally, wholeness was reflected in the application of the data analysis process in which the researcher entered the hermeneutic circle to seek a comprehensive and complete understanding of the experience. Lastly, a more comprehensive understanding of the experience was achieved through triangulation of space. The researcher used purposive sampling to ensure that selected participants worked in different units and across different organizations in Ontario, Canada.

Honesty

According to Watson and Girard (2004), honesty is manifested when the meanings derived from raw data, or the text, are done in a way that supports the truth of participants. To establish honesty as a key component, the thesis advisor helped guide the development of the themes for the study. Additionally, quotes of participant descriptions were used to support and explicate each theme and subtheme. Finally, honesty was demonstrated with the use of an audit trail that ensured decisions related

to data analysis were documented. The audit trail included all raw data, data analysis and notes, and instrument information such as interview questions and schedules.

Soundness

Soundness is expressed in the dissemination of the research and essentially means the study is well explained; the story is told in a manner that readers find plausible (Watson and Girard, 2004). The researcher worked closely with the thesis advisor to ensure that the story was told in a sound manner. Similarly, the researcher also invited other thesis committee members to critique and offer their expertise to build a comprehensive report that is clearly explained and easily understood.

Ethical Considerations

The study posed minimal risk to participants. However, the complex nature of qualitative research presented ethical concerns that were considered during the design of the study. The aim was to maintain ethical principles while protecting the participants (Streubert & Carpenter, 2011). Research ethics approval was obtained from Brandon University Research Ethics Committee (BUREC) prior to commencement of the study (see Appendix E for Ethics Certificate).

The circular nature of recruitment, data collection, and analysis in HP requires that participants' consent be re-evaluated throughout the process of obtaining informed consent (Holloway & Wheeler, 1996; Streubert & Carpenter, 2011). Participants were informed of the purpose of the research. Consent was obtained prior to involvement and data collection and was subsequently revisited throughout the research process. Participants signed a consent form, were clearly informed that participation was voluntary, and that they could withdraw from the study at any time (Appendix C).

To protect the participants' privacy and ensure confidentiality, the researcher was the only person aware of the participants' identities. Interviews were audio-recorded, and only first names were used during the interview. All identifying information in narrative descriptions of experiences was removed before the dissemination of findings. All files containing identifying information, e.g., consent forms, were securely stored in a locked cabinet. All data were stored in password-protected files and will be destroyed five years following the study completion and thesis defense, in accordance with Brandon University research ethics policies. Participant names were removed from transcribed interviews. The transcriptionist was instructed to use "R" and "P" to indicate the researcher and participant's respective contributions. At the end of data analysis, the researcher selected pseudonyms for each participant that were used to report findings. Pseudonyms cannot be contextually connected with unique participants.

Data were shared with the researcher's advisor and a transcriptionist, who transcribed audio-recorded interviews into a written document. The transcriptionist had a clear understanding of confidentiality and signed a confidentiality agreement prior to receiving the data (Appendix D). Upon completion of data analysis, the transcriptionist deleted all electronic files related to this task.

Research Design Summary

HP was selected as the methodology for this study as it is considered helpful in studying topics that require a new perspective. HP is rooted in the theory of interpretation and the consideration of context and knowledge to uncover the meaning of experiences. The research design and process of the study were guided by the philosophy of hermeneutics. Choices made during participant selection, data

generation, and data analysis were consistent with HP and ensured the integrity of the research. Additionally, choices made by the researcher maintained the ethical principles of protecting and respecting participants. Study findings that include demographic information and phenomenological themes uncovered during data analysis are described in the next chapter.

Chapter 4: Research Findings

The purpose of this hermeneutic phenomenology study was to explore the lived experiences of medical-surgical nurses caring for patients with mental illness. The research findings included demographic information for study participants, interview transcripts, and observations made by the researcher during the interviews. Participants' demographic information included their age and gender, their highest level of education completed, the number of years of nursing experience, the number of years of medical-surgical nursing practice, and their current area of employment. The demographic information and phenomenological themes uncovered during data analysis are described in this chapter.

Participants

Ten medical-surgical nurses with experience caring for patients with mental illness participated in the study. All participants met the study inclusion criteria and agreed to participate in the research process. At the time of the interview, each participant worked in a medical or surgical setting caring for adult patients in Ontario, Canada. Two participants were male, eight were female. Years of experience in medical-surgical nursing among participants ranged from two to 25. All participants had worked in medicine or surgery for the duration of their nursing experience. Areas of nursing practice included general surgery (three participants), general medicine (two participants), combined medicine-surgery (one participant), medical oncology (one participant), surgical oncology (one participant), and specialized surgery (two participants). All 10 participants had completed a Bachelor of Nursing degree, one was

master's prepared, and another had completed a doctorate in another field. One participant worked in a rural hospital, while the remaining nine worked in urban settings.

All participants were very engaged in the research process and displayed genuine interest in the topic and research method. Several participants expressed a desire to follow up with the researcher and view the results of the study. The researcher plans on sharing results upon publication of the manuscript. Participants were assigned pseudonyms to protect their identities.

Phenomenological themes

Participants provided rich descriptions of their experiences during the interviews. Themes and subthemes emerged through the circular, in-depth process of hermeneutic analysis. The five themes identified during data analysis were "hope in recovery", "caring in complexity", "the nurse-client relationship", "moral distress", and "change is needed". Caring in complexity was categorized into three subthemes: "dealing with difficult behaviours", "focus on the physical", and "feeling ill-equipped". The nurse-client relationship was categorized into the subthemes: "starting from a place of mistrust", "spending time", and "using a different approach". Subthemes for moral distress included "feelings of helplessness", "mental health service gaps", and "advocating is unproductive". Change is needed was categorized into two subthemes: "continuing education" and "increase support, improve collaboration". See Table 1 for a summary of phenomenological themes and subthemes.

The underlying essence to the experience of caring for patients with a mental illness in a medical-surgical setting was one of helplessness, emotional strain, and frustration. The nurses described feeling helpless as they watched the needs of patients with

mental illness go unmet; they were also frustrated and experienced emotional strain knowing a patient required additional support they were not able to provide. Helplessness, emotional strain, and frustration were feelings participants expressed about many aspects of caring for patients with a mental illness. These feelings were present throughout the themes and subthemes identified. Analysis of the interviews revealed barriers (i.e., person, organization, and system-level) that nurses face while caring for patients affected by mental illness and the resulting impact on nurses' morale and patient outcomes.

Table 1

Summary of Themes and Subthemes

Themes	Subthemes
Hope in Recovery	
Caring in complexity	• Dealing with difficult behaviours • Focus on the physical • Feeling ill-equipped
The Nurse-client relationship	• Starting from a place of mistrust • Spending time • Using a different approach
Moral Distress	• Feelings of helplessness • Mental health service gaps • Advocating is unproductive
Change is needed	• Continuing education • Improve collaboration, increase support

Hope in Recovery

Hope in recovery represents the fulfillment that participants feel from their work in medical-surgical nursing. Participants consistently described their jobs as rewarding.

> *I recently was talking to a patient, and she was saying: "How can I ever say thank you? It will never be enough". And I said to her "You have to appreciate that as much as we give to you, you give to us." I get a lot back from my patients which is why I have a hard time leaving. As challenging as the work is, I still get a lot back. (Morgan)*

Participants felt rewarded when their nursing interventions were effective, and patients were able to clearly express gratitude to them:

> *Being there for those patients, having people be so grateful for the little things you're doing for them, the compassionate piece, being unconditionally there at 2 a.m. when they're having a hard time breathing and sorting that out for them, or helping with their pain…I find it very rewarding. (Gillian)*

Overall, the hope participants experience in their work was linked to bearing witness to their patients' recoveries.

> *It's nice to be able to see a patient coming back from the operating room and then being able to kind of follow their journey for the next couple days or weeks or sometimes they're even there for months. It's nice to be able to see them recover, see them go home after. You know their life is going to change for the better because they just had this cancer tumor taken out. So, they don't have anything to worry about anymore. We've helped them a lot. (Cecile)*

Caring in complexity

All participants recognized the prevalence of diagnosed mental illness and undiagnosed mental health issues amongst their patients. As Morgan stated: "Well, I would say that both diagnosed and undiagnosed, it's prevalent probably throughout every part of my job." Not only did participants recognize the prevalence of mental illness, but they consistently described the experience of caring for patients with mental illness as both difficult and complex. Each subtheme for the caring in complexity theme

represents challenges faced by study participants in their day-to-day activity of caring for these patients.

Dealing with difficult behaviours. Each participant described at least one experience in which the behaviour of a patient with mental illness affected them in some way. As Steve explained:

> *The other cases are the ones where I personally get very frustrated with and it's the behavioral. […] I think really, they all have issues which really lead to the behavior: like acting out. I haven't really had a whole lot of experience with younger people and violence. But the yelling, the screaming, refusal to cooperate is really frustrating for us.*

Patients who asked a lot of questions or expressed anxious feelings despite constant reassurance led to feelings of frustration for Gillian:

> *That's the one I see the most, for sure, is high anxiety that is brought out by whatever they are admitted with. Sometimes, having to go through things a number of times, very slowly, it can be a little bit trying on your compassion.*

Gillian went on to explain that the behaviour of a patient with severe anxiety impacted the nursing care she provided:

> *That whole cluster of anxiety in that room, that it made it [so that I did] not even want to go into that room. That was a bad situation in terms of impacting care because it was like…I have meds to give, but I know I'm going to be in there soon so I'm just going to not go in there now—I'm gonna cluster my care because it's gonna be a lifetime that I'm going to be in there.*

Heather and Chelsea both provided examples where a patient was not engaging in the treatment plan for their physical recovery because of their depressive symptoms. Heather observed that for surgical patients with depressive symptoms, refusal to participate in post-op care often resulted in slower recovery:

> *Specifically with depression, depending how bad it is or how well treated it is, specifically for surgical patients it impacts them in their recovery because I find that if they have very bad depression, they're not motivated to get better.*

Watching patients make choices that negatively impact their recovery is difficult, as Chelsea explained:

> *It was challenging for her and then it's also kind of, I know this is going to sound bad, but it was frustrating for us. It was like: let's go for a walk and she's says no. And you tell her you know this is important. When you're thinking that all my other patients who had a lot bigger surgeries than you are going for walks, why can't we just get up for a walk. But that's one of the manifestations of depression is you have no desire to do anything. She was an independent person at baseline, and she got so deconditioned. I know it's hard to see someone do that to themselves from like a mental illness.*

Like most participants, Heather described feeling guilty with her frustration when faced with patients who display difficult behaviours:

> *It's then frustrating for me as a nurse because [I] want to help you get better but you have to help yourself as well […]. When I talk about this in retrospect, I feel kind of guilty because it's not her fault she's depressed but it doesn't change the way it makes me feel about it.*

Participants also described the impact of difficult behaviours on the dynamic within the health-care team. Teamwork was cited as an essential aspect of medical-surgical nursing: "If you don't have good team members and if you're not a good team member yourself, the place falls apart." (Katie). Despite the importance of teamwork, participants noted that their colleagues were less likely to be helpful when patients are engaging in behaviour that is perceived as challenging. As Steve explained, "the other thing is working with the other nurses; they're not going to want to go [and] handle your behavioural patient." Heather described it as a nursing culture issue:

> *I also think in a nursing capacity in my experience, where there's a real physical issue going on, be that an acute medical crisis situation, people jump in, people are available. But when you have a patient who, unfortunately, has mental health challenges diagnosis or undiagnosed, often that patient is labeled as annoying or problematic and people avoid that patient. So, nobody is jumping in to help you, or not consistently. So, to me that's a nursing culture challenge, probably a challenge anywhere—any workplace, but I find that's one of the biggest challenges. Because if I had a patient that was crashing, everybody would jump*

> *in. But if I had that patient who rings maybe 600 times for the same thing over and over again, people aren't going to help you with that.*

Focus on the physical. The complexity of care for patients with mental illness on medical-surgical units is again reflected as participants described the experience of focusing on the physical needs of a patient while leaving mental health needs unaddressed. Participants explained that patients have so many physical needs that mental health assessments and interventions are minimal. As Cecile stated:

> *We're definitely focused on the physical [needs of] patients. You know what's coming out of their drains and their tubes, and other vital signs. How's their pain and their nausea. We definitely focus on that. Then we have like a little box on our charting form that's like psychosocial. That's their mood and their affect and their ability to express their needs and desires, that sort of thing. It's a very small part of our assessments.*

In cases where patients were receiving treatment for their mental illness, participants typically did not complete mental status assessments or assess the effect of the medication but rather focused on the possible physiological side effects. Steve provided a clear example of this practice:

> *I don't really have a whole lot of other training. Even think of it this way, my expertise is, like… somebody's on clozapine, I'm thinking we watch the white blood cell count, not the effect of the antipsychotic.*

Participants recognized that because of the focus on addressing the physical needs of patients, medication is often offered as the first intervention when verbal de-escalation or emotional support may have been equally or more effective. Lynn stated:

> *Our tools to use with this population is sedation, medication very much so. It's like: oh, you're anxious, okay, I'll get you like your Ativan or I'll get you your Seroquel. I find a lot of time, especially with anxious patients, that's what they're looking for anyway. But I'm sure it would be helpful to be able to sit down and have a conversation with them. To have them open up and get it off their chest.*

Katie likened the use of PRN ('as needed') medication as the initial intervention to a general reluctance on the part of nurses to engage in other ways with patients.

> *But like there's sort of an unwillingness to try. I think it's probably time constraints for them as well. […] I'm thinking about how we deal with somebody in a crisis and the first thing people do is look for what PRN medications are on people's charts. I mean it's kind of nice to try conflict resolution first, rather than just trying to get rid of agitation.*

Feeling ill-equipped. Participants attributed the focus on the physical needs of patients, in part, to feeling ill-equipped to provide adequate care for the patient's mental health. Participants perceived mentally ill patients as requiring different, or additional care they cannot provide due to lack of knowledge, skills, time or required support. In mental health settings, mental status exam assessments and therapeutic support are standard practice. In contrast, all the medical-surgical nurse participants expressed feeling uncomfortable and ill-equipped to care for patients with mental illness.

> *I don't think I would feel that I would have the right words to say when people tell you some of the very tragic or awful things like that they're thinking about. I don't know how I would respond to be honest. I wouldn't feel comfortable, I don't think. (Lynn)*

For Ross, feeling ill-equipped was described as a lack of confidence in knowing how to plan care for patients:

> *I don't think I would have enough knowledge to be like: okay this is what we need to do. In terms of knowledge that is based on evidence or what is the best practice.*

Many participants attributed their discomfort and feeling ill-equipped to lack of support, lack of knowledge and lack of education related to mental health. Participants referred to having no orientation that addressed patients with mental health issues:

> *Basically, really my orientation was because we're a med/surg floor and we didn't have anybody at the time who was [admitted involuntarily]. We just basically went off whatever I had known already. […] then it's like your psycho-social and*

> *mental health assessments: is the patient disheveled, are they having hallucinations, what's their mood today. The hospital didn't really include any form of mental health orientation. (Steve)*

Other participants focused on the minimal amount of mental health content in their entry-level nursing education, leaving them ill-prepared to support mental health in practice.

> *It's one of the areas where, soulful work or not, you get your one credit of psych nursing training in nursing school. I did an accelerated program, so it was like 6 weeks. I surprisingly got 3 credits in psych nursing, like in clinical placement. But you have that and then you're just put on the floor where everything's moving so quickly, and you can feel really overwhelmed by it. (Katie)*

The Nurse-Client relationship

Participants discussed the various factors that impact the nurse-client relationship when caring for patients with mental illness. Mental illness and the fast-paced environment of medical-surgical units were seen as barriers to forming trusting relationships, although each participant described helpful approaches in overcoming these barriers. This theme was comprised of three subthemes: “starting from a place of mistrust”, “spending time” and “using a different approach”.

Starting from a place of mistrust. This subtheme described how participants perceived patients with mental illness to be mistrusting of health-care professionals, making it difficult to establish any kind of nurse-client relationship. Participants felt this mistrust was learned from past experiences with health-care professionals:

> *One of the things I've noticed sort of across the board, and again this [is] more for moderate to severe mental illness. Somebody who might have experienced a crisis at some point. There's a lot of suspicion towards health-care workers because they've been mistreated. […] It's almost like the more severe the mental health the more fearful they are of health-care workers because the more likely it is that they have, at some point, been abused, ignored, not trusted, or not believed. They've had some negative horrible experience with health-care workers, specifically with medicine nurses. (Katie)*

Mistrust was also recognized by participants as part of a person's mental illness. Morgan described an example of a patient whose mental illness impacted the nurse-client relationship:

> *They struggle with decision-making because of the mental illness, they struggle with comprehension, they struggle with trust with the caregivers. I've had patients who were good in the morning and then in the afternoon they were suspicious, they were worried about me, they didn't trust me.*

For some participants, the mistrust from patients affected by mental illness was difficult to work through, as Ross described:

> *I reflect back when you don't have a proper or good interaction with the patient and there was no reason from your part. Like you didn't do anything differently. Like they were not really rational, just anxious, and paranoid and mistrusting. And they didn't think you were right even though you were giving the right information. It's like they were questioning your expertise or knowledge. It's very difficult to not take that personally. You have to learn to grab yourself a little. It is difficult because in those situations it's like I'm telling you, like believe me, I would not be wasting my time.*

Spending time. Building rapport with patients requires time and resources, especially if patients are starting from a place of mistrust due to a previous experience with health-care providers or because of their mental illness. Participants expressed feeling torn between wanting to spend time with patients with mental illness to build rapport and provide support and the need to attend to their other responsibilities. Ross described this experience as an ethical dilemma:

> *Sometimes you see a patient and you just need to do an intervention or do your assessment and it leads to crying or they start talking about something that's not related to what you intended to do. And then in your head you start thinking: oh my gosh, you start thinking about the other things you need to do like after, and you go into this dilemma: do I actually listen to this person or do I interrupt. And the need to make a decision, I don't like that. It should be obvious what the decision is but it's not because you're not just responsible for this person. It sucks a little, you're crying and I want to be caring but I can't.*

The contrast between mental health needs and physical health needs was present within the theme of spending time. Participants frequently expressed frustration when dealing with patients with mental illness who required time-consuming support. The frustration was associated with not being able to provide the required support or when spending time meant they were not attending to their other patients. Participants often referenced experiences of being with a patient who needed time-consuming emotional support, while carrying the weight of another patient in their assignment who required immediate support for their physical health. As Cecile explained:

> *It's hard with the pace of the unit to be able to sit with someone and like walk them through their anxiety or talk to them and try to explain rationales for why you're doing things when they're clearly overwhelmed by what's going on. And you're like: OK well I'm trying to R.A.C.E (Rapid Assessment of Critical Event) the guy in the other room so we're going to come back to this but that's not really fair to them and you're not really caring for them in a holistic way.*

In many ways, the act of spending time with patients to provide mental health support did not match with the pace of the units as described by participants:

> *I'm not opposed to working with patients with mental health challenges or psychiatric illnesses. It's just that I'm not set up in an environment to support them. I'm set up in an acute facility where it's like go go go, super-fast super busy, even with the chemotherapy, even with all those challenges. And I don't have a lot of time to sit and give that time. (Morgan)*

Despite feeling frustrated, and at times annoyed, by the time demanded by patients with mental illness, all participants recognized the importance of spending this time and that the inability to do so compromised the quality of the care they were providing.

Using a different approach. Undeterred by the frustration with time constraints, participants described ways in which they alter their approach with patients with mental illness to nurture the nurse-client relationship.

> *So, if I see a person with mental health issues is on my assignment for the day, I actually will approach them. I try to be gentle, I try to give extra space, I try to make sure, I try to do this for everybody, but with certain types of mental health if you can help to build safety for the person, they're going to feel better. (Katie)*

When tailoring their approach to care, participants first consider the patient's history and the nature of their mental illness. Participants described offering more information, support, and reassurance to patients with anxiety. As Heather explained:

> *I find that with a lot of my patients who I see there is anxiety in their history. To me specifically in terms of surgery and in post op I feel like information and education is really what they're looking for so before I ever do anything I'll say so this is what I'm going to do, this is going to be our plan for the day. If that's okay with you. We're going to get you up in the morning and we're going to try and take off your IV medication but don't worry I'm going to give you pills instead and I'll also make sure you don't have nausea. I find that just explaining things to them reduces the amount of questions that they may have.*

Cecile also described her change in approach specific to patients with anxiety:

> *If you know they have anxiety, then I find myself changing my affects to be a little bit more bubbly and making sure that I'm a bit more attentive: Like is there anything else you need? Is there anything I can do for you? Just to help them stay calm, I guess*.

Personality disorders, substance use disorders, and thought disorders were all mentioned by participants as illnesses that required management of expectations, clear boundaries, and limit setting. Katie described limit setting as a helpful tool for establishing boundaries that protect her time:

> *I don't know what the technical terms are, but what I find really helps with him is establishing really clear boundaries. So, when he asks me for something, it's like I don't have time to pick peas out of your soup. I'm sorry, I wish I did. I wish I could give him everything in the world, the poor guy. But there are things that it's like you have to establish limits. By establishing them from the get-go before I get frustrated.*

In addition to changing how they approach patients, nurses described using a different approach to reviewing a patient's history. Participants recognized that both

time constraints and dealing with difficult behaviours when caring for patients with a mental illness tended to wear their empathy down. Some nurses recounted how they gained a better understanding of their patients' stories to help restore and strengthen their sense of empathy.

> *When you start seeing the same person like over and over and over again your empathy just gets worn down. But then you hear the patient's story again: and it's because their wife died like 5 years ago and they haven't got back on their feet, or their kids were killed in a car accident, and it set off a relapse. So then when you hear them you really have to get past that wall. (Steve)*

Moral Distress

Moral distress occurs when moral values are compromised. The Canadian Nurses Association (2017) defines moral distress as a situation where "nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm. In this theme, participants described moral distress, often resulting from the inability or perceived inability to provide the appropriate care and support, when caring for patients with a mental illness. Three subthemes emerged in this category, each of which represents a source of moral distress: "feelings of helplessness", "mental health service gaps", and "advocating is unproductive".

Feelings of helplessness. In this subtheme, feeling ill-equipped, a focus on the physical health issues, and the inability to spend adequate time with patients all contributed to feelings of helplessness amongst nurse participants. Participants recognized situations in which providing support to their patients with mental illness could be helpful. Despite this, they felt frustrated by the difficult behaviours, didn't have

the time, or simply did not know how to approach the situation. Morgan described her experience when she was not able to meet the needs of her patients:

> *The converse of that they're really unsatisfied in terms of the care that you're providing because you can't meet all their needs. And you want to. It's not that you don't want to. So, for me that's probably my biggest challenge with those patients if I have a 4-patient load and I have one patient who is taking up ¾ of my time, I'm stressed because I can't see the other three patients. But then I recognize that person still needs me. It's just really challenging, frustrating, challenging.*

These feelings of helplessness are prevalent in medical-surgical nursing and participants who described their overall roles as fulfilling would leave their shifts feeling deflated:

> *It happens a lot and it's incredibly frustrating, incredibly disheartening and most of the time when you have a patient who has either an undiagnosed or unrecognized mental health issue you go home feeling horrible. Because you can't do a good job with them. (Katie)*

Katie went on to explain the moral distress from these feelings of helplessness will ultimately be why she will leave medical-surgical nursing:

> *It's so incredibly frustrating to know that someone needs help, not know what that is, because I am not a psych nurse and I'm certainly not a psych doctor. But to know that this person needs help and know that I can't give it to them makes me…it will be one of the reasons that I quit medical nursing.*

For Gillian, the moral distress from feelings of helplessness led to seeking a temporary change in position, away from the bedside:

> *Having to care for some people who made me feel like I was losing my patience a bit was uncomfortable, I didn't feel like myself, which was a challenge. I think that's partially because we don't have the time to be able to give these people everything that they need-part of it is a system issue. If I could be one-to-one with that patient maybe I wouldn't have felt as burnt out. I think having to feel myself get frustrated and short with these people who I'm supposed to be caring for affected me enough that I felt I needed to change roles, which is pretty significant.*

Mental health service gaps. Participants described experiences in which they watched the health-care system fail to meet the needs of patients living with mental illness, and how that added to their moral distress. They recognized aspects of the health-care system that impeded quality care, resources that were not available or not accessible, and provider decisions that did not support the mental health needs of their patients.

Participants gave accounts of hospital processes and pressures that negatively impacted the support patients with mental illness receive:

> *You've got pressure from management and other floors to move these patients out. It's this constant bed flow. You're getting patients coming up out of Emerg, so you have to get the patients here stabilized and moved on. It's this constant movement that's going around. A lot of times when you get these patients up here, if you're waiting and waiting and waiting and you don't have the resources, you don't really have the time. By the time you pass them on to a floor that is now 6:1 patient to nurse ratio…then they've got even more of a chance to fall between the cracks. […]. So, I think honestly if there were more resources, if we weren't in such a hurry to move these patients on, and there was a more organized approach to how we should deal with these patients. (Colleen)*

Additionally, participants felt that resources for mental health on their units were scarce, leaving them and their patients without adequate support. Chelsea explained:

> *[Patients who are] not 65 then you have to get referred to psychology or psychiatry. But there they have a big patient list as well. […] I've seen them do their conversation plus assessment and then they'll write them off pretty quickly […] We don't really use psych as much as we should. When they come in with EtOH or overdose, psych will see them originally in the ER. But if they are deemed not a risk to themselves, from that point on they won't see them for the rest of the hospital visit. Then it's just our social worker, like here the programs that we have. Good luck man and off they go.*

Participants described consultative mental health services as busy, with support for patients often limited to medication recommendations and safety assessments. Patients who did not have acute safety concerns received no follow-up or ongoing support.

Usually they (psych) come in for a very specific reason though. They might have suicidal ideations. […] But if they are deemed not a risk to themselves, from that point on they won't see them for the rest of the hospital visit. (Chelsea)

Despite being taught to provide holistic care, participants gave examples of how providers terminated care when their medical or surgical needs were met, leaving known psychological or social concerns unaddressed:

> *There's a real focus in medicine, you know somebody comes in with say, diabetic ketoacidosis. The doctors are all focused on the diabetes, focused on getting those ketones down. Once the sugars have stabilized, they write them off. They're done. If, in the meantime, you notice okay this person is marginally housed and in a difficult situation; we might be sending them back to the street; they might not be able to afford their insulin; and: oh, I think they might have a personality disorder that's influencing all of the different social determinants of health. If you try to get anything done with that, it's nearly impossible. (Katie)*

Participants cared for patients who were admitted with medical issues caused by their mental illness (e.g., injuries from a suicide attempt). However, the focus on a person's physical health in medical-surgical settings left nurses feeling as though the care provided did not address the root of the problem. Gillian summarized this well:

> *I was also thinking about how mental health can lead to medical issues and how we don't really address that. Somebody who has borderline personality disorder and diabetes and they're playing with their insulin… Someone with Crohn's who is not taking their medication…you know…it can really impact that underlying disease. That's a situation where we don't look at the underlying mental health because they are so, so acutely unwell that it's not even on the table. But if you don't address that…ultimately, it's the problem, they are unwell but that's a symptom, but actually their airway right now is the priority problem. It's not something that we address and it's causing people to be extremely unwell.*

Participants also described feeling worried about discharging patients knowing they may not have access to adequate support or resources outside of the hospital:

> *I wonder who follows up with them? Like what happens? Because if you don't show up for your appointments nobody's knocking on your door to say: "your cancer's growing, you should come and get your chemotherapy." They'll call you a few times but eventually they just have to keep going on. I think money is a blanket way of saying we need more supports we need more services. (Morgan)*

Participants explained that when patients do not receive the appropriate support in hospital or adequate follow-up in the community, they end up being readmitted for similar problems and further stigmatized with labels such as “frequent flyers”, leaving nurses feeling discouraged by the health-care system:

> *Yeah. It's discouraging to see. Because you really hope for the best every single time. You set them up as much as you possibly can that our system allows to set you up for success. So, when you see him again a month later, or two months later, and they’re worse, it’s sad. It takes a toll. (Chelsea)*

Advocating is unproductive. When participants identified and expressed that their patients had mental health and social needs, their requests were frequently disregarded by the health-care team. These situations contributed to the nurses' moral suffering. For Heather, this also meant feeling like she was not being heard:

> *Really what I want is for the physician to listen to me. If I’m telling you this, it’s because it’s what I’m seeing, and I’ve been with this patient for my two day shifts or my two day shifts and two night shifts. I’m telling you that I feel this is in the best interest of my patient. So, I feel like they need to listen more and trust our judgement.*

Change is needed

Despite the consistent expression of helplessness, emotional strain, and frustration, participants remained hopeful that with the right support, the experience of caring for patients with a mental illness can be improved and they can find hope in the recovery of this patient population. In the final interview question, nurses were asked if anything at the person, unit, or system level could improve the experience of caring for patients with mental illness on medical-surgical units. All participants clearly expressed the need for change. This theme was comprised of two subthemes: “continuing education” and “improve collaboration, increase support”.

Continuing education. While organizations provide continuing education for nurses in medical-surgical settings on a regular basis, several participants remarked that training related to mental health was minimal. As Heather described:

> *I've never seen an education day that was related to mental illness. Not once, we've had birth, palliative care, wound care, something like that would be helpful. I would go to that for sure. Maybe our educators could have, because we do all these in-services, but there is nothing related to mental health.*

Improve collaboration, increase support. While discussing possible changes, Ross thought education was needed, but upon reflection recognized that perhaps better collaboration between the mental health experts supporting patients and medical-surgical nursing staff would be helpful.

> *I think it would be a band aid of a fix to just say we just need education. Yes, maybe. But that won't solve the problem. I think that what needs to happen sometimes . . . That's a really hard question. One possibility is better communication with psychology and psychiatry. I really like reading their notes and talking to them after they've spoken to the patient. Because sometimes after you talk with a patient, they feel good. Someone in psychology or spiritual care talks to them and they start crying and telling them all their problems in their life. There's something more there. I think that's important to have that debrief or conversation with the nursing staff.*

Ross also recognized a gap regarding nursing care planning for mental health support:

> *I can do the general stuff like you do an assessment and then what? I think that's the biggest thing. We can do an assessment, sort of, just understanding a person. But then what do you do with that information. Obviously, you can call for a psychiatrist or someone in psychology. But in terms of nursing-wise what do you do after? You do an assessment and it's a good assessment, but I don't know what to do after.*

In fact, many participants identified that support with mental health-care planning from a mental health expert such as an advanced practice nurse would be a positive change to improve the nursing and patient experience. As Gillian explained, nurses in medical-

surgical settings are not focusing care plan goals for mental health needs and an additional support person to do this would be helpful:

> *If there was, I don't know, this is ideal world, no budget considerations…if there was another nurse on the unit who was a mental health nurse and would be able to work with that mental health-care plan. […] There are a ton of mental health things that we need to work towards as med-surg nurses that are just off the table. We're only dealing with surgical, oncology, or whatever…so if there was an extra resource who was just there working on mental health plans, that would be a great tool to have.*

Morgan pointed out that supports for specialty care areas exist with the exception of mental health:

> *We have a nurse for wound care, we have a nurse for your ostomy bag if it blows, we have a nurse for your diabetes, we have a nurse for your pain. But why don't we have a nurse for mental health? […] We're always doing nurse conferencing, always talking, and sharing ideas. But it would be nice to tap into somebody who has the resources and the knowledge.*

To clarify, participants were not looking for someone to take over the care of mental health patients. They felt having access to the expertise of a mental health nurse would promote better care planning, support the nurse experience, and decrease potential frustrations because the patient's needs are being met.

Summarizing Themes

Participants shared their experiences of caring for patients with mental illness in medical-surgical settings. The themes that emerged in the data analysis process were "hope in recovery", "caring in complexity", "the nurse-client relationship", "moral distress", and "change is needed". The meaning of the data was further developed through subthemes. Participants described their overall work as rewarding, yet the experience of caring for a patient with a mental illness was wrought with barriers leading to feelings of frustration, helplessness, and emotional strain. Despite this, participants

remain hopeful positive change is possible, leading to improved support for nurses and patients alike.

Findings from this study highlight the difficulties that nurses experience when caring for a patient with a mental illness in a medical-surgical environment. Nurses, nurse educators, and nurse leaders can improve the quality of care delivered to patients living with a mental illness by recognizing and addressing these difficulties. Further discussion of the themes and subthemes, and implications for improving nursing practice will be explored in the next chapter.

Chapter 5: Discussion

Hermeneutic phenomenology (HP) was employed to document the lived experience of medical-surgical nurses caring for patients with a mental illness and to provide a more complete, contextualized understanding of this experience. This study explored the experiences of 10 registered nurses and is the first study of this phenomenon from a Canadian perspective. Several fundamental ways the nurses make meaning of their experience were found. Five themes emerged through data analysis: “hope in recovery”, “caring in complexity”, “the nurse-client relationship”, “moral distress”, and “change is needed”.

This chapter begins with a discussion of study findings and key reflections in the context of the current literature. Next, implications for nursing practice and policy are examined. Finally, the strengths and limitations of the study, areas for future research are reviewed, and conclusions are drawn.

Discussion of Findings

As discussed in Chapter 2, available literature examining nursing care in medical-surgical settings for patients affected by mental illness is minimal. Overall, many aspects of the study findings are consistent with the literature, yet important distinctions can be made within the identified themes.

Hope in Recovery

Nurse participants in this HP study conveyed tremendous empathy, a desire to competently care for patients with mental illness, and a desire to improve the coordination of care for this group of patients. Earlier studies have shown that the negative attitude of medical-surgical nurses impacted their ability to care for patients

with mental illness (Arnold & Mitchell, 2008; Atkin et al., 2005; MacNeela et al., 2012; Mavundla, 2000). Conversely, authors of a 2015 Canadian study also reported that while most non-psychiatric nurses recognized the importance of attending to the mental health needs of patients, most did not always feel able to do so (Gibson et al., 2015). The experiences of nurses in the current study aligned more closely with Gibson and colleagues' work. Participants described finding hope in recovery. They indicated they were fulfilled by their roles in medical-surgical nursing when their interventions had a direct impact, and they could see their patients recover. However, while some participants shared positive experiences in which they felt they contributed to the recovery of patients with mental illness, most described instances in which the complexity of care, the strain on the nurse-patient relationship, and observing patients with unmet needs caused them to feel moral distress.

Caring in complexity

The theme caring in complexity represented the many challenges faced by study participants in their day-to-day activity of caring for patients with mental illness. Participants described experiences in which patient behaviours caused frustration, impacted the delivery of nursing care, and slowed patient recovery. These findings support descriptions in the literature of difficult behaviours impacting and interrupting nursing care (Atkin et al., 2005; Giandinoto & Edward, 2015). Another challenge related to the complexity of care described by nurses was the prioritization of physical needs over mental health needs. This prioritization is described in the literature; however, prior studies have found that nurses devalued mental health when compared to physical health (Atkin et al., 2005; Ross & Goldner, 2009). In contrast, the participants in the

current study recognized the value of supporting mental health and attributed the focus on tasks to support physical needs was due to competing priorities amidst time pressures. A study by Renolen et al. (2018) found that staying on track and completing tasks is important to medical nurses. This finding is also supported by Chan et al. (2013), who found that time pressures felt by nurses lead to the prioritization of tasks over patient-centred care. Furthermore, participants in the current study described feeling ill-equipped to provide adequate care for the patient's mental health due to a lack of knowledge, skills, time or required support. This finding supports descriptions in the literature of nurses who do not feel they possess the specialized knowledge to care for patients with mental illness (Ross & Goldner, 2009; Giandinoto & Edward, 2015).

Nurse-Client Relationship

Despite feeling ill-equipped to care for patients with mental illness, participants understood the importance of establishing trust and building rapport in the nurse-client relationship. Furthermore, nurses were able to clearly articulate barriers in the nurse-client relationship that are consistent with the literature. Participants described situations where establishing trust with patients affected by mental illness was difficult because of their perceptions of health-care professionals. Indeed, patients with mental illness often delay or avoid seeking treatment for their physical health due to distrust of health professionals and the health-care system (Chadwick et al., 2012; Mojtabai et al., 2014). Again, participants identified competing priorities and lack of time as major barriers to building rapport with patients, as had been noted in studies examining barriers to the therapeutic relationship (Harris & Panozzo, 2019).

Moral Distress

As previously stated, moral distress occurs when moral values are compromised (CNA, 2017). Earlier studies on this topic have focused on the nurse perception and attitudes toward patients with mental illness. Nurses are described as having a negative attitude related to mental illness, and the experience of moral distress in relation to caring for patients with mental illness had not been considered (Arnold & Mitchell, 2008; Atkin et al., 2005; MacNeela et al., 2012; Mavundla, 2000). In this study, participants valued supporting the mental health of their patients and described having to compromise this value for several reasons. The causes of moral distress in the study, such as low confidence, competing priorities, lack of resources, and physician practice, are consistent with the determinants of moral distress described in the literature (Ghanzanfari et al., 2021).

Change is Needed

Education and training are consistently identified in the literature as strategies to support integrated mental health care in medical-surgical settings (Atkin et al., 2005; Gibson et al., 2015; MacNeela et al., 2012). Participants commented on the minimal mental health content in their undergraduate education and continuing education opportunities. Additionally, participants described feeling ill-equipped to care for patients with mental health issues due to gaps in their knowledge. These findings are consistent with previously identified gaps in nursing education, and further support the need for nursing programs to incorporate content and clinical experiences that support students in meeting the entry-to-practice mental health and addiction competencies developed by the Canadian Association of Schools of Nursing and CFMHN. That said, participants

demonstrated fundamental knowledge of mental illness and ways to support this patient population by strengthening the nurse-client relationship in the description of their experiences. This finding could reflect progress in undergraduate nursing education in recent years (Gu et al., 2021; Happell et al., 2014; Patterson et al., 2018). Moreover, when asked what supports would improve their experience, participants said that additional or better education would help but that organizational and social changes to increase the integration of mental health support on medical-surgical units are essential. As participants reflected on ways to increase the integration of mental health with physical care, they unanimously arrived at the conclusion that an advanced practice nursing role for mental health had the potential to address many of the identified barriers in meeting the needs of this patient population.

Reflections on Barriers to Integrated Mental Health Care

Culture in Medical-Surgical Settings

In describing their experiences of caring for patients with mental illness, the participants portrayed a culture on medical-surgical units that values task-oriented work and physical health over patient connections and relationships. Several factors appear to contribute to this culture, including high workloads, organizational pressures and priorities, and physician-led care.

Participants described busy shifts and perceived their workloads as heavy. They also described a culture in which completing tasks was important due to high workloads. Nurses work under significant time restraints and often feel they do not have adequate time to build rapport with patients. Furthermore, participants observed that patients with mental and medical comorbidities often displayed time-consuming, difficult behaviours

that pulled them away from their required tasks. Similar concerns were reported by Renolen et al. (2018) in a study on medical wards that aimed to generate a theory about integrating evidence-based practice into the daily work of clinical nurses. The authors identified that the risk of getting off-track in their work tasks, i.e., loss of workflow, was a major concern for medical nurses who sought to integrate evidence-based practices (Renolen et al., 2018). Participants recognized that taking time to build rapport, offering support, and listening to a person's story greatly improved their capacity for empathy, the nurse-client relationship, and the patient experience. Despite this knowledge, participants reported focusing on and prioritizing the tasks that supported the physical health of their patients. A similar experience was observed by Chan et al. (2013), who examined the impact of time on nurses and found that time pressures can lead to the prioritization of completing tasks as opposed to providing patient-centred care (Chan et al., 2013).

All participants described receiving in-depth orientation and regular continuing education sessions. While many expressed an interest in furthering their knowledge of mental health, the topic did not appear to be an educational priority. Furthermore, participants described situations in which leadership applied pressure to transfer or discharge medically stable patients without consideration for the patient's mental health and specific needs. In defining the concept of caring, Morse et al. (1990) described this exact phenomenon: nurses are expected to care for people in workplaces that do not enable caring.

Medical and surgical units are focused on the provision of curative care. Physicians who lead this care practice within the limits of their respective specialties

and discharge patients if their health, within the limits of that specialty, is adequate. The prioritization of physical needs over mental health needs described by participants demonstrated the influence of medicine's body-mind dualism on nurses. Turkel et al. (2012) described the paradox of medicine and nursing as a harsh reality for the professional identity of hospital nurses because the verbal and written language of the environment is "grounded in the medical paradigm and shaped by external regulatory agencies" (p. 195). Indeed, the focus and prioritization of physical health resulted in moral distress for participants who wished they could offer more holistic care. In addition, nurses who advocated to involve other specialties like psychiatry or mental health support for patients were often met with resistance from physicians. Torjuul and Sorlie (2006) examined the experience of surgical nurses in ethically difficult situations and found that the value of nurses providing holistic care to patients often conflicted with that of the surgeons to diagnose and treat conditions. Similarly, participants identified holistic care as an important value but reported feeling powerless when their work environments and demanding workloads forced them to compromise this value. Several participants recognized these limitations within their unit culture and sought additional support for patients affected by mental illness only to be met with another frustration: not enough resources.

Mental Health Service Gaps

Participants were acutely aware of hospital and community mental health service gaps. They described challenges in accessing mental health services in hospital, including having to repeatedly advocate for a patient consult with mental health services and the resulting delays in accessing services experienced by patients. Participants

also described the limitations of existing mental health services overall. Consultative mental health resources were described as busy, with support limited to medication recommendations and safety assessments. Patients without acute safety concerns received no follow-up or ongoing support. Lastly, participants reported minimal collaboration with mental health services. Nurses in the study expressed a desire to discuss their patient's needs with mental health experts and learn from them. However, the integration of mental health support into the nursing care on medical-surgical units appeared to be hindered by the limited availability of mental health supports. There is a paucity of research examining hospital service gaps for mental and physical care in Canada. However, this topic appears to have been studied extensively in England where similar gaps in service, such as delayed psychiatric consultations and poor integration of mental health services, negatively impacted the overall quality of care for patients with mental and medical comorbidities (National Confidential Enquiry into Patient Outcomes and Death, 2017).

The impact of gaps in community mental health services was described by participants. These nurses were troubled when patients with mental illness were discharged without adequate supports in place. Furthermore, patients with mental illness who did not receive appropriate supports in the community were often readmitted, and the participants described feeling as though the health-care system had failed them. Gaps in mental health resources in Canada, and more specifically in Ontario, are well known. In 2018, 43.8% of Canadians and 46.1% of Ontarians reported unmet or partially met mental health needs (Statistics Canada, 2019). A shortage of accessible mental health professionals in Canada is one of the contributing factors

(Moroz et al., 2020). This study demonstrated a lack of resources as a contributing factor to moral distress amongst frontline medical-surgical nurses.

Implications for Nursing Practice and Nursing Policy

This HP study on the experience of medical-surgical nurses caring for patients with a mental illness has implications for nursing practice and policy. By enhancing our understanding of the challenges faced by nurses on medical-surgical units in Ontario, Canada, its findings may benefit individual nurses, nurse educators, nurse leaders, and policymakers.

Nursing Practice

Nurse participants recognized they had a more positive experience when the environment and their schedules allowed for patient-centred care, such as building rapport and understanding a person's story. The culture of medical-surgical units limited the nurses' ability to provide holistic, patient-centred care and contributed to their feelings of moral distress. In the face of this culture, nurses must work to cultivate a strong professional identity that is grounded in holism. A stronger professional identity will allow nurses to confidently work against the separation of body, mind, and spirit. Newman (1999) stated: "We have to recognize the fallacy of this divisive way of thinking and let go of it. The reality of our world demands that we engage in a science and practice that honor the evolving pattern of the whole" (p. 228). Research endorses holistic, patient-centred care in both medical-surgical and mental health environments. However, nursing workload and unit environments make this approach to nursing practice challenging to sustain. Nursing leadership within medical and surgical units must recognize the importance and the time required to provide patient-centred care

and take steps to support it. Adopting an essentialist perspective and engaging in critical reflective practice are two ways that nurses can prioritize patient-centred care.

Keeping the Essential. Creating meaningful connections with patients requires time, and time is at a premium for nurses working on medicine and surgery units. The drive to complete tasks and prioritize workflow can inhibit nurses from building therapeutic relationships with patients, or from incorporating other evidence-based practices into the care provided (Renolen et al., 2018). Richards (2015) described this need for efficiency, to maintain workflow, and being overwhelmed in doing so, as the disease of “busyness”. According to the author, “Busyness serves to create walls that prevent intimacy and starves any connection between us and others.” (p. 117). Busyness is a pervasive culture in health care and can lead to chronic stress for staff and reduced patient safety (Kerfoot, 2006). Nurses can combat the disease of busyness by adopting an essentialist perspective. Nurses must recognize the limitations of what they can accomplish in a day and focus on the essential (Richards, 2015). By focusing on what’s important and not succumbing to the busyness of their environment, nurses can create room in their workdays that allows time to engage with patients. This time offers meaning to the patients’ experiences and promotes their mental health. Nurse leaders must also recognize the danger of this culture of busyness and incorporate slack into the nurses’ schedules “so they can unleash their genius, reinvent health care, and fix health care from the inside out” (Kerfoot, 2006, p. 170). By letting go of busyness, nurses and leaders free up time for the creation of meaningful relationships with patients, incorporation of evidence-based care, and practicing patient-centred care.

Critical Reflective Practice. When a nurse's internal environment—their values and perceived duties—conflict with the demands and dominant perspectives of the external work environment, moral distress occurs (Epstein & Delgado, 2010). Moral distress, if left unattended, can lead to burnout and a decision to leave the profession (Epstein & Delgado, 2010). While some level of moral stress in nursing can be expected, its effects can be mitigated through several strategies such as voicing concerns, moral distress education, advocating for organizational change, and critical reflective practice (Epstein & Delgado, 2010; Lawrence, 2011). Lawrence (2011) defined critical reflective practice as “being mindful of self within or after professional practice situations” (p. 258). Where reflective practice requires reflection of one’s own values in decision-making, critical reflective practice moves beyond examining the influence of personal values and beliefs in decision-making by considering the influence of organizational structures and socio-political factors (Lawrence, 2011). Due to the number of external factors that contribute to nurses’ moral distress when caring for patients with mental illness in medical-surgical settings, the concept of critical reflective practice has relevance and may warrant further exploration.

Nursing Policy

The Ontario Ministry of Health and Long-Term Care (MOHLC) (2014) provides clear direction for policy action that develops “innovations in patient care for people suffering from simultaneous mental and physical illness” (p. 3). High readmission rates of individuals affected by medical and mental comorbidities suggest an overreliance on community resources that may not be meeting the needs of this population (Šprah et al., 2017). Organizations seeking to revitalize or restructure services to promote the

integration of mental health and medical care have several options and models to consider, such as expansion of the psychiatric liaison team, full integration of medical and mental health services, and the introduction of a mental health clinical nurse specialist (CNS). Medical-surgical nurse participants in this study favoured the latter option, noting that the model of a CNS in other specialty areas such as pain management, wound care, and diabetes has been effective in supporting both patients and nurses.

The clinical nurse specialist (CNS) role was introduced in the 1970s to balance a fragmented delivery of care with the need to ensure patients have equal access to holistic care (Gardner et al., 2012). The Canadian Nurses Association (CNA) (2014) defined the CNS as a “registered nurse who holds a graduate degree in nursing and has a high level of expertise in a clinical specialty” (p.1). A CNS for mental health is not a new concept. Even so, little information can be found regarding this role in Canada (Brinkman et al., 2009). The discussion below presents the implications for a CNS role within the context of the current study. These implications are considered within each of the CNS competencies outlined by the CNA (2014) framework: “clinical care”, “system leadership”, “advancement of nursing practice”, and both “evaluation and research”.

Clinical care. According to Donald et al. (2010), the provision of direct clinical care to individuals, families, and communities by a CNS is a small part of the role. The focus is on the other competencies. Nevertheless, the CNS should possess extensive knowledge of mental health to perform assessments, short-term counselling, or follow-up with patients. The clinical care component of a mental health CNS is the conduit through which change is made possible beyond the client level. Engaging with patients

on a medical-surgical unit would make the mental health CNS part of the team, create opportunities for collaboration and education with other team members, and help to identify potential problems that could be explored through research.

System leadership. With their in-depth knowledge of research, administration, and education gained in graduate degree programs, CNSs are qualified to advocate for improved care and access at the organizational and systems levels (Pauly et al., 2004). Clinical nurse specialists are advanced practiced nurses who frequently have opportunities to build relationships with key stakeholders and decision-makers in their respective organizations. According to Bryant-Lukosius (2010), it is through these relationships that the CNS has an opportunity to implement system-level change. A mental health CNS can help bridge the gap between medical-surgical nurses and policymakers, bringing pertinent issues (e.g., patient-centred care barriers) forward for consideration.

Advancement of nursing practice. The competencies in this category are what set advanced practice nursing and the CNS apart from other consultation/liaison services in health care. CNS roles were originally created to support front-line staff as medical care increased in complexity (Kaasalainen et al., 2010). Currently, nurses rely on limited mental health support services delivered by physicians who are stretched thin and do not always communicate directly with nursing staff. A mental health CNS could ensure nurses receive regular education regarding their specialty and help to coordinate and plan care for patients with mental illness on an ongoing basis. The mental health CNS also acts as a mentor for registered nurses by providing opportunities for critical reflective practice, encouraging an essentialist perspective, and the integration of

evidence-based practices into nursing care. Furthermore, through education and mentorship, the CNS can support nurses in navigating ethically complex situations, thereby mitigating the effects of moral distress. Through education, mentorship, and increasing access to evidence, the CNS can "advocate for and implement[s] changes that optimize the development of RNs in their roles" (CNA, 2014, p. 7).

Evaluation and research. Participation in research activities is considered one of the core competencies of the Advanced Practice Nurse (CNA, 2019). One doesn't have to look far in the literature to understand that more research is needed for the ongoing development of nursing knowledge. The role of the CNS in knowledge development and dissemination at all levels of care is crucial to the profession. The CNS has the knowledge and ability to incorporate and disseminate the most up-to-date evidence into direct and indirect clinical care, identify and integrate data needed for quality management, and evaluate outcomes of system and program changes using research principles. Furthermore, the CNS has an important role in mentoring and guiding others to ensure widespread research integration in nursing (Burns & Quatrara, 2013).

Mental health CNS implementation has the potential to revolutionize the support offered to patients affected by mental and medical comorbidities. When a rural Canadian health centre in Rocky Mountain House, Alberta, successfully launched a CNS position to address the gaps in the mental health service, patients in medical-surgical inpatient units and clinics experienced improved accessibility (Brinkman et al., 2009). The psychiatric and mental health advanced practice registered nurse (PMH APRN) is an established role in the United States that is often used to address the

shortage of psychiatrists (Delaney et al., 2018). The functions of the PMH APRN align with the CNS competencies described above, although the scope of the PMH APRNs also includes diagnosis and prescribing of medication (Scheydt & Hegedüs, 2021). Patients treated by PMH APRNs have reported high levels of satisfaction with their care (Parrish et al., 2013). Additionally, oncology nurses who were supported by PMH APRNs benefited from the education and mentorship and reported increased well-being (Frankenfield et al., 2018).

Mental health CNSs offer additional support for patients, provide ongoing education to nurses and other staff, engage in research, challenge negative attitudes by empowering clients and staff, and promote collaboration and integrated care in hospital and at discharge. The value of such a role is coveted by medical-surgical nurses who acknowledge that it bridges an existing gap—patients receive additional support, and nursing staff gain competence through learning opportunities—that addresses the patient-specific needs of individuals affected by mental illness.

Strengths and Limitations

The purpose of this research was to explore the lived experience of medical-surgical nurses caring for patients with mental illnesses. The findings of this study add to our developing knowledge of what it means to care for patients with mental illness in medical-surgical settings in Canada. The results shed light on several elements that may assist or hinder nurses in providing this care. The HP methodology used in the study was appropriate and allowed for rich narrative descriptions to support the findings. Additional strengths included the wide range of practice settings (medical, surgical, and combined units), years of experience among participants (from two to 25), and

education level (from undergraduate to doctorate). Finally, since the researcher did not work with or amongst the participants, the credibility of the nurses' responses was not affected by a bias of familiarity.

The experience of the study participants was influenced by their respective practice environments and personal histories. While all participants worked in Ontario, Canada, the ratio for urban to rural hospital settings was 9:1 and the ratio for female to male gender was 8:2. Since these numbers are not representative of those for medical-surgical nursing in general, the study's findings may not be generalized for all medical-surgical nurses' experiences across Canada. Furthermore, study findings may have been influenced by sampling limitation. Nurses with a particular interest in the study topic may have been more inclined to participate. Similarly, nurses who may have offered a different perspective would not be represented in the study's findings.

Areas for Future Research

In Canada, patients with mental illness have prolonged medical-surgical hospital stays and often report having unmet care needs (Johansen & Sanmartin, 2011). Nurses in these settings can play an important role in destigmatizing mental illness and meeting patients' needs by advocating for them to receive adequate support. Instead, these nurses are overwhelmed by heavy workloads and feelings of helplessness when caring for this complex population. A better understanding of how nurses can effectively meet the needs of patients with mental illness in medical-surgical settings may be possible with additional research. The voice of patients is largely underrepresented in the literature and may provide insight into how health-care organizations and nurses can work to effectively integrate medical and mental health care. Mental health education

and training for health-care professionals have been identified time and again as recommendations. While the findings of the current study provide some insight into the type of education nurses prefer, future research on the effectiveness of mental health continuing education strategies is needed.

Conclusion

The lived experiences of ten registered nurses caring for patients with mental illness on medical-surgical wards were investigated using hermeneutic phenomenology. The findings demonstrate that the nurses find meaning in their experience in a variety of ways. The experiences are associated with feelings of helplessness, emotional strain, and frustration—–all associated with witnessing the unmet needs of mentally ill patients––and knowing they were unable to provide additional assistance. Five themes emerged through data analysis: “hope in recovery”, “caring in complexity”, the “nurse-client relationship”, “moral distress”, and “change is needed”. The study findings add to our understanding by emphasizing the meaning of the experience and the context that may influence it. Participants recognized the value of integrated care, but the culture of medical-surgical units and mental health services gaps worked against them. Personal, professional, and organizational support and growth are required for nurses to provide patient-centred, holistic care. Medical-surgical nurses are affected by the lack of resources available to patients with mental illnesses. They have also recognized the value of advanced practice nursing in bridging this gap. Despite the difficulties and moral discomfort associated with caring for mentally ill patients, participants remain optimistic that meaningful change is possible.

This study has highlighted that more research is needed to determine how medical-surgical nurses can effectively address the needs of patients with mental illness in their units. Assessing the patient experience, implementing mental health competencies, and developing education strategies for health-care professionals would all be positive steps. Government funding is needed to ensure organizational supports and educational needs are available to provide safe, competent, holistic, and integrated care of medical-surgical patients with mental illness.

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Appendix A: Letter of Invitation

Letter of Invitation
(placed on Brandon University letter head)

Dear Registered Nurse,

My name is Natalie Pearson and I am a registered nurse and graduate student in the Master of Psychiatric Nursing program at Brandon University. I am extending an invitation to you to participate in a research study that will inform my thesis of "Understanding the Lived Experience of Medical-Surgical Nurses in Caring for Patients Affected by Mental Illness."

The purpose of the study is to learn more about the lived experience of medical-surgical nurses in caring for patients with a mental health diagnosis. The investigation and meanings derived from this experience is of significance to nursing knowledge. Research findings may lead to the development of enhanced supports for more meaningful practice for registered nurses who are caring for patients affected by mental illness in a general hospital setting. Education, research, and policy within and beyond medical-surgical nursing practice may also be impacted by this new knowledge.

The results of this study may be presented at scholarly conferences and in publications. As a study volunteer, you will be asked to take part in one 60-90 minute interview. The interviews will be conducted at a time and place of your convenience. The interview will be audiotaped and later recorded by a transcriptionist. You will also be asked to provide some demographic details such as your age, nursing education, and nursing experience.

Your name will not appear in any report or publication of the research. Your data (e.g., interview recording, interview transcripts) will be safely stored in a locked cabinet and in an encrypted file, on a password-protected computer. I will be the only person who has access to all the raw data. A transcriptionist who has signed an oath of confidentiality will have access to the recorded interviews. My thesis advisor will have access to transcribed interviews in which identifying data is removed. Thesis committee members will have access to the data analysis.

Your name will not be used on the transcription of your interview. When your interview is transcribed, your name will be removed. All data will be destroyed after the completion of the study. Paper copies will be shredded, and electronic files will be deleted.

Participation is voluntary and you may refuse to answer any question or withdraw from the study at any time. Participating or declining to participate in this study will not affect your relationship with the researcher or your place of employment.

Thank you for taking the time to read this information. If you have any questions about the study, you may contact my thesis advisor, Jane Karpa, or me. Our contact information is provided below.

The Brandon University Ethics Committee (BUREC) has approved this research. For questions regarding ethics, you may contact them at [redacted] and [redacted]

If you would like to participate in this study, please contact me either at the phone number or email listed below.

Kind regards,

Natalie Pearson, RN, BScN
Master of Psychiatric Nursing Student
Faculty of Health Studies
Brandon University

Jane Karpa, RPN, MMFT, PhD(c)
Assistant Professor
Department of Psychiatric Nursing
MPN Coordinator

Appendix B: Interview Guide

Interview Guide

[Data will be collected through semi-structured, open-ended interview questions. Asking broad, open-ended questions will be used to gather rich and detailed descriptions of the participant experiences, this is consistent with hermeneutic phenomenology. The following questions will service as a guideline and will be used with consistency when appropriate. The interview format will be adapted for specific interviews when appropriate]

General information

I would like to discuss your experience as a registered nurse working with adult patients diagnosed with a mental illness in medical-surgical settings. To understand your professional history, I will begin by asking you general information about you and your nursing practice.

How many years have you practiced as a nurse?
How long have you practiced in medicine/surgery?
Do you practice in a rural or an urban setting?
What type of unit to you work on? (General medicine, general surgery, combined medical surgical or a specialized medical-surgical unit?)
Briefly explain the other practice settings, if any, that you have worked in? (And your role in those settings)
What is your age?
What is the highest level of education you have obtained?

Medical-Surgical Units: Lived experience

The purpose of this research is to explore your experience working in medicine or surgery with patients that have a mental health diagnosis. Although experiences working with this population in all settings is valuable, please focus the discussion on experiences you have had on medical or surgical units.

How long have you been employed in your current practice setting?
Please tell me about the care setting in which you are currently employed.
What does it mean to you to be a nurse working in medicine or surgery?

Working with Patients who have a Mental Illness

I would like to understand your experiences in delivering nursing care to patients who have a mental health diagnosis.

During your career as an RN, tell me about your exposure to patients who have a mental illness.
When you consider the work you have done with these patients, what stands out for you in terms of your own experience?
How have you been affected by these experiences?
In caring for a patient who had a mental illness, describe an experience from your perspective that went well and one that did not go well.
What factors, if any, have an influence on your ability to deliver care to these patients?

Appendix C: Consent Form

Consent Form: Agreement to Participate
(placed on Brandon University letterhead)

Title of Study: Exploring the lived experience of medical-surgical nurses in caring for patients with a mental health diagnosis.

Principle Investigator: Natalie Pearson, RN, CPMHN(C)
Student, Master of Psychiatric Nursing Program, Brandon University

Thesis Advisor: Jane Karpa, RPN, MMFT, PhD(c)
Assistant Professor
Department of Psychiatric Nursing
MPN Coordinator

This consent form, a copy of which will be provided to you for your records and reference, is only part of the process of informed consent. It provides you with an outline of the research and your participation. If you would like more details about something mentioned here, or information not included here, please feel free to ask. Take the time to read this consent form carefully and to understand any accompanying information.

Purpose of study
This research study is part of a graduate degree requirement for a Master in Psychiatric Nursing program at Brandon University. The purpose of the study is to learn more about the lived experience of medical-surgical nurses in caring for patients with a mental health diagnosis. Investigation of this experience and the meanings derived from them is of significance to nursing knowledge. Research findings may lead to the development of enhanced supports for more meaningful practice for registered nurses who are caring for patients affected by mental illness in a general hospital setting. Education, research, and policy within and beyond medical-surgical nursing practice may also be impacted by this new knowledge

Inclusion Criteria and Participation
You are being asked to participate in this study because you are a registered nurse (RN) who is employed in a medicine or surgery and have experience caring for one or more patients with a mental health diagnosis in your current practice setting. Participation in this study is voluntary. You may stop at any time without any consequence or any explanation. You may decline to answer any question or you may withdraw from participating in this study by letting me know directly any time during the interview. You may also withdraw from participating following the interview by contacting me by phone at [redacted] or email at [redacted] up until completion of the study. If you withdraw from the study, your data will not be used and it will be destroyed.

If you agree to participate in this research, you will be asked to take part in an interview that will take approximately 60-90 minutes. The interview will be conducted at a time and place that is convenient to both researcher and participant. You will also be asked some demographic questions, including age, education, and experience. You will be provided with a paper or electronic copy of the interview transcription at a later date and asked to verify its accuracy.

Risks
The time it takes to be interviewed may cause some inconvenience to you. If at any point in the interview you feel uncomfortable and wish to stop, please let me know. As a participant, you may withdraw from the study at any time. If you do not wish to discuss a specific question, please let me know and the question will be omitted.

Benefits
The knowledge gained through this research will add to the knowledge and deepen the understanding of care provided to patients affected by mental illness in medical-surgical settings. The development of enhanced support for more meaningful practices related to caring for this population may assist present and future nurses working with individuals living with a severe and persistent mental illness.

Confidentiality
Interviews will be audiotaped and subsequently transcribed by a transcriptionist who will sign a confidentiality agreement prior to receiving any data collected from the interview. The researcher may also take a small number of handwritten notes during the interview. The computer files and transcripts of interview conversations will be kept confidential and only accessed by Natalie Pearson, Jane Karpa, and the transcriptionist. The computer files will be encrypted and safely stored with the notes in a locked filing cabinet and password-protected computer. When the interview is transcribed, your name will be removed and will not appear in any report, publication, or presentation of the research. Direct quotations to illustrate a point may be used, however, efforts will be made to remove any features of the interview that could make you identifiable.

Consent
Your signature on this form indicates that you have understood the information regarding participation in the research project and agree to participate. In no way does this waive your legal rights nor release the researcher from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent. Please feel free to ask for clarification or new information throughout your participation at any time.

If you have any questions, do not hesitate to contact my supervisor or me directly.
The Brandon University Research Ethics Committee (BUREC) has approved this research. If you have any questions regarding ethics, they may be contacted at (204) 727-9712 and burec@brandonu.ca. A copy of this consent form will be given to you to keep for your records and reference.

_____	_____
Participant's Printed Name	Date
_____	_____
Participant's Signature	Signature of the Researcher

Appendix D: Confidentiality Agreement

Brandon University
Confidentiality Agreement

I, _____, transcriptionist, agree to maintain full confidentiality related to any and all audiotapes and documentations received from Natalie Pearson in regards to her research study titled "Understanding the Lived Experience of Medical-Surgical Nurses in Caring for Patients Affected by Mental Illness."

Furthermore, I agree:

1. To keep all research information shared with me confidential by not discussing or sharing the information in any form or format (e.g., tapes, transcripts) with anyone other than Natalie Pearson, the researcher on this study, and to hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcribing of audiotaped interviews.
2. To not make copies of any audiotapes or computerized titles of the transcribed interviews texts, unless specifically requested to do so by the researcher.
3. To store all study-related audiotapes and printed transcript materials in a safe, secure location while they are in my possession.
4. To keep all transcript documents and digitized interviews in computer password protected files and lock any transcription programs when temporarily away from the computer.
5. After consulting with the researcher, to delete all electronic files containing study-related documents from my computer hard drive and any back-up devices.

_____

Transcriptionist Date

_____

Signature of Witness Date

Appendix E: Ethics Certificate

BRANDON UNIVERSITY

Brandon University Research Ethics Committee (BUREC)
Ethics Certificate for Research Involving Human Participants

The Brandon University Research Ethics Committee (BUREC) has reviewed and approved this ethics proposal in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2-2014)*, the *Brandon University Policy on Research Involving Humans*, and the *Brandon University Research Ethics Committee (BUREC) Policies and Procedures*.

This approval is subject to the following conditions:

1. Approval is granted only for the research and purposes as described in the ethics application.
2. Ethics Certification is valid for up to five (5) years from the date approved, pending receipt of Annual Progress Reports. As per *BUREC Policies and Procedures*, Section 6.0, "At a minimum, continuing ethics research review shall consist of an Annual Report for multi-year projects and a Final Report at the end of all projects… Failure to fulfill the continuing research ethics review requirements is considered an act of non-compliance and may result in the suspension of active ethics certification; refusal to review and approve any new research ethics submission, and/or others as outlined in Section 10.0".
3. Any changes made to the protocol must be reported to the BUREC prior to implementation. See *BUREC Policies and Procedures* for more detail.
4. Any deviations to the research or adverse events must be submitted to the BUREC as soon as possible.

As per *BUREC Policies and Procedures*, Section 10.0, "Brandon University requires that all faculty members, staff, and students adhere to the *BUREC Policies and Procedures*. The University considers non-compliance and the inappropriate treatment of human participants to be a serious offence, subject to penalties, including, but not limited to, formal written documentation including permanently in one's personnel file, suspension of ethics certification, withdrawal of privileges to conduct research involving humans, and/or disciplinary action."

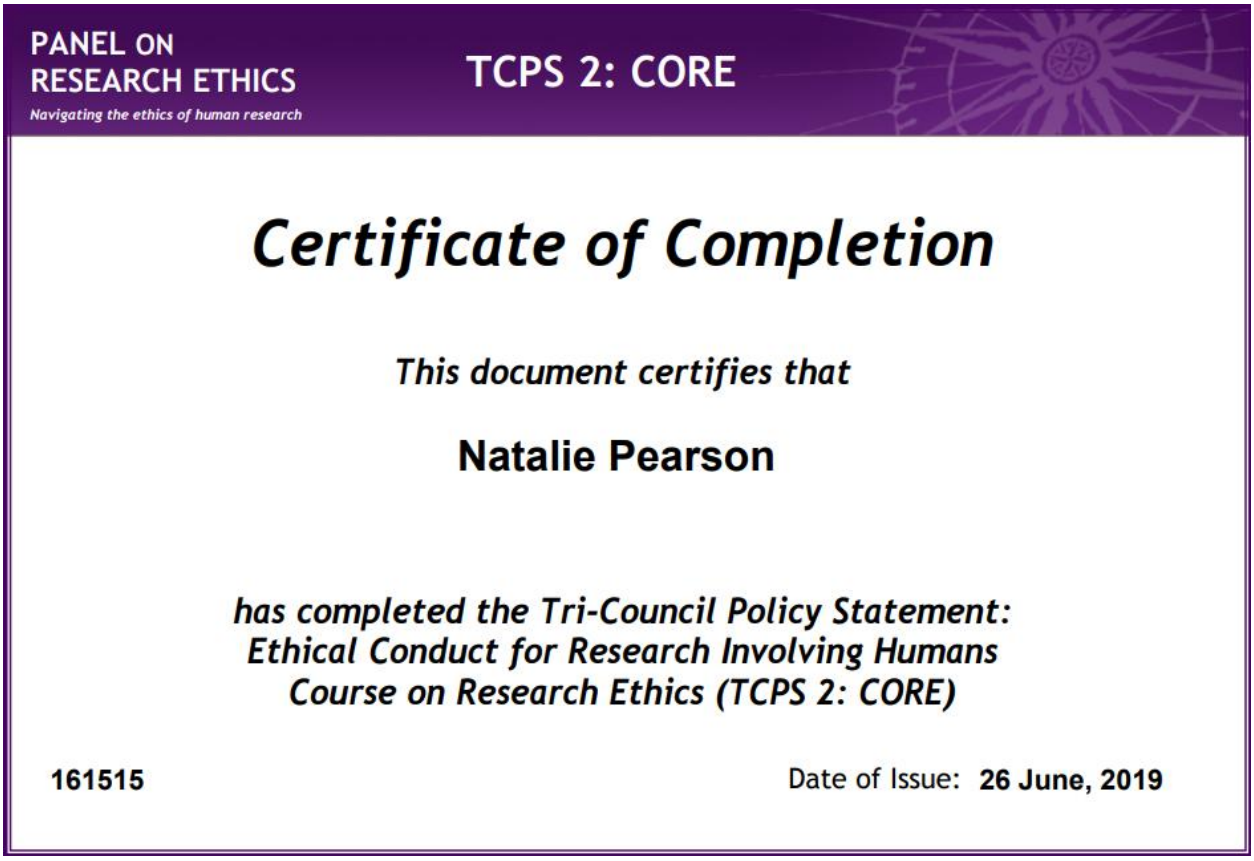
Principal Investigator:	**Ms. Natalie Pearson, Brandon University**
Title of Project:	**Understanding the Lived Experiences of Medical-Surgical Nurses in Caring for Patients Affected by Mental Illness**
Co-Investigators:	n/a
Faculty Supervisor: *(if applicable)*	Ms. Jane Karpa, Brandon University
Research Ethics File #:	22518
Date of Approval:	September 20, 2019
Ethics Expiry Date:	September 20, 2024

Authorizing Signature:

Christopher D. Hurst

Mr. Christopher Hurst
Chair, Brandon University Research Ethics Committee (BUREC)

Appendix G: TCPS 2: CORE Certificate



PANEL ON RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Natalie Pearson

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

161515

Date of Issue: **26 June, 2019**