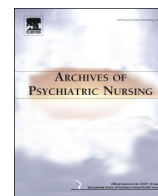




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Providing Physical Care to Persons With Serious Mental Illness: Attitudes, Confidence, Barriers and Psychological Empowerment

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ABSTRACT

The prevalence of metabolic syndrome (MetS) in people with serious mental illness (SMI) has been well documented in the mental health literature. Despite the adoption of various guidelines for monitoring risk factors for diabetes and cardiovascular risk in this population, limited translation has occurred in actual practice (Hermes, Sernyak, & Rosenheck, 2013). The Institute of Medicine (IoM) (2009) has noted a lag time in the application of knowledge within clinical settings. Evidence-based practice was deemed as a means of improving healthcare outcomes through the use of science supported standards of care. Evidence-based practice (EBP) is a process to guide clinical decision making that involves the clinician's experience, well documented research findings, and the patient's values and choices (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). The IoM has established that by the year 2020, 90% of clinical decisions should be based upon current and scientifically based information (IoM, 2009). Psychiatric-mental health nurses are challenged to utilize EBP for clients with MetS in assessing their health status and discussing the findings, educating them about their current risk and life style modifications to mitigate risk, and finally, partnering with them to maximize health and quality of life.

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BACKGROUND AND LITERATURE REVIEW

There is a growing call for integrated care for patients with serious mental illness (SMI). Mental health and physical health both contribute to a sense of well-being and this is increasingly being recognized by the health care community. Too often clinicians focus on their specialty, be that mental health or physical disease, and forget to address the needs of the whole person. This is especially true for persons with SMI who live, in general, many years less than people in the general population (Manderscheid et al., 2010).

Contributing to the health problems for persons with SMI are the developing metabolic risk factors for cardiovascular disease and diabetes. Perhaps due to genetic factors, lifestyle behaviors or medication side effects, persons with SMI are more at risk to develop metabolic syndrome (MetS), a set of factors which increase the risk of developing diabetes and its complications as well as cardiovascular conditions. According to the American Diabetes Association, MetS is present when three of the following five risk factors exist: increased fasting blood glucose, elevated blood pressure, decreased high density lipoprotein levels, increased triglyceride levels and increased waist circumference. Studies of persons with SMI have shown an increased prevalence of MetS

(Centorrino, Masters, Talamo, Baldessarini, & J., & Ongur, D., 2012; Coakley et al., 2012). Despite the fact that many of these risk factors may be amenable to interventions such as weight loss programs, exercise regimens, smoking cessation and medication adjustments, the necessary monitoring to identify the issues and subsequent treatment options are never fully addressed by members of the health care team, including psychiatric-mental health nurses. Often it is the development of a cardiovascular or metabolic complication that prompts monitoring and/or treatment (Barnes, Bhatti, & Adroer, 2015).

Psychiatric-mental health nurses, at all levels of health care, are in position to positively impact the monitoring for risk factors for MetS, the patient education to increase the person with SMI's awareness of these risks, and the implementation of risk reduction strategies to prevent development of disease. The knowledge of risk factors and monitoring related to MetS appears to be good among psychiatric mental health nursing clinicians yet implementation into practice is slow (Bolton, Knight, & Kopeski, 2016).

The question of who is responsible for the detection, monitoring and treatment interventions of the person with SMI and MetS has been discussed throughout the literature. Frequently, mental health providers cite a lack of expertise as well as limited time and resources in accessing ongoing medical care (Dixon et al., 2007). A recent study which provided a course on physical health issues in mental health practice to psychiatric-mental health nurses reported an increased

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confidence in assessment skills, but did not reflect an increase confidence in the application to their clinical practice (Terry & Cutter, 2013).

Conversely, Mangurian et al. (2013) reported in a study of primary care providers, that 40% were unaware of guidelines for patients on second generation antipsychotics. The primary care providers identified obstacles for monitoring risk factors for Met S including the degree of psychiatric illness, the dilemma of working with psychiatrists and the complexities of planning mental health outpatient care. Overall, better coordination is needed between primary care and mental health providers in determining who is responsible for monitoring metabolic parameters.

Nash (2014) conducted a small qualitative study of mental health service users' perception of diabetes care received within the mental health system. Identified factors which impeded treatment were stigma, the attribution of physical symptoms to mental illness, delay in diagnosis of diabetes while exhibiting symptoms which required a medical hospitalization, and lack of coordination between physical and mental health services. The study participants noted that although mental health nurses were knowledgeable, there appeared to be a limited ability of the nurses to translate practical interventions for diabetes care. This important study further reported that inpatient mental health nurses endorsed the value of physical health assessment of persons with SMI and viewed this as a function of their roles. However, there was a range in their confidence scores from being very confident for obtaining vital signs, weight measurement and glucose checks to a lesser confidence level with reviewing physical and mental health histories and lifestyle patterns. They reported no confidence in their ability to review laboratory results.

The literature supports that nurses are knowledgeable regarding the need for physical assessment in the person with SMI, however this assessment is often not being implemented within their practice (Bolton et al., 2016; Howard & Gamble, 2011). Howard and Gamble (2011) further report that while valuing physical health screening and assessments, nursing documentation in the medical record did not reflect this. Barriers within the workplace that may be affecting the psychiatric-mental health nurse's ability to fulfill their role in health screening and assessment need to be evaluated.

A Swedish study reported that mental health workers endorsed and valued the use of EBP, however there was a reduction in the ability and/or readiness to incorporate the evidence in their actual practice (Engström, Jacobson, & Martensson, 2015). The adoption of EBP is significant for nursing and the mandate to integrate best practices into clinical decision making is essential (Stevens, 2013). The transfer of evidenced-based research to practice is facilitated through the use of clinical guidelines for the nurse to tailor to the individual's need. Majid et al. (2011) reported 64% of nurses reported positive attitudes toward EBP however barriers within the workplace impeded their application to practice. The barriers to using EBP cited by nurses included a lack of time due to caseloads and staffing shortages, difficulty accessing resources, and limited support (Majid et al., 2011; Melnyk et al., 2004).

Other authors have noted organizational barriers such as time constraints, perception of not being able to change one's practice, insufficient knowledge and skills related to EBP, lack of mentors, and lack of resources and support from administration (Gerrish & Clayton, 2004; Melnyk, Fineout-Overholt, Stillwell, & Williamson, 2009). Additional barriers not previously reported by nurses were unavailable information and opposition from other nurses, physicians and nurse managers (Melnyk, Fineout-Overholt, Gallagher-Ford, & Kaplan, 2012). These cited barriers point to how the cultural norms of an organization can impact practice.

Kanter's (1993) theory of Structural Power explains how employee behaviors may be more influenced by work place conditions rather than personal characteristics. Kanter details that the role of power and the capability to get the work done originates from structural conditions and not the individual attributes of the employee. According to this

theory, positions with formal power are prominent, essential to the mission of the organization, and permit discretion in decision making. Informal power stems from relationships among co-workers to facilitate completing the work (Kanter, 1993). Laschinger (1996) described Kantor's theory of Structural Power in relation to nurses' work environments, and Purdy, Laschinger, Finegan, Kerr, and Olivera (2010) note that the lack of empowerment in workplace settings impacts patient satisfaction, nurse satisfaction and nurse retention.

Empowered employees need access to resources in order to fulfill their responsibilities. A comprehensive literature review on workplace empowerment and nurses' job satisfaction reported that an empowered workplace promoted a professional practice environment, enhanced job satisfaction and affirmed the caliber of patient care (Cicolini, Comparcini, & Simonetti, 2014). Laschinger, Gilbert, Smith, and Leslie (2010) proposed a nurse/patient empowerment model that suggests when nurses are empowered within their work environment with access to support, information and resources, they in turn empower others, including their patients. While structural empowerment within organizations has been described as a significant factor related to employee behavior, the need for nurses to be empowered to make decisions, developing the blueprint for their work environment and opportunities for professional growth and development were identified as essential elements for enhancing patient safety, (IoM, 2004). Nurses need to be able to manage their practice. This has been recognized by the profession over the last several decades.

Being empowered to direct ones' practice activities can also impact patient care. Menon defined psychological empowerment as "a cognitive state characterized by a sense of perceived control, competence and goal internalization" (Menon, 2001, p.159). The focus is on the employee's experience of empowerment based upon enabling strategies implemented by the organization. The three empowering components are a sense of perceived control, which fosters an ability to influence ones' work environment, perceived competence whereby one believes they are capable to meet the work demands, and lastly, goal internalization of adopting the vision and values of the organization (Menon, 2001).

Laschinger, Finegan, and Wilk (2009) noted the working relationship between the nurse manager and nursing staff is crucial in fostering an empowering practice environment. The nurse manager facilitates access to resources for goal attainment, sets the professional tone of the environment, and supports decision making for patient care; in this study, structural empowerment supported psychological empowerment. Wang and Liu (2015) discussed the impact of psychological empowerment as a means of increasing the nurses' confidence in their ability and knowledge to accomplish their work. For example, the integration of new graduate mental health nurses into the work environment is influenced by the relationships between senior nurses and the multidisciplinary team. This opportunity for dialogue provides an empowering supportive learning environment, which fosters professional growth and confidence in the mental health nurse (Wright, Lavoie-Tremblay, Drevniok, Racine, & Savignac, 2011).

PURPOSE

In a previous study the researchers noted that mental health nurses knowledge of the evidence regarding metabolic risks and related monitoring and treatment of persons with SMI did not translate well into practice (Bolton et al., 2016). Therefore, this study sought to explore attitudes, confidence and barriers in providing physical health care for persons with SMI who are at risk for or are experiencing Met S and if attitudes, confidence and barriers were related to whether physical care activities were routinely conducted in practice. Finally, we explored whether nurses' perceived psychological empowerment or ability to influence practice related to Met S in their workplace was related to the performance of physical care activities.

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