NURSES’ RESILIENCE IN A NEW MODEL OF CARE IN A NEW UNIT

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Abstract

Aim: Environmental changes and the implementation of a changed model of clinical care in a Mental Health Inpatient Unit for Older People are described and data are reported on selected outcomes as well as the effects the changes have had on nurses’ perceptions. The concept of resilience in this process is discussed.

Context: The transfer of an inpatient mental health unit for older people from a dysfunctional building to a purpose-designed unit was the trigger for a new model of care and practice for inpatient nurses. The transformation from an antiquated, dilapidated unit to a purpose-designed facility allowed the clinical focus to be the care of older people with a functional mental illness as well as those with dementia-related behavioural changes.

Primary Argument: Implementation of positive change was achieved by the provision of regularly updated information as well as design consultation and specialist education over 12 months. Resilience of the nurses was demonstrated by pre- and post-transition staff surveys indicating improved perceptions of the hospital environment, shift climate and staff morale despite increased activity and changes in the functional profiles and diagnoses of the patient population.

Conclusions: Major change in nursing practice and models of care can be implemented with good planning, education and leadership. Resilience is a key factor in the ability of nurses to respond to major change effectively. Individual resilience can be enhanced by a cohesive, supportive team environment that allows nurses to remain informed and involved in current and future changes.

Key words: Change; Inpatient Unit; Mental Health; Older People; Resilience

Introduction

The relocation of Mental Health Services from James Fletcher Hospital to the Mater campus in June 2009 coincided with a decision to change the role of the Mental Health Unit for Older People (MHUOP) to include the management of patients with a functional mental illness whilst still providing care for patients with severe behavioural and psychological symptoms of dementia (BPSD).

Boronia House, an antiquated and dilapidated 18 bed unit at James Fletcher Hospital managed mainly dementia patients with BPSD. It had very little or no capacity, from an environmental perspective, to manage elderly patients with functional mental illness. A 1840s colonial military barracks building, it had been used since 1871 for various inpatients. The internal environment of the building was grossly unsuitable, overcrowded and unaesthetic in appearance. The building was remote from other units on site and from emergency response. Day areas were separated from institutional dormitories and bathrooms by the public entrance and reception area. The day area for patients was behind closed doors, where safe visiting was not possible. Ambulant patients with high level behavioural symptoms in an overcrowded space showed high levels of intrusion, catastrophic reactions and aggression. In a space that was unsupportive of independence, orientation or enablement, there were high levels of chair restraint for aggression and high levels of sedation but no access to bedrooms to care for sedated patients.

A task management nursing model of care was imposed by poor environment and staffing levels.

This unit was replaced with a purpose-designed unit where the focus was changed to also provide care for older people with non-dementia mental illnesses. The facility design at the Hunter New England Mental Health Centre has allowed the MHUOP (22 beds) to manage both patient groups, but predominantly patients with a functional mental illness. The model of care changed from subacute planned admissions on referral to acute admissions managed by a facility bed manager of the Psychiatric Emergency Centre with access to the Psychiatric Intensive Care Unit if required.

Processes

Implementation of positive change was achieved by design consultation and specialist education as well as the provision of regularly updated information over 12 months.

Design input from staff included the use of space, patient flow, fittings and facilities. The original design was adapted to incorporate a six-bed wing where intrusive, disorganized, disruptive patients could be separated from the other therapeutic areas in a low stimulus environment. A mix of communal and quiet spaces allows for both group and individual therapeutic activity. The unit is aesthetically modern and spacious. Patients have unrestricted access to their bedrooms; all but two rooms are single rooms with ensuites. There is an atmosphere of openness allowing normalised visiting. Mechanical restraint for behavioural emergencies has been eliminated. The average length of stay decreased from 130 to 46 days, admission and discharge rates tripled and the workload around Electro-Convulsive Therapy (ECT) and medical appointments markedly increased.

The new environment and the model of care were the trigger for a number of practice changes for inpatient nurses. A model of nurse care coordination replaced centralized discharge planning; shift patient-nurse allocation replaced a task orientation model; and, the nurse-patient staffing ratio improved.

The design consultation was managed through regular design user group meetings with the architects and facility planners; written submissions were invited from and reports given back to direct care staff unable to attend meetings. Selected senior staff undertook formal site visits (interstate and to New Zealand) to similar units.
A staffing benchmark study was undertaken to support increases in nurse-patient ratios. Full day workshops for all nurses, funded by the Nurse Strategy Initiative outlined areas of professional development to support the new patient population and model of care, including acute assessment, altered presentations in older people, medico-psychiatric treatments, nursing interventions, care coordination, and legislative and procedural changes. Regular brief in-services and hard copy resources supported the workshops.

Change forum meetings were chaired by the Service Director. There was ample time and opportunity to resolve most practical issues and much of the furniture, fittings and equipment were selected by the nurses. Two senior Registered Nurses adopted the roles of Change Champions, initially on existing rotating shifts, to assist with practical implementation of processes, orientation manuals, equipment and furniture. Two weeks prior to the commissioning of the unit they provided feedback on the planning of the commissioning.

Pre and post-transition surveys conducted by the Centre for Brain and Mental Health (MHS-TYE) revealed positive changes in staff morale (0.5 on 1to 5 point scale); shift climate (2.1 on a 10 point scale) and significantly improved perceptions of the hospital for patients in the areas of personal and general comfort, privacy, safety and security, activities, hospitality services and overall atmosphere.

**Discussion**

Wagnild & Young (1993) defined individual resilience as a positive personality characteristic that enhances individual adaptation. Resilience is a combination of abilities and characteristics that interact dynamically to allow an individual to bounce back, cope successfully, and function above the norm in spite of significant stress or adversity (Tusaie & Dyer, 2004). Resilience is a means of adapting to stress in the workplace (Gillespie, Chaboyer & Wallis, 2007) and is related to job satisfaction in nursing more broadly (Aronson, 2005).

Resilience has been identified as a factor relating to job satisfaction among mental health nurses (Warelow & Edwards, 2007). Despite the demanding nature of mental health nursing many mental health nurses have not succumbed to the pressure of the work; rather they have continued to remain enthusiastic, empathic, and skilled in their clinical approach to care (Happell, Martin & Pinikahana, 2003). By definition, a resilient individual is able to prevail in the face of stress, and resilient nurses could be well suited for work in the mental health environment (Matos, 2010).

The potential for an individual to develop resilience involves a relationship between the individual and their environment. Tusaie & Dyer (2004) argue that this relationship can be characterised by intrapersonal and environmental factors such as emotional intelligence, creativity and humour, but resilience can also be developed by individuals as a result of the caring environment of the team in which they work (Edwards, 2005). Fostering resilience in the workplace through modelling and supportive environments has the potential to reduce workplace stressors for mental health clinicians. (Edwards & Warelow, 2005).

Job satisfaction is an affective state that depends on the interaction of employees, their personal characteristics, values and expectations, with the work environment and the organization (Mueller & McCloskey, 1990). Ablett & Jones (2007) found that agreeable environments, sufficient time to spend interacting with patients, reasonable workload and supportive peers and colleagues were factors related to job satisfaction. Matos (2010) identified factors that influence job satisfaction among mental health nurses in inpatient units. Of the eight factors identified, three were positively affected in the MHUOP transition: schedule, environment and staffing. The other factors; pay, co-workers, supervisors and doctors remained unchanged.

Environmental changes and the implementation of a changed model of clinical care had the potential to create stress in the working environment of the inpatient unit. Changes in work processes, patient flow, patient population, disorders and nursing management created challenges to an individual nurse’s existing skills and knowledge base. Despite this, nurses rated morale, climate and the working environment positively. It can be argued that in the context of major stressful change the personal resilience of the nurses as a group, as well the strategic approaches of design consultation, specialist education and information served to balance these challenges.

**Conclusion**

Major change in nursing practice and models of care can be implemented with good planning, education and leadership. Resilience is a key factor in the ability of nurses to respond to major change effectively. Individual resilience can be enhanced by a cohesive, supportive team environment that allows nurses to remain informed of and involved in current and future changes.

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**References**


