What prevents one to one care?

This study explores the barriers to effective interaction between nurses and service users in acute settings.

In this article...
- Developing a therapeutic relationship with service users
- Challenging stigma and promoting client engagement
- Improving the efficacy of one to one sessions
- Helping nurses make the most of their existing skills

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● This article has been double-blind peer reviewed

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Mental health nursing is complex and demanding. A fundamental part of the mental health nurse's role is forming a therapeutic relationship with service users and their family or significant others. Recent government policies (Department of Health, 2010; 2008) back this approach, as do many researchers who believe this relationship is the core of mental health nursing. Nolan (1993) suggested the great strength of mental health nurses is their closeness to clients, while Wilkin (2003) said the emphasis of mental health nursing is on the development of a therapeutic relationship or alliance. Reynolds (2003) also stresses the importance of "one-to-one" working, believing that a therapeutic relationship is the crux of nursing. In practice, this means nurses should seek to engage with the person in their care in a positive and collaborative manner. This empowers service users to draw on their inner resources, in addition to any other treatment they may be receiving.

The Mental Health Foundation supported greater access to talking therapies (www.mentalhealth.org.uk/campaigns/need-to-talk), and the recovery approach within mental health services has become a guiding vision that promotes the need to work in partnership with service users (Chandler, 2010; Shepherd et al, 2008). However, this is only possible if nurses spend quality time with service users. According to the NHS Institute for Innovation and Improvement (2008), ward nurses in acute settings only spend around 40% of their time on direct patient care.

Background
This project was initiated after a 2007 visit to West London Mental Health Trust from the Mental Health Act Commission (now the Care Quality Commission), which identified several issues needing investigation (Mental Health Act Commission, 2008). The commission questioned service users and staff and looked at a wide range of services, resulting in a number of further visits to monitor progress.

One major concern was that interaction between nursing staff and service users had to be more effective. Service users said they often felt their care plan could apply to anyone. Achieving personalised services can mean challenging stigma and stereotypes about mental illness among medical and nursing staff; service users should be recognised as individuals not categorised by legal status or diagnosis.

The commission suggested that services should provide individualised, holistic care that promoted recovery and inclusion, and that service users and carers must be involved in care planning. It also recommended that efforts be redoubled to ensure ward staff actively engaged with service users wherever possible.
Despite this, they said one-to-one sessions towards doing their jobs effectively. Preset topics and follow-up probes encouraged the participants to elaborate on their responses. There was no questionnaire, but a crib sheet was used to explore the initial topics identified systematically. Resulted analyses were not always synchronised, which leaves nurses feeling as though they have little control over admissions. They also feel disempowered when others make decisions that affect their work and the time available to spend in one to one care with service users.

**RESULTS**

Interview data was collated and subjected to a content analysis; five themes emerged.

**Administrative duties**

Nurses said there was too much administrative work – from making and answering phone calls to writing in the ward diary and in service users’ notes – as most activities taking place during a shift had to be recorded. They said this took priority over spending time engaging with service users on a regular, one-to-one basis.

Employing a full-time administrator for each ward could prove more efficient than having nurses doing so many office tasks. Writing in service users’ notes could be done during one-to-one sessions.

**One-to-one sessions**

It was clear there was a lack of understanding of what one-to-one sessions should entail, or how long they should last. A great deal of discussion takes place during interactions with service users, such as assessments or medication rounds, but time was not always set aside to specifically engage with them in a therapeutic way.

Nurses felt that psychiatrists or psychologists were more likely to set up fixed appointments for therapeutic intervention, whereas nurses were only able offer one-to-one sessions when they could fit them in.

The ward managers also acknowledged that it was difficult to engage with disturbed and demanding service users. Comments indicated staff thought some were a “lost cause”, especially those who were regarded as “revolving door” readmissions; those diagnosed with a personality disorder were seen as “incorrigible”. This was frustrating for staff who felt too familiar with service users and did not know how to engage with them in a meaningful way. While some staff did not know how to engage, it was suggested that others “could not be bothered” and merely adopted a containment approach.

Managers suggested that developing guidelines and structure for one-to-one sessions and interventions would help. Not all staff have the skills or confidence to engage effectively on a one-to-one basis, so staff training needs were identified.

**Workload control**

Ward managers felt they had little control over their workload and bed management dictated the pace of work. People were viewed as part of the core work of the nurse.

The project

The project was set up to investigate the discrepancy between the role of the mental health nurse described in the literature and mental health nursing practice at the trust.

**Phase one**

We set up informal one to one meetings with four senior nurses from the trust’s acute care services to identify key concerns and nurses’ views about staff spending time with service users. The nurses were given the opportunity to check the accuracy of meeting notes. The issues identified are outlined in Box 1.

**Phase two**

The initial meeting provided a project baseline. We decided to contact all ward managers in acute areas within the trust as these were running the wards and providing leadership. Eleven ward managers – representing all the trust’s acute wards – were interviewed; the issues identified in phase one were the focus for these semi-structured interviews. Preset topics and follow-up probes encouraged the participants to elaborate on their responses. There was no questionnaire, but a crib sheet was used to explore the initial topics identified systematically.

All the nurses had a positive attitude towards doing their jobs effectively. Despite this, they said one-to-one sessions with service users did not take place in a consistent or efficient manner. Some said sessions only occurred at weekends or in the evenings when other professionals were not around; this suggests it was not seen as part of the core work of the nurse.

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**Workload control**

Ward managers felt they had little control over their workload and bed management dictated the pace of work. People were
admitted to wards and those admitting them had no real understanding of the staffing levels and the demands on the wards. The message appeared to be: “You are an admissions ward so must accept admissions.” Other comments included:

» “There are too many service users in seclusion.”

» “One-to-one observations take up too much time.”

» “Psychiatrists want many admissions immediately put on one-to-one observations. This depletes staff availability for more therapeutic and structured one-to-one sessions.”

Other concerns were that escort duties took up a lot of time and reduced staffing levels, and a lack of consistency or continuity with bank staff.

The ward managers felt the nurses dealt with the real difficulties on the wards, while the other professionals just “came and go”.

Nurses said they tried to engage with service users at least twice a week about care plans but this differed from ward to ward. Some suggested that more protected time could help with regular appointments (Edwards et al, 2008).

**Staff needs**

Staff training and supervision were major concerns; one-to-one sessions, when they did take place, varied depending on the level of training and support staff had received. Participants suggested involving former service users and role modelling by senior staff could be beneficial.

Some ward managers thought staff were “burnt out” and not truly engaging with service users. They also thought the admissions process was not well thought out regarding staff levels and there was no appreciation of staff’s psychological needs. Some saw sickness as a metaphor for stress and the need for personal space.

Some long-term staff were seen as resistant to engaging with service users on a one to one basis and quite content to function in a containment role.

Recruiting and replacing staff was a concern as it increased the burden on regular ward staff. The fact that agency or casual staff had a lower level of commitment than regular staff was also mentioned.

In some areas, support from service managers was seen as very positive, with clear leadership and good teamwork. However, it was suggested that overall supervision needed to be improved. Supervision for staff was said to occur monthly in most areas, but was not always seen as successful. When group supervision took place, it was felt facilitators did not always have the necessary skills or confidence and were ill-prepared to make it effective.

**Ward culture**

The ward managers felt administrative issues, such as recording the number of admissions, discharges and incidents, took precedence over contact with service users. This was the dominant culture on the wards and was seen as having greater importance than valuing human contact.

Staff attitudes were also highlighted. New members of staff could feel stifled by established staff seniority and the negative stereotypes attached to service users with conditions such as personality disorders.

Participants also suggested that some nurses found it tough to adopt a therapeutic role and give greater priority to managing and containment. Many saw coping as the dominant cultural expectation, rather than proactive, effective and meaningful engagement with service users. There also appeared to be conflict over whether acute wards should provide therapy or containment, and getting the right balance could be difficult. One to one sessions were conducted on a casual basis and targets for admissions and discharges took precedence over time for compassionate care.

As nursing on acute mental health wards was seen as a high pressure job, it was suggested that during quieter periods some nurses metaphorically put their feet up to recharge their batteries.

**Discussion**

The benefits of working one to one with mental health service users are evident from the literature, but this study revealed many barriers to this therapeutic process. According to the Royal College of Nursing (2009), four in ten nurses working in mental health believe they are not able to make full use of their skills. If service users do not receive regular therapeutic intervention from nurses, we have to ask whether they are being treated or simply contained. The extent to which mental health nursing is still rooted in its more custodial historical past requires further discussion.

Much progress has been made at the trust since this study was conducted; education and training to help nurses increase the amount of direct care time given to service users has improved, and the trust has implemented Releasing Time to Care: The Productive Mental Health Ward (NHS Institute for Innovation and Improvement, 2008). These improvements have been acknowledged by the CQC and work to increase the amount of one-to-one time service users spend with nurses continues.

**Conclusion**

This study has identified some of the issues surrounding one-to-one care for mental health service users and how they can be addressed. Since it was only conducted at one trust, however, it is impossible to say whether the findings would be the same elsewhere. Replicating the study nationally would enable us to see if other trusts have faced similar issues, and what they did to improve practice. NT

**References**


