EVALUATING PROTECTED TIME IN MENTAL HEALTH ACUTE CARE

This is a summary: the full paper can be accessed at nursingtimes.net

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A protected time initiative was introduced in a mental health acute care unit with an agreed protocol to enable nursing staff to spend more time with patients. This study aimed to investigate implementation of the initiative.

Patients and nurses in four wards were invited to complete questionnaires. Sixteen nurses and 17 patients responded.

The results suggest a variety of reasons why nurses do not spend sufficient one-to-one time with patients. Patient responses were inconsistent and at times contradictory and the findings suggest nurse supervision needs to be made more readily available.

A clearer understanding of protected time and a consistent approach are required, as well as venues that allow patients to discuss sensitive issues without disruptions.

INTRODUCTION

The Department of Health (2002) called for improvements to ‘ensure adequate clinical and support inputs to inpatient wards and to maximise the time spent by staff therapeutically engaged with service users’.

Yawar (2008) reported that only 16% of patients’ time was spent in ‘what can loosely be termed therapeutic interaction’. The remaining 84% was spent aimlessly either pacing up and down the ward or sitting around doing very little.

The Mental Health Act Commission (2008) reported that ‘nurses frequently complain of being too busy to develop therapeutic rapport with patients’.

INTRODUCING PROTECTED TIME

These issues were discussed at the trust and we introduced ‘protected time’ in our own areas. This was defined as a designated period when only ward-based staff would be present to ensure they were not constantly interrupted by other people’s demands.

Two periods in the week were initially identified. These were at 3–5pm on Tuesday and Thursday afternoons. These times would be spent offering one-to-one sessions, although it is important to stress this did not preclude individual sessions outside this time.

This initiative had already been introduced in other parts of the trust. The notion of protected time is not new and it is supported in the chief nursing officer’s review of mental health nursing (DH, 2006).

Other trusts have introduced such practices but the extent to which they are successful and have been evaluated is unknown.

AIM AND METHOD

This study aimed to evaluate the implementation of the protected time initiative. A nurse research interest group had been set up. This group took on the task of devising questionnaires to seek nurses’ and patients’ views about protected time. In keeping with the trust’s protocol, I submitted a proposal for ethical approval and the audit department gave permission to carry out the evaluation.

The unit has four wards and all nursing staff and patients were invited to take part. A sealed box was provided for returned questionnaires, thus ensuring anonymity.

The nurses’ questionnaire comprised 14 questions. There were 10 Likert-scale questions and four that were open ended and sought qualitative data. The patient questionnaire was similar. Sixteen nurses and 17 patients responded.

RESULTS

Nurse responses

Nurse responses to the Likert-scale questions were somewhat mixed but overall were positive about the potential of such a system.

Nurse responses to an open-ended question were almost unanimous in recognising they had responsibilities to engage with patients and they welcomed the opportunity to do this without other demands.

Comments included: ‘Being able to talk to patients in depth about their feelings, listening to them and allowing them to ventilate their feelings.’ One comment suggested certain reservations: ‘Better if staffing levels increase during those days, my responsibilities increase with not enough staff and a fear of things going wrong with difficult patients on the ward.’

The questionnaire also asked nurses how often they received supervision and from whom. Overall, responses suggested
that supervision is inconsistent and does not focus on enhancing skills for one-to-one sessions.

Nurses were also asked what changes they would like to see to the system. They mentioned the need for more regular staff as staffing levels determine the amount of time that can be protected.

Two respondents suggested the day needs to be changed. Some gave opposing views: ‘One hour is not enough for staff to utilise with protected time as well as writing in the patients’ notes’ and ‘Shorten the time because patients don’t want to spend a lot of time speaking to us’.

The last question asked for any other comments. Responses included: ‘Need to be flexible when the ward is unsettled, may need to postpone PT [protected time]; ‘Places good emphasis on patients and staff spending time together’ and ‘Most of the patients don’t want to participate; they don’t want to talk even after explaining to them what it is for. Mostly they say they have nothing to talk about.’

Patient responses
The first question asked patients how long they had been admitted to the ward. This reflects a diverse range of lengths of admission and therefore the opportunity to have participated in the protected time initiative.

Two questions asked patients whether they had had two sessions a week of protected time with their allocated nurse in the past month, and how long these had usually lasted. Eight said they had had two sessions a week, eight said they had not, and one stated they did not know. Patients reported a range of different lengths of sessions, from over two hours to less than 30 minutes.

Patients were also asked to rate the environment in which sessions took place. Three said it was excellent, three said good, five said alright, two said there were some problems and two said it was poor.

Additional comments included ‘In a room where everyone can see you, very frustrating’ and ‘It was in my room, everything went really well.’

When asked what they normally discussed, comments included: ‘About welfare and medication’, ‘Nurse only talks when I have been bad’ and ‘Talk about children and when I can go home’.

Three patients said the sessions were very useful, seven said useful, two said it dependd, two said they were not usually useful and one said never useful.

When asked how they would like to use this time, patient responses included: ‘Find the right treatment and praise when I have not hurt myself’ and ‘Talk about what I need in hospital.’

Patient suggestions to improve the sessions included: ‘By staff listening to my opinion and give advice on issues’, ‘Spend more time with our allocated nurse’ and ‘Keep it to half an hour and talk about important things’. For tables and graphs showing the results in full, see nursingtimes.net.

DISCUSSION
Overall nurses’ responses recognise the potential and advantages of such a system. The greatest concern tends to be about staffing levels and how this affects the continuity and consistency of the initiative.

The open-ended questions identified a number of positive aspects but, again, the issue of staffing appears to be of concern. The RCN’s (2007) survey of mental health nurses showed 66% of respondents considered staffing numbers were insufficient and 42% reported that low staffing levels compromised patient care at least once every week.

Other comments suggested patients did not want to participate. This last point may reflect the ambivalence of some nurses.

While staff levels are important in enabling nurses to spend more time engaging in one-to-one relationships with patients, it could be argued the issue is more to do with how staff prioritise work.

Engaging with patients’ distresses may be difficult for some nurses because some of these issues may also be concerns and traumas of individual staff. Clarke (2008) suggested that nurses can be affected by vicarious trauma and it may leave them emotionally overwhelmed. This is where supervision should play its part and this study suggests its availability is inconsistent. Patients’ length of stay varied from under one week to over one year and their responses are inconsistent and at times contradictory. Not all patients appeared to receive regular one-to-one sessions but those who did said they were satisfied and sessions were useful.

The environment in which the sessions take place is an issue that requires monitoring as some patients expressed concern regarding privacy and confidentiality, as well as timing.

CONCLUSION
Protected time can be a way of helping to promote nurses’ therapeutic role but, without adequate supervision, they may well withdraw into a custodial role as a defence against their own vulnerability and lack of expertise. Mental health nursing is not a straightforward or easy task. However, nurses have to try to make sense of the difficulties and complexities in patients’ lives.