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Acute wards: problems and solutions

Nursing matters in acute care

A woman, who was an in-patient, provided an interesting summary of mental health wards when she stated that she felt extremely sorry for the nursing staff. She disliked intensely the experience of being an in-patient but, she said, at least she would soon be discharged. The nurses, she declared, had no such hope and were destined to remain incarcerated in the ward, unless they could get another nursing job.

There were perhaps two important flaws in her observations. First, her optimism about discharge was perhaps misplaced. She could probably only look forward to becoming another statistic among the ranks of the new psychiatric scapegoat, the 'bedblocker'. Second, nurses are currently leaving ward settings in their masses, whether or not they have secured an alternative nursing job, and 85% of NHS trusts have reported general difficulties in recruiting and retaining nursing staff (Sainsbury Centre for Mental Health, 2000).

Of course, there are in-patient units which provide good treatment and care and, in spite of the challenges, innovatory nursing practice can be found (Barker, 2001). Some are in suitable buildings, enjoying good levels of permanent nursing staff, rather than placing excessive reliance on bank and agency nurses, and having manageable bed occupancy rates. Crucially, some operations are co-ordinated with services designed to prevent unnecessary admission in the first place, and those that enable timely discharge and ensure quality aftercare, when admission is necessary and appropriate.

However, most in-patient units are quite appalling and are viewed with disdain by patients, their families and the nursing staff who try to maintain a measure of a safe and supportive milieu within them, 24 hours each day. There is nothing new in this situation. The literature of earlier decades includes many hospital inquiry reports highlighting acts of shameful cruelty, understaffing, overcrowding, a lack of respect for patients' privacy, dirty kitchens and even dirtier lavatories (Nolan, 1993).

There have been many more recent reports which indicate that policymakers, purse-holders and sadly, perhaps, some professionals have learnt little from these earlier accounts. In-patients continue to experience poor opportunities for therapeutic and recreational interventions and they are at risk of self-harm, suicide, physical attack and sexual abuse, while nursing staff lack opportunities for development and training in the management of aggression, and experience unacceptably high stress levels (Department of Health, 1999). Meanwhile, in-patients themselves complain that their contact time with staff is only 15 minutes or less each day. They find the ward atmosphere bleak, depressing, unsafe and frightening and report that it is hard to sleep at night, difficult to obtain adequate food and fluids and that the toilets are (still) dirty! (Mind, 2000).

We clearly require a fresh analysis of our expectations of in-patient settings and the nurses working within them. Is the goal a continued descent towards a custodial refractory sump, or a genuine commitment to provide hope-laden, first-class, in-patient nursing and medical interventions in quality environments for those who want and need them? If the latter, then in-patient wards require urgent investment at a level which not only recognises the size of the problem but also shows a commitment and political will to bring about change. A whole systems philosophy must also be adopted that ensures in-patient care is set within a network of mental health services which recognises both its centrality and the inter-dependence of all services, one upon the other.

Mental health nurses will continue to lobby for improvements, attempt to influence and seek to contribute to policy arenas. One way of achieving this is by examining some of the constituent parts of the overall problem in more depth. The Royal College of Nursing (RCN) Institute's Mental Health Programme has been making such contributions through its research into patient observation, and inquiries into the training and education needs of nurses in in-patient settings.

The observation of patients in acute in-patient settings is a fundamental part of the care provided by mental health nurses. Spending time with those who are distressed and vulnerable can provide an opportunity for nurse–patient therapeutic interaction. However, it seems that, in such wards, this nursing intervention has become primarily a custodial task, with nurses often playing the role of 'custodian' rather than 'carer'. Little research has

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been done on patient observation and even less focuses upon the patient perspective. The RCN Institute's Mental Health Programme has tried to address this gap by conducting a pilot study exploring the patient experience of being observed (Jones *et al*, 2000). The study was conducted in a single mental health care trust. There were interviews with 28 in-patients (using semi-structured interviews and the repertory grid technique) who had all had the experience of being observed closely by nurses. The main finding of this study is that the patient experience of being observed is strongly influenced by the behaviour and attitude of the individual nurses who are observing them. Specifically, patients who are observed by nurses whom they know and who are prepared to talk and engage with them feel safer, more reassured and more cared for. Conversely, patients feel less safe and cared for, frustrated and annoyed when observed by nurses they have not met before and who make no attempt to engage with them. Suicidal patients, in particular, found the latter experience to be very negative.

The main message from the study is simple: nurses should be actively engaging with patients in acute in-patient units. However, as discussed above, we know that in many places this does not occur. The reasons for this are complex but relate to issues that include: staff shortages; piecemeal approaches to clinical supervision, support and leadership issues; the overburden of paperwork and the perceived 'blame' culture in the NHS. These all conspire to sap the morale, enthusiasm and energy of in-patient nurses. There are also specific gaps in the knowledge and skills of these mental health nurses that are not being addressed by current educational and training opportunities (Department of Health, 1999). The RCN Institute's Mental Health Programme is currently examining the post-registration training and education needs of mental health nurses working in acute in-patient psychiatric settings in the UK. The findings will be available shortly but it is clear that the support, development, education and training of nurses working in these settings requires attention.

With acute mental health care in such crisis, we should consider every mental health nurse working in an acute in-patient setting as a valuable resource. Until this view is adopted, many nurses who perceive themselves to be ill equipped for the demands placed on them, undervalued and underpaid, will continue to leave.

More positively, acute in-patient care has recently begun to receive welcome attention. First, new guidance from the Department of Health (2002), which acknowledges that 'in-patient services are not working to anyone's satisfaction', presents ideas to stimulate local action in pursuit of improvements. It highlights positive initiatives which have been, and can be, developed. It also demonstrates the achievements of nurses, their colleagues and patients. A further publication focused on training and education issues for nurses and others are expected in due course. Second, the Sainsbury Centre for Mental Health, in collaboration with the RCN, the Royal College of Psychiatrists and other organisations, has initiated the 'search for acute solutions' project. This will offer four acute in-patient settings the chance to develop, test and implement new ways of working, with the results being shared with other settings.

These demonstrations of commitment and resources must be sustained and developed if staff morale is to be raised and patients' experiences improved. As the woman said, the in-patient ward was an experience she disliked intensely.

Declaration of interest

None.

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