“It’s not my job”
Mental health inpatient Registered Nurse, in a discussion about monitoring the physical health status of mental health inpatients, September 2011

There is overwhelming evidence about poor physical health outcomes in the population of people with mental illness. Despite this, it is still possible to encounter mental health clinicians who regard their role as exclusively attending to patient’s mental well-being, ignoring the impact of physical health on that well-being.

This is the fourth in a series of four mental health fact sheets. The others in the series are:

- Mental health fact sheet 1: An overview of recognition and response systems
- Mental health fact sheet 2: Operational considerations
- Mental health fact sheet 3: Communicating about physiological deterioration

Performance management is one way to address resistant or negative attitudes from clinicians, but it is a fairly blunt tool. Engaging people in the process of change is likely to yield better long-term results. Clinicians in the team who effectively integrate physical health monitoring into their mental health work can positively influence ward culture. Recognising and respectfully addressing the underlying attitudes contributing to negativity is also likely to yield long-term improvement.

Some of the possible reasons for resistance amongst mental health clinicians to incorporating the physical care of patients into their role are listed below:

- Clinicians may lack recent training in physical health monitoring, and/or lack confidence in using these skills.
- Mental health clinicians have less physical contact with patients as part of their clinical roles compared to other clinicians. This may have a negative influence on their ability to undertake routine monitoring. For example, in a recent survey of psychiatrists 80% stated that although they thought that their patients’ girth should be measured at least every six months, only 7% either measured this themselves or ensured that the measurement was done.
- Some patients in mental health wards may stay for long periods, or present frequently. Complacency may lead to observations being neglected over time. In addition, issues with physical observations being resisted may be encountered more frequently than in some other health settings.
- Monitoring physical health can be conceived as contributing to workload pressure and this can engender resentment and defensive behaviours.

Some useful strategies to deal with the challenges of implementing recognition and response systems are listed overleaf.
Leadership matters

- Governance arrangements should demonstrate strong executive and clinical support and provide reporting and review mechanisms, including processes for the escalation of significant issues.
- Identify medical and nursing champions to help lead implementation – these should be clinicians who are well respected by their peers, genuinely committed to the project and are able to articulate why it matters.
- Ensure that organisational leaders and clinical champions are visible, deliver consistent messages and follow up when they say they will.

Staff involvement

- Develop clear pathways for staff to provide feedback and contribute to the development, evaluation and review of all aspects of the recognition and response system. Involving staff in the development of guidelines and processes can improve usability and help to foster a sense of ownership in making things work.
- Trial new tools and processes and be prepared to adjust them to improve usability.
- Discuss the outcomes of root cause analyses, and mortality and morbidity reviews with all clinicians – too often new directives are given to staff disembodied from the knowledge that would help them to understand the reasons for change.
- Clinicians are busy - use meetings that are routinely scheduled to gather information about how the system is performing and to highlight patient experiences.

Engagement through education and training

- Educate mental health clinicians about the development of recognition and response systems in general, as well as giving specific information about the system in use locally. This will set the change in context, and underline that introduction of these systems is not a specific imposition on mental health staff, but part of a quality improvement process across all acute care settings.
- Use local patient stories where recognition and management of physical deterioration was less than optimal to illustrate why recognition and response systems are being implemented. Patients and families might be invited to share their stories with staff directly, or educators might use de-identified case notes to highlight errors, omissions and opportunities to improve care.
- Provide training in effective monitoring of physical health and management of physiological deterioration for all clinical team members. This training should involve formal theoretical learning as well as opportunities to practice skills on real people and in simulation.
- Engage mental health clinicians to deepen their understanding of the influence of physical health on mental health. Many people with mental illness live in poverty and social isolation, and admissions to mental health units are opportunities to rebuild social and functional skills that can contribute to improved physical health, for example good nutrition and self-care.

Remind mental health clinicians of the core principle behind this work: ‘Remember it’s all about the patient, and that what you are doing makes a real difference to what happens to the patients in your care’.

References


Further Information

Further information about implementing recognition and response systems can be found on the Australian Commission on Safety and Quality in Health Care web site.

www.safetyandquality.gov.au

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