‘Accountability matters’

Nurses’ accountability enactment for consumer involvement in care planning in one Australian inpatient unit.

by

Josephien Rio

Thesis
Submitted to Flinders University
for the degree of

Doctor of Philosophy

College of Nursing and Health Sciences

8 April 2019

ACKNOWLEDGEMENTS

I would like to acknowledge the support of a number of people who have accompanied me on this journey and without whom this PhD would not have been completed. It has been an extraordinary time since commencing a completely new topic a few years into my PhD.

Throughout, my primary supervisor Emeritus Professor Jeffrey Fuller has supported me, even beyond retirement. The gentle way of providing feedback often via an email outlining a step by step process or explanation has provided me with so much more insight and understanding. The frank comments on my work has raised my writing skills to a new level.

To Associate Professor Kerry Taylor, who has been there to support me from the commencement of my PhD. Thank you for being able to drop in and discuss any concerns or fears. Your feedback and assistance in the creation of a poster made all the difference when I took on this task without any prior knowledge or practice.

To Professor Eimear Muir Cochrane, for your support and honest feedback which made me sit back and think again. As a result of your approach and high expectations I now critically analyse my own work. To Professor Tara Brabazon, Dean of Graduate Research, who read my completed chapters and provided feedback which catapulted my research forward. To the Australian Government and the contribution of the Australian Government Research Training Program Scholarship.

To the nurses in the inpatient unit where I did the research I give my sincerest thanks. Thank you for your time, honesty and the fearless way you answered my questions and that your contributions will lead to a better understanding of accountability. To senior management in the Local Health Network and the

support of the Clinical Director at the time, Dr Jörg Ströbel, who supported the research and actively encouraged an improvement in care plan development. To Simon Moody, team leader of the Murray Mallee Community Mental Health Team, and the many conversations we had on the way to work. Your leadership in facilitating an improvement in care plan development has been inspirational.

Finally, I would like to thank Peter, my main support from day one. Thank you for the cups of coffee, the cooked dinners, presentation practice, the counselling and feedback. You believed in me and kept telling me I would finish this marathon.

LIST OF FIGURES

TRANSCRIPTS

Throughout the thesis, participants' transcripts (quotes) appear in italics using pseudonyms. The quotes are indented. The pseudonyms and the number of the line in the interview transcript identify the excerpts from the participant interview.

For example:

> *Some have said that they have felt put down or they're just not confident…*(Karen, Interview 5, line 226).

> *The Safety Learning System is not punishment, it is that learning system. It needs to be used as a system's approach to see why things were not done* (Mark, Interview 9, line 173-174).

FIELD NOTES

Field notes are used throughout the text and are identified and referenced by 'field notes' followed by the date the field note was taken.

For example:

The Clinical Director walked in and explained to all the staff present that from that week onward there would be daily 'huddles' at 14.00 for the senior nurses and medical staff (Field notes, 29/09/2015).

ABSTRACT

Policy rhetoric promotes the use of care planning processes to empower consumers in the active management of their own recovery, however mental health consumers continue to re-present to our services with low levels of wellbeing, mental and physical health challenges and a reduced life expectancy. Evidence suggests that care plans are not routinely created, discussed or updated. My thesis is that the lack of meaningful care plan discussion between mental health professionals and consumers is influenced by and is the outcome attributable to a failure of accountability enactment.

The aim of this study is to explore how the management of accountability impacts on the development and use of care plans by mental health nurses and to examine if there is a relationship between a unit culture of accountability and consumer involvement in the development of care plans by these nurses.

A focused ethnography involving mental health nurses and other health professionals was undertaken in one inpatient unit of an Australian psychiatric hospital from August 2015 until February 2016. Data from in-depth semi-structured interviews with 12 nurses and 6 months of non-participant observation of multidisciplinary meetings and clinical handovers were analysed using the theory of accountability, the role of the mental health nurse and care planning in the inpatient unit.

The unit environment was found to be medicalised with attention to acute treatments and risk management that was driven by a focus on reducing the length of stay rather than recovery. Nurses felt their role was diminished, with their decision making and accountability enactment directed to medical management. As a result nurses forewent commitments regarding consumer

involvement in care plan developments and therefore the provision of high quality therapeutic engagement.

My original contribution to knowledge is that a lack of meaningful consumer engagement by mental health nurses occurs through non-fulfilment of accountability obligations. Despite the use of organisational processes such as mental health service accreditation and auditing to ensure accountability, unless individual nurses include consumers in development and maintenance of their care plans then quality oriented care will be absent. It is this therapeutic engagement in the processes of care plan development and subsequent advocacy, which forms the basis of accountability enactment that can facilitate recovery. I argue that therapeutic engagement with the consumer is a key role of mental health nurses that needs to be reinvigorated.

The care plan and the recovery model are intrinsically linked and for the care plan to succeed and become an integral part of everyday mental health practice, the recovery model needs to be embedded in routine practices within mental health services. Beyond the rhetoric of consumer recovery outlined in policies, this requires attention to the culture of the work environment, how nurses weigh up the factors that drive the current service approaches and how these influence mental health nurses' decisions about their practice.

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree of diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Josephien Rio Date: 8 April 2019

CHAPTER 1 INTRODUCTION

1.1. INTRODUCTION

As a mental health nurse with 11 year of experience in inpatient and community mental health service settings in different states, I have been struck by the ill health of many mental health consumers. While I have encountered consumers who showed an improvement in psychological health and wellbeing I have also seen with some who demonstrate, at best, no improvement, or worse a gradual deterioration in mental and physical health. I have regularly witnessed consumers of mental health services who experience poverty, homelessness and despair. Mental health consumers continue to re-present to our services with low levels of wellbeing, mental and physical health challenges and a lack of empowerment (Ewart et al. 2016).

I have asked myself the question what my role as an accountable mental health nurse can or should be and what accountable mental health services should be doing to alleviate consumers' distress. Data collected by the Australian Government indicate that in some instances inpatient mental health services do not make a difference to consumers. Key performance indicators compiled by the Australian Institute of Health and Welfare based on the sum total of HoNOS scales (Australian Government 2018) showed that over the period 2015-2016, 22.8 percent of mental health consumers experienced 'no change' in mental state after a completed inpatient admission. This proportion was significantly higher for ambulatory treatment (Australian Institute of Health and Welfare 2018). More specifically in South Australia 29.9 percent of consumers in 2015-16 did not experience a change after an inpatient admission while 5.1 percent experienced a 'significant deterioration' over the same period compared to 4.4 percent in

2007-2008 (Australian Institute of Health and Welfare 2018). At the same time the number of residential mental health episodes (treatment, rehabilitation or extended care) per 10,000 population increased from 2.5 in 2011-12 to 3.2 in 2015-16. Based on these data the question can be asked how accountable we are as mental health nurses or mental health clinicians? How can we justify our sense of accountability for our practice if the mental and physical health of some of our consumers during inpatient admissions remains unchanged or deteriorates? How does accountability function in the daily work environment? How do we as mental health nurses experience and enact accountability? These are important questions as it is a sense of accountability which can drive our practice and act as a guarantor for quality care provision.

The foundation of quality mental health service provision is consumer involvement in individualised care planning (McHugh & Byrne 2012; Bee et al. 2015a; Bower et al. 2015b). Mental health care planning can be defined as a five step process incorporating a needs assessment, formulation, outcome and intervention planning, implementation and evaluation in light of the care received (Hall & Callaghan 2008). The consumer care plan includes the time frames, goals and aims relevant to the multiple life domains of the consumer and the strategies and resources to achieve these outcomes (McHugh & Byrne 2012). Involving consumers and their carers in mental health care planning and promoting shared decision making is a central part of contemporary mental health policy in Australia (Commonwealth of Australia 2009; Australian Government 2010; World Health Organisation 2012; National Safety Quality Health Services Standards 2017). Health policies suggest that consumers and their carers are major stakeholders in service delivery and must be regarded as participants rather than recipients of mental health care (Bee et al. 2015 a). Some small studies suggest that involving consumers and carers in the planning and delivery of care can

have a positive impact on service and individual outcomes (Thornicroft & Tansella 2005), reduces the rate of enforced admission and treatment for people with severe mental illness (Henderson et al. 2004) and increases consumer esteem and empowers individuals to get control over their own recovery and care (Henderson et al. 2009). Consumer involvement with shared decision making can be a means to achieve better satisfaction with the treatment and better health outcomes (Coffey et al. 2016). Benefits of consumer involvement in care planning also includes enhanced services development, improved staff attitudes and increases consumer self-esteem (Crawford et al. 2001). Evidence suggests that consumer involvement in care planning improves the care provided. Grundy et al. (2016) found that for the vast majority of consumers their involvement was conceptualised in terms of the alliance that was established between themselves and their clinicians. User involvement necessitated regular and meaningful engagement initiated from the outset and sustained throughout the consumers' journey with mental health services. Consumer involvement included a need for content that was both relevant and current hence ensuring currency in care planning documentation and up to date care provision (Grundy et al. 2016). Yet despite the research supporting the value of consumer involvement and government policies, evidence suggests that in practice it is not always achieved.

Studies show that some mental health professionals in the community and inpatient setting fail to develop meaningful well thought out care plans with consumers. Meanwhile, consumers openly express their unhappiness and concerns about mental health services including a lack of therapeutic relationships (Rydon 2015; Tee et al. 2007; Walsh & Boyle 2009; Theodoridou et al. 2012) as well as dissatisfaction with their physical health (Ewart et al. 2016). Participants in a study by Laitila et al. (2018) emphasised the need for consumers to be more involved in decision-making about their own care and

treatment. They specifically felt that they were given too little information and that information about medications was especially inadequate. Poor information exchange and the need for information about medications and related choices was found to be one of the main barriers to meaningful consumer involvement in care planning as it left the consumer excluded from the process (Bee et al. 2015a; Bee et al. 2015b). Consumers wished to be treated with more respect and dignity, more involved in decisions regarding their own care, to have more information and to be given more access to talking therapies and other activities and to be listened to by staff (Chambers et al. 2013).

In their enactment of accountability mental health nurses need to adhere to the practice standards. Standard 10.4.8. of the National Standards for Mental Health Services outlines that:

> 'There is a current interdisciplinary treatment, care and recovery plan, which is developed in consultation with and regularly reviewed with the consumer and with the consumer's informed consent, their carer(s) and that the treatment, care and recovery plan is available to both of them' (Australian Government, National Standards for mental health services).

The requirement to develop a care plan with consumer involvement is also outlined in Standard 2 of the National Safety and Quality Health Services Standards (2017). In all, care plan creation with consumer involvement is an element of policies and standards developed by the Australian Government and an integral part of the recovery model. Consumer involvement in care plan development by mental health nurses is however not always routine practice. Accountability is foundational to professional nursing practice and described as a core aspect that underpins nursing practice (Krautscheid 2014) and accountability enactment drives daily nursing practice as decisions are made.

There is a need, therefore, to understand how the execution of accountability in regard to consumer involvement in the care plan is employed in the reality of the work environment.

As individuals who present to mental health services referred to as 'consumers' in the various government documents and policies, I deploy this terminology in this thesis for persons receiving care by mental health services.

1.2. WHY FOCUS ON ACCOUNTABILITY FOR CONSUMER INVOLVEMENT IN CARE PLAN?

Mental health consumers are among the most vulnerable people globally as well as in Australia. In 2014-2015 there were 4 million Australians (17.5%) who reported having a mental or behavioural condition (Australian Bureau of Statistics 2015). People with severe mental disorders on average tend to die earlier than the general population. There is a 10-25 year life expectancy reduction in consumers with severe mental health disorders (DeHert 2011; World Health Organisation 2014). This excess mortality is mainly due to physical illness including metabolic syndrome, diabetes and coronary heart disease which is often the result of side effects of psychotropic treatment (DeHert et al. 2011; Penninx & Lange 2018). In addition only 62% working age Australians with a mental illness are employed compared to 80% without a mental illness (Australian Government 2013). A frequent complaint by consumers with mental illness is that they feel socially isolated and lonely, which impacts on mental and physical wellbeing (Chernomas, Clarke & Marchinko 2008; Linz & Sturm 2012). In light of the above information it is important that mental health clinicians regularly discuss with consumers their concerns during moments of care planning.

The care planning process needs to be consistent with the recovery approach to mental health treatment in both empowering consumers to actively manage their own recovery and in directing treatment towards achieving goals that meaningfully influence their functioning in the community (McHugh and Byrne 2012). According to the recovery model, a person can live a full and meaningful life despite mental ill health and the related symptoms (Australian Government, National Standards for Mental Health Services 2010). Involving the consumer is one of the key aspects in recovery focused services. Yet evidence suggests that some health professionals do not speak of care plans during the many meetings that take place across different services. In these situations the consumer care plan is marginalised because it is not routinely discussed or updated (Bee et al. 2015a; Bee et al. 2015b; Bower et al. 2015; Doody et al. 2017).

Mental health services in Australia often describe their service as adhering to the recovery model but in reality, to the detriment of the health of consumers this does not occur (Carlat 2010; Welch et al. 2013). At the acute end of the continuum of care the adoption of recovery oriented approach has been slow (Rickwood 2017) and the medical model is still the predominant paradigm in mental health practice (Beecher 2009). The foundation of the medical approach is the Diagnostic and Statistical Manual of Mental Disorders, which psychiatrists use to categorise the mental health disorders of consumers (Carlat 2010; Welch et al. 2013). The medical model postulates that mental health disorders are brain diseases and emphasises pharmacological treatment to target biological abnormalities (Deacon 2013). This is often incongruent with the recovery model which involves a deeply personal and unique process and the development of new meaning and purpose in one's life (Government of Australia, National Standards for Mental Health Services 2010). The design of the medical model encourages power imbalances in favour of professionals while the recovery

approach and the care plan insist on a collaborative partnership and autonomy for consumers (Gordon & Ellis 2013). It is for this reason that the design and creation of the care plan needs to be embedded in the culture of the entire health service, the organisation and ultimately the unit environment. Consumer involvement in care planning is an important element of the recovery model and without consumer input in the development of the care plan, recovery oriented practice is not utilised. Therefore consumer involvement in care planning and the recovery model are intrinsically linked.

Quality care provision and the decision by a mental health nurse to involve the consumer in care plan development is facilitated by accountability enactment. Accountability constitutes taking responsibility for one's nursing judgement, actions and omission while upholding both the quality of patient care outcomes and standards of the profession (Krautscheid 2014). The way in which mental health nurses think about and demonstrate accountability will impact on the type of care provided and how they will involve consumers in their care planning. Analysis of the literature suggests that a lack of accountability could result in poor nursing practice (Caulfield 2005; Ganju 2006; Milton 2008; Dignam 2009; Harnett, Bowles & Coughlan 2009; Scrivener, Hand & Hooper 2011).

In the context of mental health services in Australia accountability is frequently and increasingly regarded as something that can be demonstrated by auditing and measurement of Key Performance Indicators (KPIs). Measurement of KPIs facilitates tracking by the government of progress and performance of health services (Australian Commission on Safety and Quality in Health Care 2017). The accreditation processes of mental health services support this approach (Australian Commission on Safety and Quality in Health Care 2017). Mental health work is driven by electronic information systems to gather data on activities. The government wishes to be informed on different aspects of services

such as consumer outcomes, readmission numbers within 28 days, seclusion rates and 7-day follow up. Electronic data collection is more important than ever as our sector moves to activity based funding (Independent Pricing Authority 2017). The attention has moved away from face to face engagement with our consumers while electronic documentation processes have increased in importance. This is reflected in Clancy and Happell's (2015) study where clinicians questioned the rationale of increasing documentation to withstand an audit, believing that an audit only established whether 'all boxes were ticked' and did not look at the substance of the documentation nor the context of clinical practice.

Research suggests that the work environment and events in the workplace potentially influence accountability and perceptions of accountability. There is a need therefore to explore further the relationship between a unit culture of accountability and the development of care plans by mental health nurses with consumer involvement

1.2.1. ACCOUNTABILITY

Articulating and acting upon professional values with accountability is essential for the discipline of nursing in order to ensure its integrity (Milton 2008). It is important for (mental health) nurses to reflect on their practice routines and their professional accountability and responsibility to consumers and it is the culture of their work practice that determines how this is done. Accountability is the implicit or explicit expectation that one may be called on to justify one's beliefs, feeling and actions (Lerner & Tedlock 1999). Accountability is impacted upon by the presence of others and the expectation that another will observe their performance as well as identifiability which means that what someone says or does is linked them personally. In addition accountability is manipulated by

evaluation and reason giving as people expect that they must give reasons for what they say or do (Lerner & Tedlock 1999).

There are both formal and informal rules and norms in the workplace that influence accountability (Hall & Ferris 2011; Frink & Klimoski 1998). Accountability is not a unitary phenomenon and does not stand on its own (Lerner & Tedlock 1999). The accountability relationships that govern our lives are complex and often fluid and dynamic, as each party to the accountability relationship learns to anticipate the reaction to the other, and certain patterns of mutual adaptation can be noticed. William James (1983) observed there are many distinct types of accountability as there are distinct relationships among people as well as between people and the organisations that give structure and meaning to the social world. Accountability in all its complexity is executed in ways as we are influenced by our environment. Accountability is enacted as the result of a perceived expectation that one's decisions or actions will be evaluated by an audience and that rewards or sanctions are believed to be dependent on this expected evaluation (Lerner & Tedlock 1999; Frink et al. 2008; Hall & Ferris 2011). Inherent in any discussion of accountability is the notion of expected evaluation, regardless of whether this will happen or not (Lerner & Tedlock 1999; Hall & Ferris 2011). In addition, there are elements of the work environment and culture that directly impact an individual's experienced accountability. This is how accountability is firmly embedded in a (work) culture.

More specifically in health services in an accountable relationship information of what is done is transmitted, and the person who is accountable should be able to explain and justify why something was done (Brinkerhoff 2003). The nature of accountability is specified in guidelines of practice and protocols and sanctions should be available and applied for in the case of inappropriate actions or underperforming (Brinkerhoff 2003). Results of measurement, evaluation and

justification can be incorporated into service refinement and improvement which can lead to a sustained wide uptake of evidence based practice and improved quality of care (Ganju 2006).

A culture of accountability in health services is concerned with the efficient utilisation of resources while providing maximum benefit to stakeholders such as consumers and their families (O'Hagan & Persaud 2009). As health care clinicians within these health services are guided by their own professional standards while working with others in multidisciplinary teams then they have multiple accountabilities, to the profession, to the health care team and the organisation and to consumers (O'Hagan & Persaud 2009; Ewert 2018). These multiple accountabilities to ensure high quality care are underpinned by a team approach that emphasises continuous learning and continuous improvement at the individual, unit and organisational levels (O'Hagan and Persaud 2009). In an accountable culture, decisions regarding care and direction are guided by evidence based protocols and clinical practice guidelines, but not by individual preference (O'Hagan & Persaud). This involves regular reviews by the organisation and the care team in assessing outcomes to guide improvement initiatives. Ideally, in a culture of accountability the reporting of errors is encouraged within the care team as an opportunity to learn and not as punishment (O'Hagan & Persaud 2009; Krautscheid 2014). Creating and maintaining this culture are important for improving quality and efficiency in consumer care (O'Hagan & Persaud 2009).

1.3. LOCATING SELF IN RESEARCH PROBLEM

In 2012 my practice as a mental health nurse changed when I commenced employment as the clinical lead in a community mental health team where the team leader was disinterested in clinicians' weekly clinical reviews. Instead he

requested that the team review each consumer with the care plan at the centre of discussion. As care plans were displayed on the white board in full view of the entire team it was soon obvious there had been little consumer participation in the development of the plans on display. Although initially very little progress was made, it became apparent that this novel approach encouraged clinicians to think about past and future care provision while evaluating the progress the consumer had made on their journey to recovery. It also became obvious that most team members did not entirely comprehend the concept of the care plan, the consumer's involvement in that plan and how to carefully negotiate this. Mental Health professionals who negotiate appropriate care in partnership with the consumer within a complex environment require a deep understanding of how to do this (Tee et al. 2007).

1.3. RATIONALE FOR THE STUDY

In nursing accountability underpins safe practice and is an essential behaviour supporting congruence between nursing actions and standards associated with quality of care (Schulz 2009). Despite the importance attributed to accountability, research on nurses' perceptions of accountability, their willingness to act accountably and under what circumstances is still scarce (Krautscheid 2014). It is unclear how mental health nurses act accountably with regard to consumer involvement in care planning. Despite consumer involvement being outlined in various Standards (Australian Government 2010; 2017) and research demonstrating that mental health nurses emphasise the interpersonal nature of mental health nursing (Snell, Crowe & Jordan 2009; Thomson & Hamilton 2012; Pazargadi et al. 2015) it would appear that therapeutic engagement in care planning is not always routine practice.

Consumer involvement is part of Government policies and outlined in various standards and consumers have indicated the wish to be involved in care planning (Laitila et al. 2018). Consumers have emphasised a strength based approach where their personal strengths, opinions and wishes would be taken seriously. Consumer involvement is part of Government policies and outlined in various opinions and wishes would be taken seriously (Bee et al. 2015a). Evidence synthesis suggests that many consumers still want and need to be involved in the care planning process (Bee et al. 2015b). Hence, there is a need to comprehend how nurses enact accountability with regard to the creation of the care plan and how they involve consumers in the process. While barriers and facilitators to consumer involvement in care plans have been extensively researched, as evidenced by Bee et al.'s (2015b) synthesis of 79 studies focused on consumer involvement in community mental health care and 49 studies in inpatient care, there is very little research on how mental health nurses make decisions about their multiple accountabilities and what impacts on whether they involve the consumer in the development and use of a care plan or not.

1.4. AIM OF THE STUDY

The research aim is to explore the enactment of accountability for consumer involvement in care planning by mental health nurses in one inpatient unit. The research is concerned with the analysis of decision making processes around care plan creation and consumer involvement. The study seeks to uncover how mental health nurses enact accountability in regard to care planning and the relationship between the unit culture of accountability and the development of a care plan. The study will explore ward practices and how the environment impacts (or not) on nurses' practice and their decision making to involve consumers in the development of their care plan. The aim also includes investigation of mental health nurses' beliefs and opinions on care plans and

consumer involvement and how nurses practiced accountability as a result. Finally the study explored how accountability enactment influenced the use of care planning as a form of therapeutic engagement?

1.5. RESEARCH QUESTIONS

The main research question posed within this study is:

- How do mental health nurses enact accountability with regard to the creation of the care plan and the involvement of consumers in the process?

The sub questions in this study are as follows:

- What role does accountability play in the development and use of care plans by mental health nurses?
- How is the concept of accountability understood amongst mental health nurses?
- What is the relationship between a unit culture of accountability and the development of care plans by mental health nurses?

1.6. A RESEARCH METHOD

The design and creation of the care plan is embedded in the culture of the entire health service, the organisation and ultimately the unit environment. Ethnography was therefore the appropriate method for pursuing this topic, because it allowed for an examination of the work culture that mental health nurses are employed in. In addition, a sense of accountability by mental health clinicians is likely to be embedded in the environment and the culture in the workplace. Mental health nurses do not work in isolation but interact, collaborate and communicate with other health professionals.

Ethnographic research comes from the discipline of social and cultural anthropology where the ethnographer is required to immerse him/herself in the life-world of the people studied (Knoblauch 2005; Wall 2015). The major emphasis is on discovering how cultural understandings inform health beliefs and practices (Roper and Shapira 2000). In the process the ethnographer generally relies on three sources of data to achieve such intimate familiarity: participant observation, interviews and examination of available document and/or policies (Wall 2015; Higinbottom, Pillay & Boadu 2013). By spending an extended period of time in the field the ethnographer seeks to place the phenomena in their cultural and social context. In this regard, extensive field notes provide the basis for data analysis and the final ethnographic account.

In this study I found that traditional assumptions about ethnography did not hold. My research questions, the study population of mental health nurses, and my unique positioning as a researcher among them required a few methodological adaptation which I will describe more in depth in chapter three. The main divergence from traditional ethnography was that ethnographic researchers do not typically enter the filed with a formally specified question (Roper & Shapira 2000), tending to begin the project with no prior conceptions of the field. I began however with a formulated research question about the enactment of accountability of mental health nurses with regard to care plans. In addition, my starting point required that I have both insider and background knowledge and previous experience in the field of study. I had five years of inpatient unit experience and I had knowledge of the general culture of mental health nursing. I also had experience with policies and standards in regard to nursing in general and mental health nursing in particular. While I chose focused ethnography as an appropriate methodology, the theoretical framework of this study is informed by the theory of accountability in organisational culture, the knowledge domain of

the role of the mental health nurse and theory around care planning in mental health services. Chapters three and four provide further information and explanation on this.

1.7. CONTEXT OF THE STUDY

Perspectives were obtained from mental health nurses in one specific mental health unit via interviews. Observation data included actions of mental health nurses as well as all the health professionals in this inpatient unit collectively as a multidisciplinary team. The study setting was an inpatient unit in Australia which is part of a Local Health Network (LHN). The LHN where the research as undertaken is one of five LHN's in the state. The unit employs mental health nurses on a permanent basis but also utilises agency staff. The unit is also staffed with psychiatrists, registrars, medical officers, occupational therapists, social workers, psychologists and Aboriginal Mental Health Workers. Voluntary and involuntary consumers are admitted to this unit and consumers have a wide variety of mental health conditions. The average time consumers spent on the unit was two weeks at the time of the research.

1.8. OVERVIEW OF THE STUDY

Chapter one sets the scene for the study, providing background and justification. It also presents the concept of the care plan and describes issues of accountability in mental health services which is critically important and considers the significance of the study in the wider context.

Chapter two reviews the literature and examines the role of the mental health nurse in mental health services and specifically in relation to care planning and the complexities around accountability in the context of (mental) health services.

Chapter three addresses methodology, describing ad justifying focused ethnography was the chosen methodology. The rationale for selecting this particular approach is presented, along with an overview of methodological issues encountered within this study.

Chapter four focuses on the methods and the specific activities undertaken in the conduct of the research and approaches to analysis. It provides rationales for the chosen approaches, describes decision making in relation to planning and implementation and addresses issues of ethics and rigour.

Chapter five introduces results derived from interview and observations regarding how the practice of care planning is impacted by the larger context of the health organisation and relationships within the multidisciplinary team.

Chapter six discussed the results regarding the role and identity of the nurse. Potential dilemmas were created as nurses dealt with crisis management while at the same time needing to support the recovery model. Risk management and a risk averse environment was shown to influence the enactment of accountability regarding the care pan.

Chapter seven critically examines and interprets the significance of the findings considered in chapters five and six in light of what is already known about the enactment of accountability. The chapter explains new insights about accountability enactment in relation to the care plan.

Chapter eight returns to answer explicitly the research questions outlined in chapter one. It highlights what this study has contributed to knowledge on accountability by mental health nurses and presents the limitations of the study and then its main recommendations.

1.9. SUMMARY

In this chapter I discussed consumer involvement in care planning which is the core of quality mental health provision and part of the recovery model. Government policies support recovery oriented practice and the need to involve consumers in care planning. Involving consumers and their carers in care planning has a positive impact on services provided and outcomes as health professionals gain up to date knowledge on the concerns of their consumers. This involvement in the development and use of a care plan is a part of accountable health care practice, however this involvement has been found in some cases to be deficient. Hence it is important to understand how mental health nurses view their accountability obligations and how this then impacts on their involvement of consumers in care planning. The next chapter will provide an overview of the literature on the role of the mental health nurse, care planning and accountability.

CHAPTER TWO: REVIEW OF THE LITERATURE

2.1. INTRODUCTION

An individualised care plan is fundamental to quality mental health service provision (McHugh & Byrne 2012). Consumer care plans in mental health services are recommended as a key tool to achieve best possible outcomes in the consumer's recovery journey. Despite government policies and standards advocating consumer involvement, the majority of consumers and carers continue to feel marginalised in the planning of care (Bee et al. 2015b). Policies on consumer involvement in care planning remain inconsistently implemented and national and international evidence syntheses show that consumers consistently report inadequate involvement in the care planning process (Bee et al. 2015a; Bee et al. 2015b).

As outlined before, in Australia, The National Standards for Mental Health services (2010, page 25) require that there is a current interdisciplinary treatment, care and recovery plan developed in consultation with the consumer and their carer. Underlying this standard is the belief that a care plan and the involvement of consumers and carers in this plan leads to more accessible and acceptable services and improves the health and quality of life of the consumer (McHugh & Byrne 2012). Despite this requirement, evidence suggests that clinicians, including mental health nurses, do not develop care plans with consumer involvement (Bee, et al. 2015a; Bee et al. 2015b; Grundy et al. 2016) which can suggest a complication in the execution of accountability.

To gain an understanding of the available research on the enactment of accountability and consumer involvement in care planning in the inpatient unit a review of the literature was undertaken. This will include an examination of the role and activities of the mental health nurse and the identity of the nurse in the

inpatient mental health setting as the nurse is often regarded as responsible for consumer care plan creation in the inpatient environment. This chapter will also evaluate literature focusing on care planning processes in the inpatient unit and the research that explores the enactment of individual accountability by health professionals.

The Nursing and Midwifery Board of Australia (2013, page 6) outlines that:

> 'Nurses answer to the people in their care, the nursing regulatory authority, their employers and the public. Nurses are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their nursing roles including documentation. Accountability cannot be delegated'

Definitions of accountability generally convey the notion of holding someone responsible for failure to deliver services to an appropriate standard. Care plans would appear to be a necessary enactment of accountability and yet, in some contexts the evidence suggests these are not routinely executed in practice. The question may be asked then, can accountability exist in the absence of appropriately developed and implemented care plans? How do nurses enact accountability if they do not involve consumers in care plan discussions? How exactly is accountability enacted in the workplace?

This chapter will examine research literature on the role of the mental health nurse in the inpatient unit and the process of care planning and accountability enacted by individual health professionals in health services under the following themes:

- The role of the mental health nurse in the inpatient unit
- Care planning and consumer involvement
- Aspects of accountability enactment

For consumers with severe mental illness the involvement of mental health services often commences in an inpatient unit. In this environment a meaningful care plan is impacted upon by the participation of consumers and carers and consequently by the practice of the mental health nurse. What mental health nurses do in the inpatient setting impacts on consumer involvement and nurses' role in the multidisciplinary team influences if and how they engage with consumers. Accountability also influences the quality of the care plan as the nurses' notion of accountability and expectations of evaluation of their actions guides their practice (Lerner & Tedlock 1999). These expectations influence decisions (Lerner & Tedlock 1999) such as involving consumers in care plan creation. In other words, the role of the nurse, how care is planned with or without consumer involvement and accountability enactment influence the quality and content of the care plan. Therefore these topics were chosen to undertake a scoping review to determine the scope of coverage of the body of knowledge on aforementioned topics to give a clear indication on the studies available and their focus (Munn et al. 2018). The scoping review was chosen to identify and map the available evidence, to clarify key concepts and examine how research is conducted and to identify and analyse knowledge gaps (Munn et al. 2018).

2.1.1. ARTICLE SELECTION

Searches were undertaken on the role of the mental health nurse in the inpatient unit, care planning and consumer involvement and individual accountability enactment. The following databases were searched: Medline, Cumulative Index of Nursing and Allied Health Literature (CINAHL), PsychINFO, Embase, Blackwell Science and Proquest, Google Scholar and the Cochrane library. Three separate searches were undertaken with a focus on the last 15 years (2003-2018), although some key articles published earlier were also included. The first search concentrated on the role of the mental health nurse in the

multidisciplinary team (Appendix 9.2). The inclusion criteria concentrated on the role and identity of the mental health nurse in the mental health inpatient unit. The focus was on research which explored what mental health nurses do in the unit environment working within the multidisciplinary team. The same search was repeated across different data bases. Publication types were limited to accessible primary research reports in the English language. Using these criteria, a total of 234 articles were retrieved as well as 3 addition records through other sources. Four duplicates were removed and review of 233 articles indicated that 199 articles could be relevant for the review and these articles were assessed. After evaluation 180 articles failed to meet the inclusion criteria and 19 articles were included in the review.

A second search was conducted on the topic of the process of care planning and consumer involvement (Appendix 9.2). The inclusion criteria for the search on care plans incorporated all literature that referred to the development of care plans by mental health nurses. Initially the search included care plan development in community mental health services but often the studies included health professionals from other disciplines. The inclusion criteria were then limited to research that explored care plan creation by mental health nurses in a mental health inpatient unit setting. The same data bases were searched. Publications were limited to accessible primary research reports. Using these criteria, a total of 3,859 articles were retrieved as well as 12 additional records through other sources of which 3,465 were not related to the topic or were duplicates. Review of 245 titles and abstracts indicated that 63 articles could be relevant for the review and these articles were assessed. After evaluation 56 failed to meet the inclusion criteria and 7 articles were included in the review.

The third search concentrated on accountability in health services (Appendix 9.2). The inclusion criteria incorporated literature that referred to the execution of

individual clinical accountability by health professionals in a health organisation. The focus was on research that explored the enactment of accountability and the process of doing this or activities or other aspects that were thought to be related to accountability and therefore impacting on it. The same search was repeated across different data bases. Publication types were limited to accessible primary research reports in the English language. Using these criteria, a total of 2,604 articles were retrieved as well as 3 additional records identified through other sources. After removal of 271 articles which were duplicates or research not related to the topic at hand, a review of 2,333 titles indicated that 1,400 articles could be relevant for the review and these articles were assessed. After evaluation of content based on the above mentioned inclusion criteria, 1,377 articles failed to meet the criteria and 23 primary articles were included in the review.

2.2. THE ROLE OF THE NURSE IN THE INPATIENT UNIT

The care plan and the process of care planning must be considered in the wider context of the role of the nurse in the inpatient unit. The role and identity of the mental health nurse within the inpatient environment will have an impact on how the care plan is prepared. Traditionally the role of the mental health nurse has been built on the foundation of therapeutic relationships (Peplau 1952) which is often viewed as the core of mental health nursing. Therapeutic relationships and the ability to engage consumers determines the level of meaningful consumer involvement in care planning. At times however this is impacted upon by different pressures. In the process it is challenging to identify what the role of the mental health nurse is which in turn impacts on the nurses' sense of identity. Consequently the following themes are going to be discussed:

- The therapeutic relationship and its challenges
- Invisibility of practice

- Skills and identity: lack of unique role description

2.2.1. THE THERAPEUTIC RELATIONSHIP AND ITS CHALLENGES

The therapeutic relationship is accepted as the essence of the mental health nurse's role and is a reliable predictor of treatment outcomes and the provision of quality mental health care (Pazargadi et al 2015). Therefore the therapeutic relationship and what this entails and how this is executed in the reality of the inpatient unit environment is closely related to care planning activities and how nurses involve consumer in the creation of a care plan

In research by Seed, Torkelson & Alnatour (2010), McAllister & McCrae (2017) and Pazargadi et al. (2015) it was apparent that little time was spent on developing therapeutic relationships and direct consumer care. It was however not clear in any of the studies how nurses made decisions on a daily basis to forego spending time with consumers. McAllister & McCrae (2017) found that nurses in a psychiatric intensive care unit in the United Kingdom were troubled by their lack of time for consumer contact. Interviews with four nurses and six consumers revealed that both clinicians and consumers wanted more therapeutic contact but while nurses wanted longer time to spend in individual sessions, consumers preferred more interactions with nurses. Of the directly observed 234 clinicians and 309 consumer activities, 20.9% and 15.9% respectively were classified as therapeutic engagement.

These results were mirrored in the study by Seed, Torkelson & Alnatour (2010) where nurses in three inpatient units in the United States spent 2.18 minutes per shift teaching symptom management and close to two hours on paperwork. These authors explored more specifically the relationship between the role of the mental health nurse and job satisfaction through recording the amount of time 73 nurses spent on specific functions during a shift. Correlations between time spent

in specific function and job satisfaction indicated that nurses who spent more time with direct consumer care were more satisfied. The therapeutic relationship was also mostly unseen in the daily practice of the nurses who were interviewed in a small qualitative Iranian study (N=15) by Pazargadi et al. (2015). Nurse-related barriers included work exhaustion, negative attitude of the nurse towards the therapeutic relationship, negative personal characteristics and lack of skills and coercion (Pazargadi et al. 2015). Consumer-related barriers included consumer's lack of knowledge and failure to communicate with others while organisation related barriers were a large number of consumers, work overload and staff shortage resulting in less time to engage with consumers.

As in the study by Seed, Torkelson and Alnatour (2010) in Bee et al.'s (2006) study higher satisfaction with their work was positively correlated with consumer contact time. The authors observed a total of 505 hours that involved 15 registered nurses, one student nurse and 24 unqualified nursing assistants in three inpatient units in the United Kingdom. In this study half of the activity reported was staff-consumer contact but the majority was during containment activities (restraint, seclusion and forced medications). Nursing assistants were responsible for the majority of staff-consumer interaction while registered nurses were responsible for unit administration. The study demonstrated there was limited opportunity for the formal provision of structured therapeutic care and staff did not engage regularly with consumers (Bee et al. 2006). Limitations of the studies (Bee et al. 2006; Seed, Torkelson & Alnatour 2010; McAllister & McCrae 2017) included that the observer may have affected nurses' and consumers' behaviour (Hawthorne effect). Participants may also have overstated their therapeutic input to increase social desirability. Conversely it was possible that some functions could have been recorded by the researchers as a different category with tasks that were less concrete. Moreover, although the research

outlined and measured the limited time the nurses spent with consumers and possible reasons for this it was unclear how this was influenced by the daily work environment and how decisions were made about what work tasks to prioritise.

Further to the above, Goulter, Kavanagh & Gardner (2015) and Hummelvoll & Severinsson (2001) observed limited therapeutic availability as a result of organisational pressures. Nurses spent 32% of their time in direct care, 52% in indirect care and 17% in service-related activities (Goulter, Kavanagh & Gardner 2015). Fifty hours of random observation of nursing activities on three inpatient units over six weeks were completed. The authors suggested that the mental state assessment is the core activity of the mental health nurse, but in this study this accounted for just 0.1 % of observed activities although it might have been possible that mental health assessments occurred in the context of other activities (Goulter, Kavanagh & Gardner 2015). In this context Hummellvoll & Severinsson (2001) characterised nursing care as 'therapeutic superficiality'. Observation and interview data in a 12 bed inpatient unit demonstrated an acute and unpredictable character of the work situation combined with short hospital stays resulted in superficial nursing care (Hummellvoll & Severinsson 2001). The demands on treatment effectiveness created work related stress as nurses dealt with internal conflict between professional and humanistic ideals of mental health nursing and the reality of the unit environment the staff had to adjust to (Hummelvoll & Severinsson 2001).

Consumer study participants confirmed they did not consistently experience a therapeutic approach in their interactions with nurses. Perceived coercion and loss of autonomy were linked to a more negative consumer-therapeutic relationship rating by the consumers in a quantitative study by Theodoriou et al. (2012). Interviews with 116 consumers in a Swiss inpatient unit suggested that perceived coercion (and disempowerment) was related to a higher symptom level

and a lower level of global functioning at admission. The rating of the therapeutic relationship was therefore related to the symptom level. In the study by Rydon (2005) (N=21) there were incidences of consumers experiencing negative attitudes from nurses and examples of nursing practice that was not therapeutic. A limitation of both studies was the fact that it is challenging for researchers to analyse consumer participants' perspectives. Generalisability to another setting was also limited.

Another study by Snell, Crowe and Jordan (2009) highlighted that when people challenge their disorder the potential for therapeutic relationship is difficult to achieve. Through nurses' descriptions of practice the authors explored the relationship between the nurse and the consumer with eating disorders when it occurred in a situation of resistance of the consumer. Whereas Theodoriou et al. (2012) found that the symptom level was related to the rating of the therapeutic relationship, in Snell, Crowe and Jordan's (2012) research it was the specific nature of eating disorders which was associated with denial and resistance. In addition the eating disorders unit's approach to treatment was another variable that had a strong influence on therapeutic relationships. The study confirmed that managing consumer responses to inpatient treatment was facilitated by the nurse's understanding of the anxiety experienced by the consumers (Snell, Crowe & Jordan 2009). The therapeutic milieu was dependent on the nurses' ability to counter negative consumer interactions by providing a transparent process in implementing and following through with treatment interventions (Snell, Crowe & Jordan 2009). In the process nurses perceived their role at times as 'invisible' and it was through the nurses' descriptions that it became apparent. Limitations of qualitative research also applied to the studies discussed above. In Theodoridou et al.'s (2012) quantitative study the coercion might have been provoked by staff other than the nurses and the described effect may have been

over- or underestimated. There was also an underrepresentation of consumers with schizophrenia compared with the general population.

Another potential challenge to therapeutic relationships were the opinions of those medical staff who believed that therapeutic time hindered clinical working. Thomson and Hamilton (2012) found that proportionately more medical staff surveyed agreed that therapeutic time hindered effective clinical working. They indicated that therapeutic time can represent a barrier to medical assessments of consumers and communication with nurses (Thomson & Hamilton 2012). Medical staff were less in favour of therapeutic time than their nursing colleagues (Thomson & Hamilton 2012). Even so, the survey of 22 nursing staff and 25 medical staff found that the majority of staff viewed therapeutic time as important. It was seen to promote consumer recovery, reduce risk, improve nurse-patient relationships and enhance consumer satisfaction with care received. Potential problems highlighted were interference with medical activities such as reviewing consumers and communicating with nursing staff as well as a lack of staffing resources and variable consumer uptake of therapeutic time (Thomson & Hamilton 2012).

All studies, although undertaken in different countries and focusing on consumer and/or nurses' opinions, agreed on the importance of the therapeutic relationship and that this frequently did not take place. Most studies were small and not generalisable to other settings but their results were similar. Although considerable effort was put in to measure the actual time nurses spent with consumers and to explore through consumer and nurses' opinions what potential causes were of a lack of therapeutic engagement, it was not clear how the nurses made decisions on a daily basis to forego consumer engagement and prioritise other aspects of their job.

2.2.2. *INVISIBILITY OF PRACTICE*

Organisational pressures were found to prevent mental health nurses fulfilling their own expectations for professional nursing practice leading to perceived invisible practice (Cleary 2004; Fourie et al. 2005). The results of Cleary's (2004) ethnographic study in an inpatient unit demonstrated how mental health nurses work in increasingly complex environments characterised by competing priorities and new demands. Nurses spoke about the constant pressure to meet the demands which were characterised by a lack of control in the workplace (Cleary 2004). Demands such as washing consumers' cups and buying cigarettes were considered non nursing duties and the invisible background nature of nursing relegated many important nursing activities to the status of unskilled and invisible rather than therapeutic (Cleary 2004). The invisibility of practice, and nursing care which was driven by the needs of the organisation were also highlighted in Fourie et al.'s (2005) study. A key finding of this qualitative descriptive study of observation and focus group interviews was that many of the roles were related to delivering care from a crisis management perspective, which covered aspects such as assessment, stabilisation of symptoms and discharge planning. Mental health nurses saw their key roles as often concerned with controlling practices, acute mental health triage, managing organisational requirements and staff relationships (Fourie et al. 2005).

In both studies organisational pressures prevented nurses from fulfilling their own expectations for professional mental health nursing practice. Whereas in the study by Cleary 's (2004) the focus was on duties and skills that were difficult to conceptualise and therefore were relegated as invisible, in the study by Fourie et al. (2005) nurses highlighted crisis management such as controlling practices and triage activities as preventing them from fulfilling their expectations of the nurses' role. An issue is that if mental health nurses cannot practice

therapeutically then they will struggle to find a way in which to articulate both the characteristics and distinctiveness of their practice. This may impact on their decision making.

2.2.3. Skills and Identity: lack of unique role description

Overall, the literature showed it was difficult to describe the unique role of the mental health nurse. Based on Fisher's (2014) survey, nurses' skills and whether they worked in the private or public sector were found to be a determinant in their approach to engagement with consumers. The skills of the nurses impacted on their practice. An online questionnaire of practising mental health nurses (N=528) in Australia demonstrated support towards employing psychological therapies, with 93% of respondents indicating they would like to use psychological therapies in their current practice (Fisher 2014). Mental health nurses working in the private sector were less likely to state that institutional barriers restricted their therapeutic potential and prevented them from implementing psychological therapies (Fisher 2014). In addition, mental health nurses who had received formal training in psychological therapies were less likely to accept too few staff, low resources, lack of training and high turnover as barriers to practicing these therapies (Fisher 2014).

Factors facilitating the development of the mental health nurse most commonly identified by Cusack, Killoury & Nugent (2014) were knowledge, personal motivation and skills. Nurses believed, however, that a symptom-focused approach to mental health care was used by the health service and that the medical format of documentation was the main barrier to recovery oriented practice (Cusack, Killoury & Nugent 2017). This exploratory mixed methods study with 1,249 mental health nurses found that the most common interventions used by nurses were goal setting, conversing, early intervention strategies and anxiety management strategies. In both studies (Fisher 2014; Cusack, Killou Nugent

2017) the workplace and the nurses' skills were regarded as impacting on nursing practice. Although both studies were large, the online questionnaire may have lacked detail as no interviewer was involved in clarifying the answers. In addition the sample for the survey was not randomly selected which limits the possibility to make broad generalisations from the findings. Also the study by Cusack, Killoury and Nugent (2017) has limitations with regard to generalisation as the findings are only relevant to the population studied. In both studies the nurses' skills were mentioned as impacting on their practice but it was not clear how this occurred. Moreover, having certain skills does not imply that they are being used in the reality of work environment.

With regard to the identity and position of the mental health nurse, various researchers have conceptualised their role in different ways. Hurley (2009) and Deacon and Fairhurst (2008) attempted to categorise the role of the mental health nurse. Hurley identified seven identity characteristics of mental health nurses from interviews with 25 nurses. This included the mental health nurse as generic specialist, the mental health nurses adopting a service user focus, the mental health nurse as positioning and utilising the personal self, the mental health nurse as spending time with the service user, the mental health nurse as delivering talk based therapies in a different way and the mental health nurse as having transferable skills (Hurley 2009). These cluster capabilities were regarded as the professional identity of the mental health nurse (Hurley 2009). A different approach was utilised in an observational study by Deacon & Fairhurst (2008) who employed Allen's (2004) analytic framework of eight interrelated nurse activity bundles to mental health nursing in an inpatient setting. The eight interrelated activity bundles included: managing multiple agendas, circulating consumers, bring the individual to the organisation, managing the work of others, mediating occupational boundaries, obtaining/fabricating/interpreting and

communicating information, maintaining records and prioritising care. The bundle of activity relating to obtaining, fabricating, interpreting and communicating information was found to fit less well and the authors attributed this to the fragile uncertainty of knowledge in psychiatry and the constant stream of information about consumers that the nursing team are faced with (Deacon & Fairhurst 2008). In either study it was not quite clear what exactly constituted the role and identity of the mental health nurse that differentiated them from other staff and the terminology used was occupationally generic.

Hercelinskyj et al. (2014) identified role stress in relation to the identity of the mental health nurse. In the study by Hercelinkskyj et al. (2014) nurses experienced role conflict and role stress related to structural issues in the workplace and conflict between their role expectations and the need to meet organisational performance outcomes. In this small qualitative explorative descriptive study (N=11) there was role ambiguity through frustration with a perceived contradiction between policy and allocation of resources in mental health care. The practice identity of the mental health nurse was seen in their daily work with consumers while the organisational identity was driven by different requirements. Role stress was also identified as a result of working within the multidisciplinary team where there was a lack of role boundaries that typifies the generic structures of the multidisciplinary team. It can result in role ambiguity and role conflict wherein professionals are torn between their sense of being part of the multidisciplinary team and their sense of identification with their own discipline (Hercelinskyj et al. 2014). In this context nurses in the study by McCrae et al. (2014) oriented themselves more towards mental health practice than to the nursing profession. In semi-structured interviews with a sample of post graduate nurses (N=10) in the United Kingdom nurses defined their practice

in terms of values rather than skills and found it difficult to articulate a distinct role for mental health nursing (McCrae et al. 2014).

Although in above mentioned studies it was perceived to be difficult to identify the role of the mental health nurse, stigma was found to be closely entangled with the mental health nurses' identity (Sercu, Ayala & Bracke 2015). A qualitative case study with 33 nurses in four inpatient units in two psychiatric hospitals in Belgium suggested that nurses extracted meaning from stigma for their identity construction and their daily work (Sercu, Ayala & Bracke 2015). The authors identified that nurses, due to their association with mental health problems, could be considered as either stigmatising, de-stigmatising or a stigmatised group. The meaning of stigma was found to be closely entangled with the nurses' challenging relationship with the medical model of care and the nurses' quest for an independent profession and the aspiration to detach from their psychiatric frame of reference. The more nurses were absorbed in the therapeutic frameworks however, the less impact there was on their initial aspiration to counter stigma (Sercu, Ayala & Bracke 2015).

Overall it is challenging to determine the role of the mental health nurse based on the afore mentioned studies although one study identified that stigma may play a role in how nurses perceive themselves and how they construct their identity. Nurses having certain skills does not guarantee that these skills are being used in the work environment as many different factors such as the nature of the unit are at play. It depends then on the decision making process by the nurse whether these skills are utilised.

2.2.4. SUMMARY

In summary, although the therapeutic relationship is regarded as important in mental health nursing, it is often not practiced. Organisational pressures and its

consequences on nurses' practice resulted in a perception by some nurses that their practice is invisible. There was no clarity on the identity of the mental health nurse and what their role entails. It is inevitable that this has an impact on the daily practice of the mental health nurse and how they engage with consumers which influences consumer involvement in care plan development. As nurses make decisions on whether to engage in therapeutic relationships this impacts on their care planning practices. The next section discusses therefore the literature on consumer involvement in care planning.

2.3. CARE PLANS AND CARE PLANNING: CONSUMER INVOLVEMENT

Therapeutic relationships and how these are practiced and the role of the mental health nurse impacts on how they involve consumers in the care plan. Consumer involvement in their own care and the care plan has become the key in the design, provision and evaluation of mental health services (Wright et al. 2015). This section will discuss the literature on consumer involvement in care planning in inpatient units. The limited available research focused mainly on how nurses and consumers perceive consumer involvement in care planning. Consumers and mental health nurses had slightly different ideas about the reasons for the lack of consumer involvement. While nurses focused on the environment of the unit and the consumers themselves as the barrier to consumer involvement, consumers regarded the nurses' approach as the main reason why they were not involved in care planning. The sections that are going to be discussed are as follows:

- The practice approach in the unit
- Lack of communication, paternalistic approaches and stigmatisation

2.3.1. THE PRACTICE APPROACH IN THE UNIT

O'Donovan (2008) and Patton (2013) investigated nurses' perceptions on care planning and in particular the consumer involvement in inpatient units in Ireland. Both studies conducted semi structured interviews and used convenience sampling. O'Donovan (2008) found in their study (N=8) that while the Barker's Tidal (recovery) model was being utilised as the basis of nursing practice, its underlying principles were not fully embraced. Most nurses described practices of coercion of consumers as they thought that choice was rarely offered and often was only provided to consumers who raised their concerns. Nurses reported that the main model of care being offered was a medical model which prevented them from practicing patient centred care. Additionally, it was reported that no unit philosophy existed which impacted on the care provided. Difficulties described were little therapeutic care being offered, care being fragmented and nurses having inadequate support (O'Donovan 2008).

Findings in the study by Patton (2013) (N=18) suggested that nurses thought they generally involved consumers in their care although they acknowledged that this sometimes did not happen because the consumer wanted to be omitted from the process. Allowing non-involvement to happen in this way solidified the idea that inpatient unit nursing is centred on the needs and requirements of consumers in its care. Barriers to consumer involvement identified by nurses were increasing administrative duties although there was confusion about what administrative duties entailed. The other barrier nurses recognised was their thinking that acutely unwell consumers may not be able to engage in their care initially (Patton 2013). Nurses explained the approaches they used in their more in depth interactions and mentioned solution focused therapy and cognitive behavioural therapy in care provision and planning. It was however not clear if they used these effectively or if the nursing models they claimed to employ were

utilised correctly and if this made any difference to the consumers (Patton 2013). Mental health nurses who stated during phone interviews that they utilised certain practises did not guarantee that these care approaches were utilised in the work environment. Interviews with nurses only possibly provided a limited picture of the challenges involved in achieving consumer involvement.

2.3.2. LACK OF COMMUNICATION, PATERNALISTIC APPROACHES AND STIGMATISATION

Consumers had different ideas as to how and why they were not involved in the development of their own care. Four studies explored consumers' view on involvement in their care in inpatient units and in all studies the consumers were not completely satisfied with services provided and their involvement in care development. In focus groups in the study by Walsh & Boyle (2009) (N=55) consumers stated they did not feel they were involved enough in the drawing up of their care and treatment plans and they felt there was a lack of carer involvement. Although consumers believed that the most important relationship in the mental health unit was the one between staff and consumers, they indicated that when consumers requested personal time with staff they were often told the staff had no time. Consumers also felt they had little control over their circumstances in the hospital (Walsh & Boyle 2009). Consumers experienced that the major role of the staff was to prescribe medications and to ensure the rules were adhered to. There was dissatisfaction with the information provided on the benefits and side effects of medications and consumers also felt that they were not provided with enough information about hospital life which initiated feelings of powerlessness (Walsh & Boyle 2009). Overall the consumers viewed the staff and their practice as the main reason why insufficient involvement took place. Similar findings were extrapolated in Howard et al.'s (2003) quantitative study (N=204). The authors utilised the Kentucky Consumer Satisfaction

Instrument, The Mental Health Statistics Improvement Program 21-item Consumer Survey and the Client Satisfaction Questionnaire. They found in their survey on satisfaction with inpatient services and treatment outcomes in two state hospital sites that although consumers were satisfied with staff availability and the degree of comfort talking to staff, consumers felt dissatisfied with the lack of input into treatment planning, lack of family involvement and lack of medication education (Howard et al. 2003). Some consumers indicated that they were not asked what would help them get better. When consumers and their carers do not understand treatment or do not know about medication side effects, recovery is compromised and the consumer is at risk for relapse and re-hospitalisation (Howard et al. 2003). As with the previous study, the results of this US study may however not be a representation of other countries.

Likewise consumer questionnaires (N=61) and interviews with consumers (N=10) in psychiatric institutional care in Sweden showed that to the consumers important factors related to activity and participation included agreement concerning the treatment plan, discussion about expectations, creating conditions for engagement in activities and providing the consumers with opportunities to take responsibility for themselves (Daremo & Haglund 2008). The study found that consumers had limited opportunity to take part in activities in or outside the unit. Consumers who had been involuntarily admitted perceived an indifference from the staff in trying to understand their problems. They also reported that on many occasions nurses avoided them and left them alone while nurses gathered in the nursing station (Daremo & Haglund 2008). Further to this, a small co-operative inquiry by Tee et al. (2007), over a two-year period with consumers (n=8) and mental health nursing students (n=8), found that factors inhibiting consumer participation in clinical decisions included stigmatisation and paternalistic approaches, while clinical judgements were made solely on the

basis of diagnosis. Enhancing factors were a respectful culture, which recognised users' expertise and communicated belief in individual potential (Tee et al. 2007). The data in Daremo & Haglund's (2008) study were limited to consumers' reports and a larger study could provide a more generalised picture of what consumers perceived as important factors for conducting good care. Also in Tee et al.'s (2007) study the inquiry was limited to the experience of one group of eight consumers and eight nursing students. In neither of the above discussed studies was the experience of consumers in one group compared with another group, to explore if there are differences and if so what these might be.

2.3.3. SUMMARY

Consumers and nurses had different opinions on what the barriers were in relation to a lack of consumer input in care planning although both demonstrated dissatisfaction with the level of consumer involvement. Nurses mentioned the use of the medical model (O'Donovan 2008) and the lack of a unit philosophy (O'Donovan 2008) or the acutely unwell consumer (Patton 2013) as the reason why limited consumer involvement took place. Nurses thought they had insufficient support through the approach to practice in the unit and the increase in administrative duties (Patton 2013) had the potential to limit of enhance consumer involvement. The consumers focused on the individual health professionals including nurses and the lack of information sharing on medications or hospital life as well as the lack of availability of the staff (Hoard et al. 2003; Walsh & Boyle 2009). One study mentioned a perceived indifference from the staff to get an understanding of consumer's problems or avoidance by nurses (Daremo & Haglund 2008). Stigmatisation and paternalistic approaches were also put forward by consumers in the study by Tee et al. (2007).

In summary there is not much known about what actually takes place in mental health units with regard to the process of care planning and how the consumer is involved in this. The studies that are available focus on perceptions of consumers and nurses which may or may not describe the actual care provided. Mental health nurses face barriers in practicing therapeutically and find it difficult to articulate their role. They also do not routinely engage with consumer to develop the care in collaboration. This can potentially impact on the care and the quality of the care plan. Hence it is important to understand how nurses make the decision to let go of consumer involvement in care planning and so what this means about how they enact their accountability obligations as individual nurses. Therefore the next section will explore the research on individual accountability in health services.

2.4. ASPECTS OF ACCOUNTABILITY ENACTMENT

Accountability is the notion of holding someone responsible for delivering services to an appropriate standard (Donaldson 2001). Professional nursing accountability is the foundation of safe nursing practice and is an essential behaviour supporting congruence between nursing actions and standards that are associated with quality and safety in patient care (Krautscheid 2014). This appears a straightforward process but in the reality of the inpatient environment there can be complications which can impact on accountability for certain aspects of care such as the care plan. It is therefore important to understand how accountability can be facilitated and to have an appreciation of what kind of factors impact on accountability. An element of accountability is the decision making process in accountability enactment and what influences this. It is for this reason that literature on the following topics will be discussed:

- Being held accountable through auditing
- Accountability and characteristics of the workplace

- Accountability and decision-making

2.4.1. BEING HELD ACCOUNTABLE THROUGH AUDITING

Auditing is used in organisations as a way to ensure and facilitate accountability enactment but research has demonstrated that health professionals and services aim to comply with auditor standards rather than focussing more broadly on enhancing the quality of the client experience and outcomes that audit standards are supposed to deliver. In studies by Carlos et al. (2015) and Nolan et al. (2015) it was found that audit measurement increased the compliance with processes in an Intensive Care Unit (ICU) but the impact on consumer outcomes in terms of number of Ventilator Acquired Pneumonia (VAP) infections and mortality was undetermined.

A prospective analysis of 14 attending physicians' compliance with checklist use, before and after implementation of accountability interventions was undertaken by Carlos et al. (2015) in ICU's in two hospitals in the US. Accountability measures included bimonthly publications of physician checklist compliance. A total of 5,812 patient days of ICU care were assessed during part of 2013 and 2014 and compliance with checklist use during ICU rounds improved at both academic hospitals during the intervention phase. Initial compliance rates were 67% at both institutions and subsequently improved to 90% and 81% respectively after accountability measures were employed (Carlos et al. (2015). The authors concluded that physician accountability reporting can play a role in improving ICU physician compliance with rounding checklists (Carlos et al. 2015). It was, however, undetermined what the impact was on patient-specific outcomes such as infection rates. A limitation of the study was that some portion of the improvement in compliance rates for checklist completion is a positive manifestation of the Hawthorne effect. Although the pool of physicians was limited to 14, many people worked in the two academic hospitals where the

research took place and this afforded more people to ensure that checklist completion occurred during daily rounds than in most hospitals.

Similarly, a ‘morbidity and mortality peer review’ in a study by Nolan et al. (2015) included case discussions with ICU registered nurses about case history, relevant hospital course, diagnostic co morbidities and compliance with ventilator acquired pneumonia (VAP) prevention strategies (Nolan et al. 2015). The preventability of each VAP was determined by registered nurse peers. Ventilator days, VAP bundle compliance, VAP incidence, ICU length of stay, cost and satisfaction data were collected. To quantify the concept of accountability, data were collected throughout each review. Interestingly one person counted the number of times that attendees in case discussions used the ‘you’ as opposed to ‘I’ statements. A ’you’ statement indicated reduced accountability, an ‘I’ statement represented increased responsibility. The number of ‘I’ statements increased significantly which led to the conclusion that accountability had improved. Questions can be asked, however, whether the number of ‘I’ and ‘you’ statements is a true representation of accountability enactment. Unlike Carlos et al.’s study (2015) number of ventilator days and length of stay were measured but did not change significantly, although VAP bundle compliance improved from 90.1 % to 95.2 % (Nolan et al. 2015). One of the issues in Nolan’s study was that because of the low percentage of the total staff attending (<20%), the results may not be generalisable.

Measurement to determine accountability of psychotherapists was utilised by Kraus et al. (2011) but also in this study measurement did not provide sufficient information as it was unclear how effective individual health practitioners were (Kraus et al. 2011). The outcomes of 6,960 consumers seen by 969 therapists in the context of naturalistic treatment were analysed across multiple symptom and functioning domains. Providers used the Treatment Outcome Package (TOP) to

assess patient strengths and evaluate whether the patient had improved, worsened or neither improved nor worsened (Kraus et al. 2011). Researchers used the Reliable Change Index (RCI) to calculate whether patient change exceeded the measurement error of the scale. A psychotherapist was regarded an effective therapist when the average consumer reliably improved while an unclassifiable/ ineffective therapist was someone whose average consumer neither reliably improved nor worsened. A harmful therapist was someone whose average consumer reliably worsened. Results varied by TOP domain which included sexual functioning, work functioning, social functioning, depression, violence, panic, anxiety, substance use, psychosis, quality life, sleep, suicidality, depression and mania. The frequency of effective therapists ranged from 29% to 67% depending on the symptoms that were treated (Kraus et al. 2011). The number of unclassifiable therapists ranged from 30% to 59% and harmful therapists ranged from a low of 3% to 16% depending on treated symptoms. Results depended on the disorder that was treated rather than the therapist hence it was difficult to establish their accountability. A limitation of the study was that it relied on a convenience sample and clinics that paid for the processing of outcome data (Kraus et al. 2011). Questions can be asked about the reliability of the outcome measurement. The study was also limited by not including measures for all disorder categories such as borderline personality disorder and eating disorders.

In more recent research Drach-Zahavy, Leonenko & Srulovici (2018) aimed to develop and validate a questionnaire for measuring personal and organisational accountability among nurses. The measure relates to the three accountability dimensions of responsibility, transparency and answerability. An important limitation was the fact that this measure does not distinguish between different personal and organisational targets of accountability behaviour which could

provide insight into the conflicts that arise in the daily professional lives of nurses in the workplace (Drach-Zahavy, Leonenko & Srulovici 2018). In the first phase an initial database of items (N=74) was developed based on literature review and a qualitative study establishing face and content validity. In the second phase the authors established face, content, construct and criterion related validity of the initial questionnaires (19 items for personal and organisational questionnaire) with a sample of 229 nurses. In phase three, the final questionnaires (19 items each) were validated with a new sample of 329 nurses and established construct validity (Drach-Zahavy, Leonenko & Srulovici 2018). This resulted in a final version of the instruments which compromised 19 items to assess personal and organisational accountability. As detailed as this questionnaire is, the measure that was developed does not provide any insight in the decision making process and the conflicts that can arise during accountability enactment in the daily professional lives of nurses in the workplace.

Literature using measurement to determine accountability did not explain what individual health professionals were thinking and what the underlying reasons were of compliance with audits. It did not clarify how the decision making process took place and why priority was given to certain expects of care. While it is not clear what the results on patient-specific outcomes such as infection rates were in the study by Carlos et al. (2015), even in the study by Kraus et al. (2011) where there was some outcome measurement the process of provision of therapy was not investigated. There might have been confounding variables impacting on the consumer's condition and the effectiveness of therapy. For a more in-depth understanding of accountability and how it works in the daily work environment it is necessary to investigate factors that together determine accountability in the context of the work environment and as a result the quality of care.

2.4.2. ACCOUNTABILITY AND CHARACTERISTICS OF THE WORKPLACE

2.4.2.1. JOB SATISFACTION, EMPOWERMENT AND TEAM EFFECTIVENESS

In the complex process of accountability enactment certain factors may impact on how accountability is enacted. The research literature provides some insight into what might be required to manage a service where health professionals practice accountably. This is relevant when exploring how nurses enact accountability for consumers' involvement in the care plan. Moderate job satisfaction, a moderately empowering work setting and adequate time and autonomy may be necessary for health professionals to feel accountable and act accountably (Spence, Laschinger & Wong 1999; Sorensen et al. 2009; Raschkovits & Drach-Zahavy 2016). The research reviewed did however not establish a link between satisfaction, empowerment, time and autonomy on the one hand and actual care provided and consumer outcomes on the other hand. Findings of a descriptive correlational study in the US, which measured and described the relationship between job satisfaction and accountability among registered nurses (N=294), indicated that accountability was perceived relatively high and job satisfaction moderate (Sorensen et al. 2009). Accountability and job satisfaction were significantly correlated at a moderate level. One of the instruments used to measure individual nurse accountability and job satisfaction was the Specht and Ramler accountability Index-Individual referent in which the participants had to circle the number under the best description of the extent they agreed or disagreed with each statement of accountability. The McClosky-Mueller Satisfaction Scale was used to measure the satisfaction of hospital staff nurses. The scale has 31 items measuring 8 subscales of satisfaction while each item is measured on a 5 point Likert Scale ranging from very satisfied to very dissatisfied (Sorensen et al. 2009).

Although the correlations between the subscales of the McClosky-Mueller Satisfaction Scale and accountability were all statistically significant, they were weak. The subscales with the highest correlations with accountability were control and responsibility, praise and recognition and professional opportunities (Sorenson et al. 2009). The authors argue that to hold nurses accountable without attending to variables that influence job satisfaction such as rewards and recognition and control and responsibility, could be frustrating to nurses and therefore attention needs to be paid to these variables. Study limitations included that the a convenience sample was used and there was a possibility that there were factors that influence nurse job satisfaction and nurse accountability that were not captured by the instruments used to measure the concepts.

Further to the above, a moderately empowering work setting which encourages autonomy will facilitate accountability while work pressures and providing routine performance feedback might decrease the motivation to perform (Spence, Laschinger & Wong 1999; Rashkovits & Drach-Zahary 2016). Nurse empowerment was examined using Kanter's Theory of Organisational Empowerment (Spence, Laschinger & Wong 1999). This theory claims that managers should create conditions for work effectiveness by ensuring employees have access to the information, support and resources necessary to accomplish work and provide ongoing opportunities for employee development. The researchers proposed a model based on the predictions from Kanter's model. A cross-sectional correlational survey design was used to test the model. A randomly selected sample (n=672) was drawn from 2,200 registered nurses employed at a medical centre in Canada.

Results of the study were supportive of the proposed impact of staff nurse empowerment on employee accountability and perceived work effectiveness. Staff nurses' workplace empowerment and accountability for outcomes were

related to their ability to be effective in getting the work done and to contribute to organisational productivity goals (Spence, Laschinger & Wong 1999). Empowerment measures of opportunities, information and support and resources were related to study variables of accountability, productivity and work effectiveness. This suggested nurses' perceptions of their access to information, resources and opportunity in the work environment are important determinants of collective accountability and the ability to be effective at work. This is an essential strategy for assuring high quality patient care. Informal power was most strongly related to accountability, productivity and work effectiveness, highlighting the importance of alliances with peers and subordinates in the organisation in fostering a sense of collective accountability for practice (Spence, Laschinger & Wong 1999).

To enhance accountability it is not enough to achieve team learning and team effectiveness as there is also a need to provide nursing teams with adequate time and autonomy. Rashkovits & Drach-Zahavy (2016) suggest the need to be cautious with performance feedback as this may motivate nurses to repeat routine work strategies rather than exploring how to improve work. They used a cross-sectional design to test the moderated-mediation model and found that the relationship between accountability and team effectiveness is complex. Forty-four nursing teams participated in the study and head nurses completed validated questionnaires regarding team resources for learning (availability of team, autonomy and performance feedback) and nursing team's effectiveness. In addition, nurses answered Likert-type scale questionnaires regarding teams' accountability, learning and effectiveness. Mixed linear regression showed that nursing team accountability was positively linked to team learning when time availability and team autonomy were high rather than low and when team performance (in terms of repeat tasks) was low rather than high (Rashkovits &

Drach-Zahavy 2016). When performance pressure increases, team learning may decrease since higher motivation to perform well interferes with experimentation and learning and is translated instead into increased efforts for doing more of the same rather than investing in improving the processes.

Results suggested that when there was high rather than low availability of performance feedback to nursing teams, there is no link between team accountability and team learning, most likely due to the heightened performance pressure (Raschkovits & Drach-Zahavy 2016). Feedback is however necessary as services and health professionals need to know how they are performing. It might depend on the sort of performance feedback, who gives it and the purpose of the feedback whether team learning and experimentation will follow. This study was limited by the fact that the researchers did not consider the moderating role of other resources such as social capital and the impact of networks and relationships of employees in the team accountability-outcome link. In addition, future research may consider more comprehensive and complex measures as this study used a single-item measure.

2.4.2.2. ACCOUNTABILITY AND THE WIDER WORK ENVIRONMENT

A restructured work environment with a move to a different organisational model and documentation reforms were found to impact on health professionals' accountability enactment (Rappolt, Mitra & Murphy 2002; Choinere 2011). Occupational therapists (N=23) in the greater Toronto area reported in interviews that restructured contexts of practice with a move to managed competition and economic accountability had an overall negative impact on their capacity to practice occupational therapy as they believed it should be (Rappolt, Mitra & Murphy 2002). Participants perceived loss of control over the content of their work, instability of occupational therapy positions and feelings of isolation from peers. Participants felt unable to use research evidence to guide their clinical

practices (Rappolt, Mitra & Murphy 2002). This study confirms the afore mentioned research on the impact of empowerment or a lack of it and that this is possibly linked to accountability enactment (Spence, Laschinger & Wong 1999). It is however unclear how this impacted on consumer outcomes and the daily decision making by occupational therapists' on how to practice. Another limitation was that the data were gathered through in depth interviews with a small sample or relatively experienced therapists and as such they did not represent objective evidence of the inability of occupational therapists to meet professional standards for accountability.

Another aspect of reform was investigated by Choiniere (2011) who explored the implications of documentation reforms in Canada on nurses and patients and captured direct care Registered Nurse's (RN) experiences of accountability tensions. The author undertook semi structured interviews and focus groups with 63 general nurses. Nurses suggested that the charting reforms and the use of tick boxes and minimized reporting led to discouragement of the communication of important information. Not everything worth reporting was captured in these forms which could potentially impact on patient care (Choiniere 2011). The promised enhancement of accountability had not occurred. RN's reported a growing conflict between their accountability to patients and accountability to management, with the former often being sacrificed to the latter. Findings suggested that nurses were suffering a disconnect between their accountability to patient care, professional expectations and their own well-being on the one hand and their accountabilities to administration on the other hand (Choinere 2011). Although the results of both studies cannot be generalised across all health services, it is an indication that reforms can have an impact on how accountability is perceived. Both studies explored opinions and perceptions of health

professionals but it remained unclear what the consequences of the reforms were on their day to day practice and decision making.

2.4.3. ACCOUNTABILITY AND DECISION MAKING

2.4.3.1. PERCEPTIONS OF ACCOUNTABILITY

It can be argued that health professionals' perceptions of accountability play a crucial role in the process of decision making and enactment of accountability. Ethnographic research on nurses' perceptions and understanding of accountability in a private General Practice in the United Kingdom found that the meaning of the term 'accountability' was elusive and ambiguous (Savage & Moore 2004). A limitation of this research was the fact that the practice was relatively affluent and was not representative of many other General Practices or any public health services. In addition the use of vignettes during interviews may have shaped the answers given and it was not clear how perceptions of accountability impacted on practice.

Observations were undertaken as well as interviews with 13 employees including GPs and practice nurses. Some described accountability as a retrospective explanation of actions particularly as a way of accepting blame. On the other hand, accountability was perceived as something that can motivate action and good practice and that it implied a readiness to take consequences of action. Accountability was used as a way of describing certain relationships such as those between employers and employees (Savage & Moore 2004). Some practitioners were seen as more accountable than others, especially staff who were considered to have the most expertise. Partners (senior GPs in the practice) were viewed as carrying the ultimate accountability and practice nurses believed that accountability could be passed on from one practitioner to another with a narrative or an account of decision making (Savage & Moore 2004).

The passing on of accountability between practitioners was investigated in more detail by Chin et al. (2012) and Crotty (2013). Chin et al's (2012) study indicated there was ambiguity around the transition of accountability in the clinical handover process amongst physicians and maternity clinicians in a maternity unit (Chin et al. 2012). Potential issues identified were the possible psychological impact with a clinician feeling on-going responsibility and accountability (real or misinterpreted) despite having given a handover, while on the other hand blurring of boundaries could result in no one taking responsibility (Chin et a. 2012). Similar results were found by Crotty (2013) who highlighted there was confusion as to where responsibility and accountability lie within handover amongst medical officers. As a result of the traditional culture in medicine the hierarchy amongst medical officers potentially affected understandings of responsibility and accountability (Crotty 2013). There appeared to be a lack of overt and observable responsibility and accountability being transferred between the parties that can have detrimental consequences as clarity is needed on who is accountable for what (Crotty 2013). Both studies on accountability in the handover process were localised to one study site which limited the scope to one hospital in each case. Despite the limitations, the research on perceptions of accountability indicated potential confusion around the meaning of accountability which can have a harmful impact on consumer care.

2.4.3.2. ACCOUNTABILITY DILEMMAS

Some research highlighted that accountability dilemmas can be experienced in the decision making process (Mitchell 2001; Cleary 2003; Freeman et al. 2009; Manuel & Crowe 2014; Leonenko & Drach-Zahavy 2016). Interviews with 21 occupational therapists in one Canadian province revealed the dynamic interplay of accountability elements with the decision making involved in fulfilling

professional accountability (Freeman et al. 2009). Occupational therapists had to respond to practice standards, legal obligations, a client centred practice model and resource justification, referred to as external factors. The internal factors referred to the occupational therapists' expectation of themselves and an internal commitment to provide good quality care (Freeman 2009). The fulfilment of these externally and self-imposed, internal expectations was challenging. As a result of accountability dilemmas practitioners set accountability priorities which was the core of their accountability enactment (Freeman et al. 2009). Decision making incorporated two components: thinking processes to make decisions and the nature and sequence of the decisions made. In their thinking process professionals moved back and forth between conscious decision making (juggling accountability expectations) and implicit ongoing practice (operating on auto pilot). In the context of the nature and sequence of the decisions, therapists established priorities and in this process considered some decisions to be non-negotiable, while others were negotiable (Freeman et al. 2009). Practitioners tried to find a place between fulfilling their accountability expectations and acknowledging the reality of limits which added to the dilemma when they said I did 'the best I can' (Freeman et al. 2009). The degree to which study findings hold relevance for other professions such as nursing may however be limited as well as the generalisability of the conclusions as a result of the focus on one localised sample of health professionals.

Dilemmas were also encountered by health professionals in a study by Leonenko & Drach-Zahavy (2016) when they weighed up the unit's accountability level and calculated risks and benefits before executing accountability. The findings of this Israeli study, from semi-structured interviews with bedside nurses (N=1) and their managers (N=7) suggested that nurses perceived transparency and answerability as unjustified. Bedside nurses had their reservations about the ability to

assimilate transparency as a value directing behaviour in the work routine and felt that transparency was an invitation to criticism by managers and staff (Leonkeno & Drach-Zahavy 2016). Managers, on the other hand, thought that there was insufficient transparency. The authors concluded that the nurses' individual accountability was insufficient to generate accountability behaviours. An important finding was that nurses tended to weigh up the unit's accountability level in gauging risks, such as isolation and bullying, and benefits, such as empowerment and pride, before enacting accountability (Leonenko & Drach-Zahavy 2016). As a small study, findings cannot be generalised. In addition, the sole reliance on staff perspectives might neglect other stakeholders such as consumer and their families.

Other accountability dilemmas were created by the tensions between therapy and control in a 22 bed mental health inpatient unit. Cleary (2003) found that while findings indicated that the nurse-consumer relationship remained the foundation to nursing practice, the relationship raised challenges in relation to issues surrounding power and control. While the principle of 'least restriction' guided nursing care, nurses needed to balance interests and wellbeing of the consumer with safety concerns and nursing responsibilities. Nurses must be able to account for and justify why they promoted one good over the other which is difficult in that treatments like medications can be viewed as both treatment and control (Cleary 2003). Non-administration of medication in accordance to consumer wishes may adversely affect the wellbeing of the consumer while the enforcement of medications to promote wellbeing, contrary to consumer wishes, could be interpreted as an infringement of rights and use of power. Findings from observations and 10 interviews illustrated that nurses were aware of the power and control the mental health system let them assume in daily practice to manage safety and least restriction. Findings also demonstrated how the

consumer stabilisation role of the unit located the imperatives of relationships, power restrictions and safety as central to the delivery of nursing care (Cleary 2003). The study gives an interesting insight into how in dealing with accountability dilemmas, nurses negotiated treatment, managed safety and decreased the power differentials as they aimed to develop meaningful relationships with consumers.

Mental health nurses' conflict with their accountability within daily practice was explored by Mitchell et al. (2001) who identified the importance of team support, clinical supervision and debriefing as methods which help mental health nurses deal with issues that affect their accountability. Mitchell (2001) investigated how 22 mental health nurses dealt with critical incidents that conflicted with their accountability. Cormack's (1996) technique for analyzing critical incidents was utilised to analyse the data. Results indicated that the majority of staff involved in conflict were doctors and nurses and that inadequate communication led to conflict in accountability enactment and complicated decision making. The focus on critical incidents was also a limitation of the study as critical incidents are relatively rare and it would have been helpful to explore mental health nurses' decision making processes in regular day to day care.

The dilemma nurses experienced in Manuel and Crowe's study (2014) was that the influence of risk management (as part of accountability) led to non-therapeutic defensive processes as a strong focus on documentation and referring decision making to the psychiatrist (Manuel & Crowe 2014). Nurses calculated decisions based on wanting to protect themselves from blame against what they believed were the best interests of the consumer. Nurses suggested the organisation was more concerned about possible outcomes from having their policies audited than the quality of patient care (Manuel & Crowe 2014). When enacting accountability, the focus on risk management can potentially result in

nurses' disregarding their therapeutic responsibilities (Manuel & Crowe 2014). The authors examined how 10 mental health nurses understood clinical responsibility and accountability and its impact on practice. Being accountable identified the active process with which the participants engaged in an effort to balance the consumers' needs in an organisational climate with a focus on risk management in which they would be blamed if an adverse event occurred (Manuel & Crowe 2014). The nurses spoke about fostering responsibility as a process of providing the consumer with alternatives and they believed that in a recovery based framework it is up to the consumer to make choices about taking risks and not up to the health professional to protect them (Manuel & Crowe 2014).

2.4.3.3. TEAM RIVALRIES AND COLLECTIVE VIGILANCE

Apart from the dilemmas experienced in accountability enactment, rivalries between clinicians on the one hand (Sorenson & Iedema 2007) and collective vigilance on the other hand (Jeffs et al. 2012) have been found to impact on decision making. Sorenson & Iedema's (2007) ethnographic study in an ICU in Australia found that the knowledge and practice differences of multiple medical decision-makers generated conflict, inconsistency of practice and subjectivity of decision making. This impeded coherent clinical decision making and integrated patient care planning, coordination and care review (Sorensen & Iedema 2008). Interviews and focus groups with medical managers, intensivists and nurses were conducted. Notes were taken of observations in family conferences, in clinician interactions with patients and unit rounds. The study found that dysfunctional relationships and professional rivalries between ICU clinicians and external medical consultants, mainly surgeons, were a barrier to enacting a model of patient-centred care (Sorensen & Iedema 2008). There were no processes to ensure organisational accountability related to continuity of patient

care. Within the struggle for decision making authority, decision processes were frequently contested individually and fraught (Sorensen & Iedema 2008).

Hence poor teamwork can impact on accountability enactment, however collegial teamwork has also been found to negatively impact on accountability enactment (Jeffs et al. 2012). Constructivist grounded theory was used to explore near misses to understand how different clinicians experience and respond to them (Jeffs et al. 2012). Semi-structured interviews with 24 health professionals found that collective vigilance can potentially create risks by eroding professional accountability through reliance on other team members to catch and correct errors. Enacting collective vigilance or assuming accountability for one another's practices could lead to an expectation that others will catch and correct errors. A dilemma is created when clinicians are encouraged to support each other in their daily practice on the one hand, which can potentially lead to reduced personal accountability on the other hand (Jeffs et al. 2012). The two studies indicated that decision making in accountability enactment can be influenced by conflict and teamwork alike but no insight was provided into the workings of the decision making process of individual clinicians.

2.4.3.4. INCIDENT REPORTING AND PEER-TO-PEER ACCOUNTABILITY

Another aspects of the enactment of accountability in the health sector is incident reporting (Hor et al. 2008) and peer-to-peer accountability (Jansen Lockett et al. 2015) and the decision making process around this. Co-existing norms of social accountability between colleagues and the new norm of reporting for safety improvement can create discord and dilemmas in the social context of health care workplaces (Hor et al. 2008). A three-year ethnographic study found that local processes to communicate accountability within the team played out alongside incident reporting to the organisation (Hor et al. 2008). Field notes and unstructured field interviews highlighted that a multidisciplinary group of clinicians

chose to direct interpersonal communication with their colleagues to deal with incidents along with making an incident report. Local accountabilities can influence clinician's incident reporting practices and likewise incident reporting can affect how clinicians negotiate local accountabilities. Local factors influenced clinicians' use of the reporting system and were affected in return. The meanings ascribed to incidents were negotiable and for example the rating of the severity can be determined by criteria other than stated in the policy (Hor et al. 2008). Comments by clinicians reflected the dissonance that peer reporting can create in the social context of health care workplaces by contrasting pre-existing norms of social accountability between colleagues with the new norm of safety improvement (Hor et al. 2008). Although incident reporting is an expression of accountability enactment it may or may not influence future nursing practice.

Peer-to-peer accountability may be more influential than incident reporting in decision making processes of health professionals. Peer-to-peer accountability is implied, but not specifically defined and may be informal, spontaneous and situational (Janssen Lockett et al. 2015). Janssen Lockett et al. (2015) developed a conceptual model of peer-to-peer accountability in a grounded theory study based on the results and the themes that were extrapolated. The study results led to identifying attributes of peer-to-peer accountability, as holding self and others responsible for acceptable standards of care, giving and receiving feedback, speaking up in a respectful honest and transparent manner, communicating directly to the individual involved and exchanging information from peer to peer when observing questionable practice (Jansen Lockett et al. 2015). Positive antecedents of peer-to-peer accountability included the nurses' recognition of their ethical responsibility for their own and others' actions. This was to uphold acceptable standards of behaviour and patient care and a sense of duty or responsibility to keep patients safe. Other precursors were a strong safety

culture on the unit, supporting the expectation that speaking up was the right thing to do, perceived approachability of the recipient, hierarchy of persons involved, sense of empowerment, confidence in communication skills and the level of unit tolerance for specific behaviours (Jansen Lockett et al. 2015). Negative antecedents included unclear professional roles, fear of hierarchy, tolerance of poor performance, fear of retaliation and fear of being labelled.

2.4.3.5. FEAR AND BLAME

The decision making processes can also be impacted upon by fear or fear of blame. Internalising of unrealistic expectations regarding suicide prevention could hold nurses themselves to blame (Robertson et al. 2010). The fear of blame can lead to risk aversion by health professionals which might result in, for example, a strong focus on documentation 'to cover oneself'. Instead of spending valuable time with consumers, health professionals might focus on bureaucratic processes which can be potentially detrimental to consumer care (Clancy & Happell 2017).

Robertson et al. (2010) focused specifically on how two mental health nurses constructed accountability, blame and responsibility when talking of their experience of a suicide that occurred four years earlier. Discourse analysis was used to explore particular phrases and orientation to professional accountability which was the main theme within the conversation. When discussing the risk assessment, the two nurses described key activities they assessed namely mood, personal hygiene and appetite to support the notion the consumer was well and not a suicide risk. This was called an 'interpretive repertoire' when discussed with someone with a shared understanding. The nurses identified that a formal and informal risk assessment had been carried out which enabled the nurses to counter suggestions that any danger signs were there and had been missed. There was however an apparent contradiction, with nurses on the one hand pointing out the consumer's wellness (interpretive repertoire) while on the

other hand they knew the consumer had schizophrenia and as psychiatric nurses they should know that psychotic consumers are at a higher risk of suicide when well and waiting for discharge (Robertson et al. 2010). This highlighted the, sometimes contradictory, ways nurses attended to interactional concerns related to implicit accountability and potential inferences of blame (Robertson et al. 2010). This study offers interesting insights into the decision making processes of two nurses.

The fear for organisational blame was reflected in Clancy & Happell's study (2017) when manager participants described the importance of a responsible accountable approach at an organisational level. They pointed to the importance of ensuring processes such as documented risk assessments which would be able to withstand the scrutiny of an audit. Meeting audit criteria dominated the provision of care as risk was observed as a negative and to be avoided. Managers demonstrated a desire to ensure correct procedures were followed and accountability for practice could be demonstrated. Clinicians felt however that a pre-occupation with risk detracted from patient centred care. In-depth interviews with 22 managers and 21 clinicians on communicating risk illustrated that to managers, accountability was a very important consideration in communicating risk and therefore influential over nursing practice (Clancy & Happell 2017). Clinicians, on the other hand were more likely to view the organisational processes of communicating risk as a bureaucratic exercise and thought that audits only established whether boxes had been ticked, but did not look at the substance of documentation or clinical practice (Clancy & Happell 2017).

2.4.4. SUMMARY

Different facets of accountability can potentially have an impact on nursing practice and consequently the quality of the care plan. Studies have examined

the use of audits and characteristics of the work environment however we still do not know how the complexity of different factors play out together to determine how accountability is enacted. Studies on job satisfaction, empowerment and autonomy have not established how these factors influence individual performance of health professionals or consumer outcomes. The literature on the impact of reforms in the wider work environment do not provide clarity on the consequences of the reforms on day to day practice and decision making of individual practitioners. Although explorations on different dilemmas in decision making highlighted the complexity of decision making in accountability enactment there is no knowledge on the process of decision making by mental health nurses about whether to deliver quality care includes a meaningful care plan.

2.5. CONCLUSION

Studies were evaluated to shed light on nursing practice and decision making which impacts on the quality of the care plan. The topics of the role of the nurse in the inpatient unit, care planning and consumer involvement and aspects of accountability were explored as they all play a role in the development of a quality care plan.

The therapeutic relationship between the consumer and the nurse was central to only a few studies and consumer engagement did not routinely take place. Possible reasons for a lack of engagement were explored but it was unclear how exactly this occurred in the daily work environment. Organisational challenges impacted on nurses' practice which was perceived by participants in some studies as invisible. There was no clarity on the role of the mental health nurse. Despite the fact that nurses' skills were mentioned as impacting on their practice it was not explored how this occurred. Having certain skills does also not guarantee that these skills are utilised in daily practice.

The few studies which focused on care planning and consumer involvement revealed that nurses and consumers had different ideas as to why consumer involvement in care planning did not take place. Consumers believed that the behaviour of individual nurses and a lack of information sharing were the cause of a lack of consumer involvement. Nurses on the other hand pointed to the use of the medical model and insufficient support from the organisation. All studies utilised perceptions of nurses and consumers which may or may not represent the actual care provided. There is a lack of knowledge on the processes of care planning that take place in the reality of the work environment.

Literature on different aspects of accountability explored accountability in the context audit measurement but it did not provide any insight into the effectiveness of individual health professionals or provide details on the decision making processes and the conflicts that can arise. Studies that explored job satisfaction, empowerment and autonomy did not establish a link between these aspects and individual performance and consumer outcomes. The wider environment was also believed to impact on accountability but studies focused on perceptions of health professionals and it remained unclear what the consequences of the organisational reforms were on the day to day practice.

A few studies focused on topics related to accountability and decision making and provided some interesting insights. Confusion around accountability and responsibility was found in the handover processes which can impact on consumer care. A variety of accountability dilemmas were explored but the findings were limited to the health professionals and disciplines investigated. Most of these study findings were also based on interviews and perceptions of health professionals which may or may not be a reflection of the reality of the work environment. The team and rivalries and collective vigilance was found to impact on accountability enactment but no insight was provided into the workings

of the decision making process. Incident reporting was also investigated but although it can be regarded as an expression of accountability enactment at an organisational level it may not influence individual nursing practice. The decision making process can also be impacted upon by fear and blame and can lead to risk aversion or a focus on documentation processes but it is unknown how that decision making process takes place.

Despite the research around different aspects of accountability, questions remain how the decision making process by mental health nurses takes place and how mental health nurses decide to provide quality care through the use of a care plan that involves the consumer in the plan. Hence it is important to explore how mental health nurses enact accountability with regard to the creation of the care plan in the reality of the workplace and the involvement of consumers in the process.

CHAPTER THREE: METHODOLOGY

3.1. INTRODUCTION

To gain a better understanding of the enactment of accountability by mental health nurses in inpatient services with regard to the consumer care plan, this study employed a focused ethnography methodology. The Enactment of Accountability Study explores how inpatient mental health nurses enact their accountability obligations in the context of consumer involvement in care plan creation and focusses on the human experience and subjective influences. The enactment of accountability in the context of this study is how mental health nurses view and experience accountability and how they execute accountability obligations in the daily work environment. This chapter describes, examines and justifies focused ethnography as the methodology. The rationale for selecting this particular approach is presented, along with an overview of methodological issues encountered within the Enactment of Accountability Study. Various influences on decision making for the chosen methodology are examined. Ethical considerations and rigour are discussed in chapter four.

3.2. CHOOSING A METHOD OR STRATEGY OF INQUIRY

The enactment of accountability is embedded in the context of the work environment and it is the culture that has an overarching impact on nurses' practice and how they enact accountability (Robertson et al. 2010; Scrivener et al. 2011; Manuel & Crowe 2014). To explore accountability for consumer involvement in care planning by mental health nurses and how this is executed on a day to day basis in the reality of the work environment this study focus is on thoughts, feelings and experiences which is best explored using a qualitative paradigm. It was personal experience of working in mental health services that

led me towards a research project with a commitment to a qualitative approach. Strauss & Corbin (1998) proposed that it is common for researchers to hold convictions based on previous research and/or professional experience. Miles & Huberman (1994) suggested that the good qualitative researcher has some familiarity with the phenomenon and the setting, a strong conceptual interest and a multidisciplinary approach. These were the reasons that a qualitative approach seemed most appropriate.

Of relevance to this study was the emphasis on the meaning of accountability and how this was executed on a daily basis. This study explored how nurses enacted accountability for consumer involvement in care planning. More specifically the research focused on the analysis of decision making processes around care plan creation and if and how to involve consumers. As it is our sense of accountability which makes us act and practice in a certain way, the study aimed to uncover how mental health nurses enacted accountability with regard to care planning activities and the relationship between the unit culture of accountability and the development of a care plan. The execution of accountability is embedded in the context of the work environment (Robertson et al. 2010; Scrivener et al. 2011; Manuel & Crowe 2014) and therefore the emphasis is on ward practices and how the environment impacts (or not) on nurses' practice and their decision making to involve consumers in the development of their care plan. The aim also includes exploration of the nurses' beliefs and opinions on care plans and consumer involvement and how nurses practiced accountability as a result. The qualitative approach appeared more suitable to explore intentions, thoughts and feelings of mental health nurses in their day-to-day practice. Qualitative methods are suited to address the complexities of health care organisations and can capture the social processes and uncover the procedures of and barriers to change (Hoff & Wit 2000; Caronna

2010). They provide rich descriptions of complex phenomena to illuminate the experience and interpretation by actors with widely differing stakes and roles (Hoff & Wit 2000; Bradley, 2007).

The attraction of qualitative methods was the fact that they offer the possibility of understanding the experience of health, illness and the delivery of care from the perspective of care providers. Health work is concerned with individuals in their own social context as well as the context of institutions (Melia 2010). In addition, qualitative methods have proven valuable in determining how professionals respond to changing work environments and resources available to them as well as investigating health professionals and their decision making (Collin 2010). Qualitative studies have also contributed to determining how guidelines are actually followed by different professional groups (Collin 2010).

Most of the possible qualitative approaches such as case study, phenomenology or grounded theory, would have provided a perspective on the experience of nurses. However, not all approaches would have answered the specific questions posed in this study, which places accountability in the context of the culture it is enacted in. Therefore, in seeking to explore and understand how mental health nurses enact accountability within an inpatient unit culture, ethnography was regarded as the most useful methodology.

3.2.1. CULTURE AND ACCOUNTABILITY

3.2.1.1. WORKPLACE CULTURE

Culture is one of the main concerns of practice development (Manley et al. 2011; Plakhotnik 2011). The workplace culture is the level at which most healthcare is delivered and it is this immediate culture experienced by consumers at the interface of care (Manley et al. 2011). Frow & Morris (2010) define culture as:

> A network of embedded practices and representatives (texts, images, talk, code and behaviour and the narrative structures organising these) that shapes every aspect of social life (p. 316).

The nature of the workplace culture in the healthcare sector, impacts on the care provision by staff and on consumer outcomes. It also influences the health of staff working within the environment (Manley 2008). Workplace culture reflects the values that people share in the workplace including norms, assumptions, social order and beliefs that the workplace holds (McCormack et al. 2002; Scott-Findlay & Estabrooks 2006; Kurjenluoma et al. 2017). It is however essential to have common beliefs and values that could be shared as the staff work together towards achieving goals in the workplace. A positive workplace culture is associated with nurse retention, quality of care and employee performance (Tillot 2013).

Elements of workplace culture, for instance job stress, job satisfaction and the practice environment affect nurses' motivations to work in the nursing profession and the likelihood they will stay in one workplace. Poor workplace cultures have contributed to increased sick leave of nurses, medication errors, poor staff retention and psychological ill health of staff (Longo 2007; Manley et al. 2011). An upstanding functioning practice environment, on the other hand, is seen to have a positive impact on nurses enthusiasm for their work and raised the quality of care they provided (Nardi & Gyurko 2013). Mental health nurses identified teamwork, control over practice, leadership and autonomy as areas that positively influence their practice environment (Farmakas et al. 2014). It is well known that a conservative organisational culture can hinder the implementation of a new organisational model and resistance to change can delay improvements in consumer care (Boster & Manias 2009;; Johansson et al. 2014). Organisational culture and subcultures in the workplace have been identified as

some of the most important factors to consider during a change process (Johansson et al. 2014). It is therefore vital to critically examine culture. Health services need information to evaluate the workplace situation and establish what changes are needed to develop the workplace culture.

Culture is not a fixed entity, rather it is the context within which we engage in the complexities of everyday life or work (Draper 2015). Culture is a process more than a product (Butcon & Chan 2017) and is flexible and constantly in the making (Wright 1998) and there is agreement that people grow into cultural knowledge within a social and environmental context. Culture is dynamic because it is re-created when a new person is added to the group (Butcon & Chan 2017). It is only visible when differences emerge from the experience of the new member of the group (Butcon & Chan 2017). It is open and interactive and continuously evolving as people negotiate their identities within a conceptual space. Therefore accountability, which as previously outlined refers to the implicit or explicit expectation that one may be called on to justify one's belief (Lerner & Tedlock 1999), is part of and influenced by an existing work culture which shapes those expectations. Accountability expectations may change over time as new members arrive or existing members leave and negotiations between team members take place which may create a 'new' culture (Lerner & Tedlock 1999).

3.2.2. ETHNOGRAPHY

In attempting to explore the enactment of accountability by mental health nurses it was clear to me that I needed to interpret the experiences of the nurses in the bigger context of the work environment. Mental health nurses do not work in isolation but interact with work colleagues in the same location but also across the service as a whole, as well as with other services. As outlined above a sense of accountability by mental health clinicians is likely to be embedded in the

environment and the culture of the workplace. The choice for the ethnographic methodology was also obvious as a consequence of the concept of the consumer care plan and how this has developed over the last 25 years. During that time policy guidelines were developed which support the care plan in the context of the implementation of the recovery model in mental health services. The consumer care plan is embedded in these guidelines and the reality of the work environment, which frequently employs the medical model with a focus on diagnosis and pharmaceutical treatment (Deacon 2013; Beecher 2017).

Organisations including hospitals have their own specific cultures which is why Van der Geest & Finkler (2004) suggest the use of ethnography to explore hospital settings. An organisational culture is described as '*a learned product of group experience and is said to develop wherever there is* a *'definable group with a significant history"* (Van der Geest & Finkler 2004). As outlined earlier, there appears to be consensus that an organisation's culture consists of shared beliefs, assumptions, perceptions and norms leading to patterns of behaviours (Strasser et al. 2002). A culture results from an interaction among many variables, including mission, strategy, structure, leadership and human resource practices. The culture itself is self-reinforcing and naturally resists change (Strasser et al. 2002).

Accountability and the decision to develop care plans or not, can potentially be placed into a fuller more meaningful context. The issue of accountability in mental health services is complex and embedded in multiple systems. Ethnography occurs in natural settings characterised by learning about the culture under study and experiencing the relevant way of life before attempting to derive explanations for the attitudes or behaviour of that culture's members (Goodson & Vassar 2011). Ethnography is both a process and a product and is not simply a method or set of research techniques but a way of seeing and knowing the world

(Tedlock 2000; Prentice 2010). Ethnography has its roots in the discipline of anthropology and was concerned with 'other' (outside the home culture) cultures to understand their beliefs and practices. Modern ethnography is however largely concerned with local communities and the ways that people understand and account for their daily situations, rather than distant or 'exotic ones' (Draper 2015).

Ethnographers do not conduct research by testing informants with a narrow set of questions. They work inductively which includes a process of observing, participating, conducting formal and informal interviews, formulating interpretations and reflecting on the emerging analysis (Prentice 2010). Knowledge generated here is not scientific truth or personal experience but interpretative, emerging from social interaction and negotiation (Prentice 2010). Ethnography is not used for developing generalised conclusions but rather studying specific groups of people regarding a specific topic and drawing conclusions about what was studied (Savage 2000). It is assumed that by entering into first hand interactions with people in their everyday lives, ethnographers can reach a better understanding of the beliefs, motivations and behaviours of individuals than they can by any other method (Savage 2000).

The vast numbers of variables in the clinical setting lend themselves well to analyse with an open ended approach rather than answering questions from a survey or pulling archived data from hospital and clinic data bases (Rice & Ezzy 1999). Participant observation for example gives ethnographers opportunities to gather empirical insights into social practices that are normally hidden from the public. In addition, since it aims to generate holistic social accounts, ethnographic research can explore and link social phenomena, which on the surface appear to have little connection with each other (Reeves, Kuper & Hodges 2008). The advantage of ethnography is that it has the potential to generate accounts of

clinician's approaches to delivering care, which enables an understanding of their decision making around developing care plans and how accountability drives them to do this.

Ethnography is not simply the process of data collection, it is also the process of understanding, building meaning and presenting the outcomes of the research. What for many ethnographers is centrally important is that findings are presented in a way that conveys a sense of being there. Findings can also indicate the nature of relationships between the researcher and the researched and how this may affect the research process and findings (Savage 2006). Allen (2006) argues that the approach to ethnographic data collection and analysis does not naturalistically report the social reality of the unit. It presents reflexive accounts of reality built up through the field relationships and developed between participant observation and interview data. Reflexivity in this case means acknowledgment that the final ethnographic report is not the truth but rather the researcher's representation (Allen 2006).

A culture of accountability in a mental health inpatient unit is explored within this study but not with the purpose of gaining an anthropological picture of the inpatient unit. Instead the choice of focused ethnography was distinct from anthropological ethnography and emphasised the principle to exploring one specific practice (accountability enactment) and the thinking and decision making behind it. Mental health nurses are part of the culture of the inpatient unit. The cultural context in which they operate colours all of their decisions an interactions. This study includes other health professionals who were part of the field of observation in clinical handovers and multidisciplinary team meetings.

3.2.3. THE LINK BETWEEN FOCUSED ETHNOGRAPHY AND THE THEORETICAL FRAMEWORK

In selecting focused ethnography as a methodology it was important that the theoretical framework was congruent and appropriate to assist in answering the research question. This framework was formed by health services accountability theory, theories and literature around the role of the mental health nurse and the theory of consumer involvement in care planning. The topic of accountability and the care plan sits in the knowledge domain of health service quality e.g. care planning with consumer involvement for which accountability fulfils the function of ensuring quality. I chose this theoretical framework and domain of knowledge to inform my inquiry and will relate my work theoretically to this domain of knowledge.

Accountability is a fundamental element in all societies and to organisations including health organisations. Individual accountability has been widely considered as a subjectively experienced phenomenon, each person having their own perception of what constitutes accountability. Due to the ubiquity of accountability, the tendency of individuals to anticipate accountabilities, and the direct connection between accountability and an individual's self-image, accountability may be the most pervasive and perhaps the most powerful single influence on human social behaviour (Tedlock 2000). This means that accountability is a highly influential factor in everyday situations and interactions.

Accountability has a close relationship with culture, many aspects being culture dependent. Research confirms that the culture of the work environment in health services has an impact on individual accountability. Some studies found that moderate job satisfaction or a moderately empowering work setting which encourages autonomy may be necessary for health professionals to feel accountable (Sorensen et al. 2009; Spence, Laschinger & Wong 1999).

Likewise, nurses weighed up the unit's accountability level and calculated risk in terms of isolation and bullying and benefits such as empowerment and pride before enacting accountability (Leonenko & Drach-Zahavy 2016). Therefore, both the role of the mental health nurse in the inpatient unit and their styles and levels of accountability are embedded within the unit culture (Hummelvoll & Severinsson 2001; Cleary 2003, 2004, Fourie et al. 2015; Pazargardi 2015) where nurses make choices based on perceived accountability obligations which impacts on consumer involvement in the care planning process.

Accountability, care planning and the role of the nurse must therefore be viewed within a cultural context. This explains why focused ethnography is an appropriate methodology to explore whether and how accountability impacts the development of care plans by mental health nurses.

3.2.4. ONTOLOGY AND EPISTEMOLOGY

In considering a suitable methodology, researchers should contemplate questions about what they believe about being in the world (ontology) and how they come to know the world (epistemology). In research, ontology dictates the essential phenomena we can expect to find and may seek, as well as that which we will never find, so need not look. Ontology is socially constructed, experienced and perceived by people (Higgs & Trede 2009). At the next layer of fundamental theory, epistemologies suggest how researchers can empirically access phenomena, given the ontological assumptions about what the phenomena are (Giacomini 2010). Ontology and epistemology influence which questions a researcher will ask, what they want to know and how they believe they can know it (Roberts & Taylor 1999).

My ontological point of view originates from the formative years, which took place in another country, while speaking another language along with my education

and life experiences. My view on being human in this world has been developed through a combination of theory, practice, experience, critique and reflection. My cultural background and traditions which promote self-discipline demand reflection and a critical viewpoint on my practice. Likewise, my view on nursing as a profession and mental health nursing have been developed the same way. For instance, the current technical-economical rationality in society and health care calls for a specific kind of knowledge, which influences my views as a manager. The nursing ontology and epistemology is developed and changed parallel to the development of society (Hoeck & Delmar 2017). I acknowledge that the ontological position of others, including participants in the study, may or may not correspond with mine.

It is also important to consider epistemological issues early in a study that will include participants from a variety of backgrounds. I need to acknowledge that my background as a general nurse, mental health nurse and PhD student privilege certain ways of knowing which can be different from, but not superior to, other nurses' or consumers' ways of knowing.

So why did I chose to focus on accountability in relation to care planning? A lot of criticism has been expressed over the last few years with regard to the care provided in mental health services. Not a week goes past without the media drawing attention to the gaps currently present in mental health services. As a mental health professional and manager of a mental health team there is constant pressure to perform better and to demonstrate that performance has improved. On a daily basis I witness the life challenges of mental health consumers, their lack of empowerment and continued reduced physical and mental health. These observations and work pressures gave me a strong drive to critically examine services, including my own practice, and question aspects that were taken for granted until now.

Care planning is a crucial part of nursing care and is a good place to start when looking for ways to improve mental health services (Australian Government, National Standards for Mental Health services 2010). The experience of working in various mental health teams in different states across a variety of roles led me to believe that nurses in general assume that mental health professionals feel accountable and have knowledge of what constitutes professional accountability. This is often assumed without meaningful discussion taking place on this important topic. The research seeks to examine how accountability affects the development and use of care plans, which should play a vital role in service provision.

3.2.5. REFLEXIVITY

Closely related to epistemology is the practice of reflexivity as it encourages me to reflect on my epistemological assumptions about knowledge of the world and the implications of these assumptions on my research (Pitard 2017). Reflexivity is an important dimension of ethnography (Hammersley & Atkinson 2007) and is a form of validity or 'reflexive accounting', and an essential requirement of all qualitative research (Denzin & Lincoln 2000). Reflexivity is an important step to establish the validity of the phenomena being studied and to convey that the writing is not just an expression of my ideology (Schwandt, Lincoln & Guba 2007). It involves attempts to enhance impartiality through reducing or controlling the effects of me as the researcher on the research situation (Nazaruk 2011). Through reflexivity I engage in a critical examination of my own taken-for-granted assumptions, things that are so ingrained that we perhaps fail to realise their impact on our individual and societal or collective experience (Draper 2015, p. 38).

Reflexivity is focused on making explicit and transparent the effect of the research methodology and tools of data collection on the process of the research and research findings. In addition, we are influenced by ideologies, values and belief systems which may be difficult to deconstruct. The aim of reflexivity is to acknowledge this influence as our internalised beliefs and values may be impossible to disregard (Higginbottom 2004). This is particularly important in focused ethnographies such as this study, because I was so familiar with the culture being studied (Cruz & Higginbottom 2013). An abundance of knowledge of the culture that is going to be researched needs to be taken into account reflexively as 'members' knowledge' and it can be used heuristically (Knoblauch 2005). Even if I lacked the contextual knowledge of specific situations, I knew of these situations. There is a backdrop of common shared knowledge and in this backdrop focussed ethnographers attempt to identify differences between them and other types of persons, different scenes, settings, situations and fields (Knoblauch 2005). This 'alterity' is a condition of focused ethnography.

Reflexivity can be viewed as accountability enactment by me as the researcher as I am obliged to critically think about research practices and analyses and declare and take responsibility for my positioning as the researcher. Personal reflexivity involves considering how my own values, life experiences and assumptions have influenced the research (Mauthner & Doucet 2003). In addressing reflexivity I must look both ways: at my own values, life experiences and beliefs and also at the trustworthiness and rigour of the research design and methodology all of which are ruled by my assumptions (Mauthner & Doucet 2003; Pitard 2017). In my research I had the dual role of researcher and staff member of the same local health network and therefore it was important to self-monitor the impact of my own experiences and assumptions by looking at myself with a researcher's lens. I needed to acknowledge that it was impossible for me to stay

outside my research and I was impacting on the dialectical process through my role as another mental health nurse (Nazaruk 2011; Pitard 2017).

Awareness of internal dialogue is important and reflexivity requires for me to take time to be still, to listen, to the internal dialogue and to investigate reactions that are roused by the experience with the data (Pitard 2017). My ability to know another depends inherently on my ability to know myself. By turning the lens on myself I acknowledged my own experience of having a large work load and needing to make quick decisions in collaboration with health professionals from different disciplines while keeping the consumer's recovery in mind. This experience led to a certain way of knowing and understanding the challenges in decision making when a variety of competing accountability obligations require equal attention and action. Reflexivity also assisted me in an awareness that my experience of holding leadership positions over the past 6 years caused internal reactions and impacted on how I viewed the data with a focus on individual nurses rather than on the impact of the entire work environment. By examining the internal dialogue, stimuli from past experiences were revealed (Pitard 2017), which had an impact on the research and the data.

3.2.6. METHODOLOGICAL APPROACH: FOCUSED ETHNOGRAPHY

Although ethnography was the appropriate method for pursuing the topic of enactment of accountability by mental health nurses, the traditional assumptions about ethnography did not hold here. Classical anthropological ethnography is characterised by the long term, holistic participation of the researcher amongst a foreign group of people. This means the researcher is unfamiliar with the cultural setting under study and enters the setting with a broad undefined purpose (Roper & Shapira 2000; Mayan 2009; Wall 2015). This was not the case in this study on the enactment of accountability where I was familiar with the culture under study

and had a narrowly defined research question. Systematic ethnography, which emphasises the structure of culture more than describing it, using schematic representations of cultural knowledge was not fitting as my aim was to explore how accountability impacted on care plan creation. Likewise, critical ethnography was not deemed to be suitable either. Critical ethnography aims to critique cultural circumstances or design strategies for change. With critical ethnography the intent is to include marginalised and contrary voices and reveal hidden agendas and power centres for emancipatory purposes (Mayan 2009). This was incongruent with the purpose of my research as the aim was to explore how accountability is executed by mental health nurses daily in their work environment.

The research question about the enactment of accountability by mental health nurses, the unique study population of mental health nurses and my positioning as the researcher necessitated a few methodological adaptations. Roper & Shapira (2000) explained how traditional ethnography researchers typically do not enter the field with a formally specified research question. Accountability and the relationship to care planning in mental health services is however a specific topic which is of importance to clinicians, consumers and services. Focused ethnography can be an efficient way to capture data on one specific topic to improve care and care processes (Higginbottom, Pillay & Boadu 2013).

Focused ethnographies are characterised by selected, specified, focused aspects or issues of a field, which is relevant to the topic under investigation. The focus is on cultures, and subcultures framed within a discrete community or phenomenon and context whereby participants have specific knowledge about an identified problem (Muecke 1994; Higginbottom, Pillau & Boadu 2013). Focused ethnography, in contrast to conventional ethnography is undertaken in relatively short-term visits but relies on large amounts of data built upon diverse

impressions, interpretations and observations (Butcon & Chan 2017). Data analysis is typically intensive and time consuming. Focused ethnography was particularly suitable in this study as it analyses structures and patterns in interaction such as the coordination of work activities or the course of meetings.

The strength of focused ethnography is in its detailed way of witnessing human events, which is a quality that is useful in health care as a way to more deeply understand both the consumers' and the clinicians' world (Savage 2000; Pope 2005). When investigating specific beliefs and practices of particular illnesses or particular healthcare processes as held by practitioners and consumers, ethnography is considered focused (Knoblauch 2005). With focused ethnography the findings are anticipated to have meaningful and useful application in community or hospital healthcare practice (Knoblauch 2005). Focused ethnography is considered a useful tool in gaining a better understanding of the experiences of specific aspects of people's way of life and being (Cruz & Higginbottom 2013). As focused ethnographies are relatively brief and limited in scope they have been prone to criticism but it is the focus on cultural understandings and descriptions that define ethnography rather than the amount of data collection that occurs (Knoblauch 2005)

Focused ethnography was useful in this study in order to begin to answer the questions about what is the relationship between accountability and care planning. In which ways does accountability affect the use of care plans? This methodology often addresses particular structural questions rather than simply observing social interactions in the context of a general subject (Spradley 1980, p. 107). Focused ethnography is highly relevant as we move from the use of the more traditional ethnography to a contemporary application in current society with a highly differentiated division of labour and fragmented culture (Knoblauch 2005). When focused ethnography is used, topics of inquiry are pre-selected,

participant observation is within specific time frames and can be limited and interviews are at times highly structured around the issues (Morse 2007).

Another departure from traditional ethnography was the fact that, while early ethnographers were regarded as objective outsiders, my starting point and specific research questions were the result of having both insider and background knowledge of and previous experience within my field of study. I had knowledge of working in an inpatient unit and the challenges that mental health nurses face, as well as insider knowledge of the local health network with all its policies and procedures and potential issues. I also personally knew some of the nurses who worked in the unit through my involvement as a community mental health nurse in discharge processes and conversations with the inpatient unit. Ideally a strategy is found that allows the investigator to participate fully in activities as an insider while consciously and objectively describing and analysing the events as an outsider (Roper & Shapira 2000). To a certain extent distance must be maintained to undertake the analytic work (Roper & Shapira 2000).

On the other hand, I needed to carefully consider the degree of marginality as the perceptions of myself as the researcher by the mental health nurses were bound to affect what they shared about themselves and their culture (Roper & Shapira 2000). The quality of the information and the depth of analysis depended on my ability to establish rapport and trust which was facilitated by already existing working relationships. I needed to recognise, however, when participants considered me as a friend rather than researcher, which has methodological and ethical implications. I had an ethical responsibility to remind team members that they were participating in a research project and their consent was continually negotiated (Roper & Shapira 2000). Group members should have the right to decide when to share information (Roper & Shapira 2000).

Observation and participation are regarded as the characteristic features of the ethnographic approach (Atkinson & Hammersley 1998; Agar 2006). My focus was however very specifically on the twice-weekly multidisciplinary meetings and how the care was developed during these gatherings. I also gave attention to the clinical handovers during which care plans could potentially be developed as well. My role changed fluidly and continuously from participant-as-observer to observer-as-participant. During the team meetings, staff members were at times aware I was observing and taking notes, but then included me in the conversation of consumers with whom I was familiar. By doing this the staff indicated they viewed me as a participant rather than observer.

Participant-as-observer role increases the likelihood that the researcher will obtain key 'insider' information about what it is like to be a member of the cultural group. The advantage of my position and familiarity with the service was that it did not take long to become someone who was accepted by the team members. I moved between the mental health nurse role and the investigator role fluidly. Using the combination of participant-as-observer and observer-as-participant role, I had the best opportunity to perceive events and understand meanings (Roper & Shapira 2000).

3.3. INSIDER/OUTSIDER-EMIC AND ETHIC PERSPECTIVES

Through the process of participant observation, the ethnographer initially discovers the insider's view of the world, the emic perspective of the field of study: the reality seen, experienced, understood and expressed by the individual (Draper 2015). In addition, the investigator brings the outsider's framework, the etic perspective which relates to the larger collective or societal picture (Draper 2015). This is the view used as the ethnographer observes events and then tries to make sense of what is seen by identifying patterns and behaviours.

Ethnographers use both perspectives by participating in experiences and then stepping back and analysing the data collected (Roper & Shapira 2000).

As outlined above I undertook the Enactment of Accountability Study as both an insider and outsider to the cultural group under investigation. As the researcher, I needed to acknowledge my position as a clinical leader (in a different team), which influences my discourse and my analyses. As an insider I might identify myself as a mental health nurse who has knowledge of this particular inpatient setting. As such my ability to interpret and understand meanings and beliefs and experiences of participants may be enhanced. The leadership focus and nature of my current nursing career, however, challenges the position of the mental health nurse at times. On the other hand, I am also an outsider, as my permanent employment is not based in this inpatient unit and as such I do not have complete insider knowledge on the culture in this particular inpatient environment.

As an insider and outsider I found myself at different points of the continuum at different times. For instance, occasionally staff members asked for my opinion as consumers we knew in common were discussed during the various meetings I observed. This, once more, demonstrated that the research participants viewed me as another participant rather than an observer. As an employee of the same local health network I was recognised both as an observer and participant. Therefore my role changed fluidly between participant as observer and observer as participant placing me in the best position to perceive events.

Field relations are central to any ethnographic study and the quality of data depends crucially on the quality of relationships established in relation to the research objectives (Allen 2004). My aim was to explore if and how accountability impacted on the creation of the consumer care plan and the role of culture in this process. It was therefore necessary to have little social distance between the

mental health nurses and myself. Through my familiarity with nurses and the services I was able to establish good field relationships. Despite the fact that I was a first time researcher doing a PhD, which could easily have intimidated staff

members, this did not happen and very soon after commencement of data collection I was part of 'backstage' talk and participants spoke freely about issues 'as it is'. In addition, during interviews some nurses spoke about the existence of interpersonal tensions or tensions between different health professions and thus I became privy to an important unspoken undercurrent, which influenced much of the unit activity. I became someone who was entrusted with confidential information.

Ethnographers use both insider and outsider perspectives by participating in experiences and then stepping back and analysing the data collected. Cultural background of the researcher is however considered a powerful influence when interpreting the findings and the researcher must remain alert to the informants' organisation of cultural knowledge. According to Werner and Schoefle (1987) this combination of insider and outsider provides deeper insights than are possible by the people and culture that are studied or the ethnographer alone. The two views create a third dimension, which is the ethnographic picture. Specifically, with regard to focused ethnography it may be possible to work with common shared knowledge with participants and still be able to discover otherness, given a regard for reflexivity (Knoblach 2005; Wall 2015). This allows for a nuanced perspective on a researcher's insider and outsider status (Wall 2015).

3.4. SUMMARY

This chapter has outlined the methodology used in the study and provided arguments for the choice of focused ethnography over other methodological approaches. In doing so the chapter explored the concepts of culture and accountability. It has considered the literature related to various methodologies and presented a theoretical framework for the Enactment of Accountability Study.

It is the accountability enactment by nurses which impacts on consumer care planning and ultimately can influence recovery. Mental health nurses are the health professionals who have a 24 hour presence in the inpatient unit. As a result the care they provide and the decision making processes in their accountability enactment has a large effect on consumers.

The following chapter outlines the methods used in the Enactment of Accountability Study. It includes identification of how data were managed to arrive at an understanding of how accountability is enacted by mental health nurses. Methods are described in detail, considering the research setting, participant selection, ethical issues and research rigour within a qualitative paradigm using focused ethnography.

CHAPTER FOUR: METHODS

4.1. INTRODUCTION

The methodology chosen for any research influences the way in which data are collected. This chapter describes what was actually done during the study of the enactment of accountability including the methods and the relevant guiding principles for undertaking and assessing the research. It outlines ethical issues, the study setting, the selection and recruitment of participants, collection and analysis of data and research rigour or fittingness and audibility (Roberts and Taylor 1999)

4.2. THE SETTING

The study setting has been described earlier in the thesis. The choice of this particular Local Health Network and inpatient unit as the service to undertake the research was guided by the fact that this network had identified the care planning process as an issue and senior staff were committed to improving this aspect of care. In addition, the Clinical Director at the time was very supportive of the research and had a particular interest in this topic. As the research is on accountability enactment by mental health nurses, the choice of an inpatient unit was a practical one as many more mental health nurses are employed in an inpatient unit than in community teams where nurses are often in the minority and are outnumbered by allied health staff. This means that potentially more participants were available to take part in the study. More importantly, the consumer's journey often commences in the inpatient unit where frequently their first consumer care plan is created, which then constitutes the foundation for any future care.

Focused ethnographies require the researcher to be immersed in the field for intensive periods of observation and data collection which was easier to accomplish in a health network already familiar to me and nearby. This also provided the advantage that it was easier to take on the role of participant-as-observer as mental health nurses and other staff members accepted my presence in even challenging meetings where difficult decisions needed to be made.

4.3. PARTICIPANT SELECTION

The study involved interviewing of mental health nurses to discuss and explore their experiences and practices with regard to the enactment of accountability. Participants were mental health nurses as these professionals were viewed as being responsible for the development and facilitation of consumer care plans. Interviews with mental health nurses were used to explore nurses' views on accountability and how a culture of accountability affects the development and use of care plans. Participants had different levels of experience, but most nurses had worked as a mental health nurse for 20 years or longer which is consistent with the average age of mental health nurses (Australian Institute of Health and Welfare 2016). One enrolled nurse and eleven registered nurses were interviewed. Most nurses had worked mainly in the inpatient setting but some mental health nurses had also worked in a community mental health team. Agency nurses were excluded as they generally worked only one shift at a time and as a result may have been involved in the development but not in the follow up of care plans.

With regard to observations, I could have observed any activity in the inpatient unit but the focus was on gaining understanding of mental health nurse accountability enactment in relation to care plans. Therefore, a decision was

made to specifically focus on, and observe clinical handovers and multidisciplinary meetings where traditionally most of the care is discussed, planned and created in the presence of all health professionals. Participants in these meetings included nurses but also other health professionals as discussed below.

For focused ethnography, the most common sampling technique is purposive sampling with complementary strategies including opportunistic or nominated sampling (snowballing) and solicitation (Higginbottom, Pillay & Boadu 2013). Several presentations were conducted in the inpatient unit to explain the purpose of the research and the research process. Several nurses came forward to volunteer to participate in an interview. Some nurses then suggested other participants for the research project (snowballing). This strategy then evolved to a purposive sampling strategy as participants were selected purposely based on the information needs emerging from the early findings. As I was not employed in this inpatient unit there was no influence or coercion to participate. The main criteria for participation in interviews was that the participant was employed in this inpatient unit and working as a mental health nurse.

4.3.1. PARTICIPANT DETAILS

Through my work in the local health network I had an advantage of existing relationships with some staff members in this inpatient unit which probably facilitated the process of finding participants who were willing to talk to me in a semi-structured interview. There were 12 mental health nurses from the mental health unit who agreed to participate in an interview while they also attended the clinical handovers and multidisciplinary meetings (Table 4.1). In between interviews I discussed preliminary findings with my supervisors and critical colleagues. After the 12th interview I decided in consultation with my supervisors

that data saturation had been achieved and no new information had come to light in the last interviews. Data saturation often dictates the sample size such that participants are recruited until the topic has been fully investigated and no new interpretation are formed from additional participation (Guest, Bunce & Johnson 2006). An additional 25-30 different health professionals including psychiatrists, psychiatric registrars, medical officers, the team leaders, two psychologists, one occupational therapist, two social workers and one aboriginal mental health worker participated in the multidisciplinary team meetings and clinical handovers or walked in and out of the field of observation.

Data collection took place over a six month' period from the beginning of August 2015 until the end of January 2016. At the time there were two teams who met on Monday and Tuesday mornings, each with their own consumer load. To de-identify the participants, the names of the teams were changed to the Blue and the Red team. Meetings usually took two hours but sometimes longer. During the data collection period I alternated between teams and one week attended the Blue team meeting and the next week the Red team meeting. This was to ensure I captured all aspects of the culture in the data collection. The same day I attended the multi-disciplinary team meeting, I also observed the clinical handover meeting.

Although different nurses and medical staff attended the meetings based on the team they were assigned to, allied health professionals attended all team meetings. As a result of the roster system there was a high variability in mental health nurses attending the meetings. Some nurses who attended the multidisciplinary meetings did not participate in interviews but all nurses who participated in interviews were involved in the multidisciplinary review process on one occasion or more.

4.4. DATA COLLECTION

Different methods or data collection strategies were used to answer the research questions which were, to ascertain in what way or not a nurse's sense of accountability affects the development and use of care plans. The data collection methods employed in this study as they relate to the research question included:

1. Field observation and reflective field notes
2. In depth semi structured interviews with mental health nurses to help validate observation and provide directions for future observations, collect data on issues that cannot or have not been observed and collect data on non-observable phenomena including feelings (Roper and Shapira 2000)
3. Examination of the template of the NCare Plan (multidisciplinary care plan) various policies, procedures, standards and codes of practice.

4.4.1. FIELD OBSERVATION AND REFLECTIVE NOTES

Formal data collection using fieldwork and observation took place from August 2015 following ethics approval. There are many activities that take place in an inpatient unit but I decided to observe the moments of care development. There are various instances of care plan creation ranging from the moment of care plan development between the nurse and the consumer and a variety of bigger and smaller meetings that take place to discuss consumer care. I planned to observe multidisciplinary meetings, handover meetings and the actual development of the care plans between the consumer and the mental health nurse. It is in the multidisciplinary meetings where most important decisions about consumer care are made. All health professionals from different disciplines are present and it is in this meeting that the team decided how to move forward with care provision. Multidisciplinary meetings were an opportunity for the staff to review the progress the consumer was making and how much of the treatment plan and the

consumer care plan had been realised or not. This gathering gave an insight into the use of the plan and how the consumer care plan guides the treatment in the inpatient unit or not. Consumers were not present during these meetings and consequently the presence of the mental health nurse as consumer advocate increases in importance. As a result of their role in the inpatient unit mental health nurses spend the most time with consumers and have knowledge of consumers' wishes. The handover meeting is another gathering of health professionals from different disciplines where there is an exchange of ideas on the care that needs to be implemented. Handover meetings were another occasion where the consumer care plan can be used as a guide to discuss the progress of the consumer. It was important to observe if and how nurses use the care plan in discussions on the consumer's progress during the previous shift. I focused specifically on the role of the nurse during these meetings and how they included the consumer views or the content of the consumer care plan in their contributions. I had intended to observe consumers and nurses in care plan development but the ethics committee expressed concerns regarding the involvement of involuntary (and therefore unwell) consumers in the research process. Ethics approval was granted when a voluntary consumer would provide informed consent to look at their care plan and observe care plan development. Another prerequisite was that on the day mental health nurses needed to give permission for me to ask a consumer for informed consent. Involuntary consumers were excluded from the research process. As a result of the pressures to discharge most consumers present in the inpatient unit were involuntary and therefore not considered as research participants. In addition, mental health nurses deemed most voluntary consumers as unsuitable and too unwell to provide informed consent. My working relationship with the staff in the inpatient unit was extremely important to be able to complete the data collection

and therefore I needed to respect the staff's opinion and discuss with the nurses consumer suitability for participation.

In all, field work therefore included attending weekly multidisciplinary meetings and clinical handover meetings on the same day. Field notes during these meetings collated over the research period provided extensive data for triangulation with the semi structured interviews. For example, the following extract from field notes describes and reflects on the handover style used by the mental health nurses:

FN: *17/08/2015 Clinical handover meeting*

..... Nursing giving handover - nurses using terms;; 'pleasant', 'settled', 'flat', 'up and down'

No handover according to ISBAR template....no care plan.....limited input nurses. Is this related?

Quote from interview describing handover.

'and you've sat in our unit rounds and you've heard the nurses give their handover of how the patient has slept and behaviours and that is all that is required really from nurses'....(Interview 1, line 104-105).

Field notes or reflective journals, provide contextual observations including those related to non- verbal communications. They are used to offer a heightened perspective of the data. Roper and Shapira (2000) suggest to write down events as they occur and to keep separate notes for analytic ideas and perceptions of patterns or concepts. I kept another personal diary to focus on my reactions to the people around me, the setting and my emotions and feelings. These personal notes I used to evaluate my response to observations and interviews.

4.4.2. IN DEPTH INTERVIEWS WITH MENTAL HEALTH NURSES

Half the data were obtained through qualitative interviews with mental health nurses. During semi structured interviews I sought to get an understanding of the creation and use of care plans by mental health nurses. The focus was on the enactment of accountability and if and how accountability impacted on the use of consumer care plans. After I commenced each interview with a general question about the background of the nurse I used opening questions about the purpose of the care plan and how the mental health nurse developed and used the plan. This was to put the participant and myself at ease and establish their trust (Higginbottom, Pillay & Boadu 2013). I then aimed to gather a better understanding of who the nurses thought were accountable for the care plan and what accountability meant to the nurse. How accountability impacted on care planning and if the nurses thought that the unit culture impacted on care planning was the content of the last question. Despite the interview guide each interview was different and followed the path the mental health nurse wished to follow.

I trialled the interview structure with a colleague to check the interview process and my interviewing skills and how to use prompts. Prompts can be used to illicit more detailed information. The difference between a prompt and a question is that prompts are not scripted as are the initial questions (Leech 2002). The reason is that every interview is different and there are many possible prompt situations (Leech 2002). It is important to not lead respondents by putting words in their mouth. The goal is to listen for key terms and to prompt the respondent to say more about them. Informal prompts (reassuring noises and interjections) were utilised to demonstrate that I was listening (Roper and Shapira 2000). Other prompts were used for clarification and to ensure optimal answers to questions.

Example 1

'I've got to type it up. Sometimes you've got about 16 pages and then after that you give them a copy, like when they go home (Interview 6, line 115-116)

Is that done for all clients or for some of them? (Interviewer)

Example 2

'The system is accountable' (Interview 3, line 73).

The system is accountable. Can you explain that? (Interviewer)

In addition to asking directed questions I noted the effect of the questions on the participant. I attended to nonverbal cues, such as the speed of speaking or the presence or absence of eye contact or emotional reactions such as a smile.

As a mental health nurse, undertaking interviews is my 'bread and butter' which certainly helped during the interview process. On the other hand, the formality of the interview setting and the use of audio equipment changed the dynamic between the participants and me which I tried to bridge with an invitation to talk about their background first. I found this was a helpful strategy to relax the participant and myself. It enabled us to engage in conversation and get the interview going. I did notice that over time my interview skills improved and I felt more comfortable using prompts to guide the interviews.

4.4.3. DOCUMENTS AND ARTEFACTS ANALYSED

As outlined earlier, it was not possible to view care plans as most mental health consumers were admitted on an involuntary basis which made it unethical to ask for permission to do so. The template of the NCare Plan and policies and procedures pertaining to mental health nursing were however analysed to further

understand the research question. Knowledge about policies and guidelines assisted in situating and understanding the present situation in the inpatient unit :

1. The NCare Plan (template of the multidisciplinary care plan for mental health services in the state)
2. Mental Health Clinical Redesign, KPMG Review-Response Plan (2015)
3. South Australia's Mental Health and Wellbeing Policy 2010-2015 (Government of South Australia, 2010)
4. South Australian Mental Health Strategic Plan 2017-2022 (Government of South Australia, 2017)

4.5. ETHICAL CONSIDERATION

An ethics application was prepared for the Department for Health and Ageing Human Research Ethics Committee in the state where I undertook the research. The request included permission to interview mental health nurses and to observe how they develop a care plan with consumers. The application also included observation of mental health professionals in clinical handovers and multidisciplinary meetings with a specific focus on mental health nurses and inclusion of the consumer care plan in these meetings. In addition, I requested to view consumer care plans in this inpatient unit and suggested to ask voluntary consumers for permission to view their plan (consumer care plan) and to observe how they developed the plan with the mental health nurse. Following the initial application the Ethics Committee sought more information such as the number of individual interviews and how privacy would be maintained whilst the participants were on duty as well as the management for their time away from work. Clarification was also asked for the total number of participants in interviews and observations. A number of changes were recommended regarding the

'participant information sheet and consent form' for staff and the 'participant information sheet and consent form' for consumers.

Once these issues were addressed the Department for Health and Ageing Human Research Ethics Committee in the state where the research was undertaken approved the project number HREC/15/SAH/42/AR02 specifically for the site where the research was undertaken (Appendix 9.4 and 9.5).

4.5.1. ENSURING ANONYMITY AND CONFIDENTIALITY

In the small research setting of one psychiatric inpatient unit it was always going to be challenging to ensure complete anonymity of participants. The issues of confidentiality and anonymity are closely connected with the rights of beneficence and respect for dignity and need to be carefully considered (Clarke 1991; Kaiser 2009). The inpatient unit where the research was undertaken is socially and professionally small and the LHN where this inpatient unit is part of is a relatively small community. Employees at the inpatient unit had knowledge of my research and could have assumed that colleagues I was seen with at different locations might have participated in the research which potentially could have impacted on anonymity. On the other hand, there is a high turnover of staff in mental health services (Coates and Howe 2015) and it is likely that staff members I interviewed at the time do not work for this service anymore and have moved on to another location or team.

The analysis and interpretation of interview and observation data does not identify the individuals, and their identities will remain anonymous throughout the thesis. The original plan was to interview participants away from the inpatient unit, to ensure that other staff did not know who participated in the research. In the reality of the unit environment however with 12 hour shifts, most of the nurses suggested we undertook the interview inside the campus in a room away from

the inpatient unit. According to the nurses this saved time and ensured that they were not too far away from the work place after I had explained the possible risks associated with undertaking interviews on the hospital campus. Three nurses were interviewed at a different venue during their days off. Signed consent forms were stored in a secure filing cabinet at my home office. It was not recorded on the signed forms which transcribed data belonged to which participant. Voice recordings were saved on a password protected computer.

4.5.2. VULNERABILITY, POWER AND CONTROL

In relation to the ethical conduct of this study vulnerability, power and control have an added significance because the research was undertaken in a mental health inpatient unit with vulnerable consumers. I would only discuss the possibility of viewing a consumer care plan with voluntary consumers after consultation with the mental health nurses who would have the final decision whether a consumer was well enough to provide informed consent. I would also need to ask the consumer and the nurse for permission to observe care plan creation. The intention was to ask a significant number of voluntary consumers for permission to analyse their care plans, which would then be handed to me in de-identified form. This was outlined in the ethics approval documentation. Involuntary consumers were deemed as too unwell to give informed consent. The reality of the research environment, however, turned out to be different as a result of the high acuity in the inpatient unit and a restructure in health services at the time. There were few voluntary consumers at any given time in the inpatient unit who would have been able to give informed consent for me to view their care plan or to give consent to observe how the nurse developed a care plan with them. In addition, most voluntary consumers were not regarded as well enough by the nursing staff to ask for informed consent. I needed to collaborate with the nursing staff in the inpatient and it would have been unwise to involve voluntary

consumers after clear instructions from the nursing staff not to do so. As the focus of the study was on accountability enactment of mental health nurses rather than on the care plan itself, I did not pursue this any further.

With regard to health professionals participating in this study I did not exert a particular power over them from an employment or personal perspective. I was employed in a different team as such did not hold a hierarchical authority over the nurses in this inpatient unit. However, as a researcher I acknowledge that I have power in relation to how I handle the data. Health professionals sharing information with me and articulating their frank views that may reflect poorly on their practice can be made vulnerable from an employment perspective. This required a trusting relationship between myself and the participants. All specific identifiers were removed and assurances of this were given to participants.

In relation to the values of respect, quality and responsibility it was important to ensure the consent obtained from participants was informed. There is a need to ensure that all participants understand the nature of the study and freely consent and are aware of being able to refuse or withdraw at any point (Fouka & Matzorou 2011; Nusbaum et al. 2017). Written information on the study and the implementation was distributed and verbal consent was sought from all of the staff at the outset of the study. Approval from the ethics committee was granted to undertake observations of meetings without needing to ask for permission from each individual health professional present during every meeting. It was agreed that observing these meetings carried low risk as the focus was not on the individuals present during the meetings but on observing the process of care planning. In addition, it would have been a challenging task to ask for consent from each health professional walking in and out of the field of observation. Approval was obtained after support was expressed by the leadership group and two support letters were written by the Clinical Director and the Acting Chief

Executive Officer of the health network. Two separate participant information forms were initially developed. One form for mental health nurses to participate in an interview and/or to be observed during care plan creation, and one for consumers in the inpatient unit for me to have a look at their care plan and/or to be observed during care plan discussions.

4.5.3. DATA STORAGE

According to the Flinders University requirements for data storage and protection, all related materials obtained throughout this research are required to be stored on university grounds under secure storage. I argued however that it would not be practicable and less secure to store the data at an Adelaide based facility while I live elsewhere. Information on the participants were kept in de-identified form on a computer file on the secure Flinders server. Identifiers were removed at the commencement of data collection. USB sticks, audiotapes or transcripts were kept safely locked in a cabinet at the home office until completion of the research. After the research, all hardcopies, USB sticks, audiotapes and transcripts will be kept in a secure location at the College of Nursing and Health Sciences at Flinders University in South Australia.

4.5.4. NON-MALEFICENCE AND BENEFICENCE

The study sought to ensure that no physical, emotional or other harm would result from participation and that some benefit would be gained by participants and the professional community of mental health services. Non-maleficence requires a high level of sensitivity from the researcher about what constitutes harm (Fouka & Matzorou 2011). Discomfort and harm can be physiological, emotional, social and economic in nature (Burns & Grove 2005). I needed to consider all possible consequences of the research and balance risk with proportional benefits and if the risks outweighed the benefits, the study should be

revised (Burns & Grove 2005). The risks of the study were mainly related to the possibility that in trying to learn details of the nurses' practice old wounds might open in discussing past events or incidents. Therefore the phone number and contact details of the Employee Assistance Scheme and other counselling services were provided to the staff.

It is anticipated that the benefits of an increased understanding of how accountability works, particularly in relation to care plan development and use, will impact positively on the daily practice of mental health nurses and consequently improve consumer care and benefit their psychological and functional wellbeing. Any improvement in health service delivery for consumers in this particular inpatient unit and the wider local health network may benefit other mental health services in the state or other states and territories. This may include an improvement in the development of consumer care plans and an impetus to include mental health consumers in the development of their own care which might lead to better health outcomes. In addition, an increased understanding and knowledge of accountability in action on a day to day basis and how it affects certain areas of care in mental health services might provide opportunities to improve other areas of care.

4.5.5. BENEFITS VERSUS RISKS

In ethical research it is necessary for benefits to outweigh the risks to participants. Individuals can make informed decisions to participate voluntarily only if they have information on the possible risks and benefits of the research. Free and informed consent needs to incorporate an introduction to the study and its purpose as well as an explanation about the selection of participants and the procedures followed (Fouka & Mantzorou 2011;; Nusbaum et al. 2017). To this end I held two information sessions for the staff in the inpatient unit where the

research was conducted. The sessions included information on the topic of research and the substance of my research interest. This was an opportunity for mental health nurses to ask questions and seek further clarification. The topic appeared of interest to the mental health nurses present during the presentation as throughout both information sessions discussions and conversations on the topic of care plan creation commenced. I informed the nursing staff about the methods to be used to protect anonymity and the freedom to withdraw was explained (Fouka & Mantzorou 2011). The staff in the inpatient unit were involved in this topic from the commencement of the project and appeared to enjoy the interactions. There were a few staff members who offered to participate in the research as they had an interest in this topic and were eager to share their opinions.

The risk to mental health nurse participants was relatively low as their anonymity provided protection from critique of their practice on how accountability guides their practices. However, it is acknowledged that discussing how accountability affects the development and use of care plans might evoke unresolved issues for nurse participants. Mental health nurses mostly welcomed the opportunity to reflect on accountability and were of the opinion that anything that could improve their practice would be a good thing. Participants were advised they could contact the researcher if they wished to discuss any further issues and that the professional employee assistance services were freely available to them.

As outlined before, I conducted most interviews on the campus where the inpatient unit is located. To maintain confidentiality, we met in a room away from the inpatient unit as suggested by most of the participants. Most staff preferred this and requested to not meet after hours or during their days off. The rooms we conducted the interviews in are often used for meetings or informal conversations. I used the interview guide during each interview to ensure I asked

each participant the same questions but allowed the participants to direct the course of the interview by sharing what they felt was important, using a few prompts.

No consumers were directly involved in the research. At the time of data collection the inpatient unit had admitted many consumers on an involuntary basis and therefore permission was not sought to view care plans or to formally observe care plan creation between the nurse and the consumer. Consumers who are involuntary and therefore unwell are not able to give informed consent and it would be unethical to pursue this as outlined in the ethics application.

4.6. THEMATIC ANALYSIS APPLIED TO THE DATA

I considered the research questions on accountability enactment with regard to care plans could be answered best through thematic analysis which is appropriate in an ethnographic study. In much qualitative research the process of analysis begins during data collection as the data already gathered are analysed and shape the ongoing collection (Roper and Shapira 2000).

4.6.1. WHY THEMATIC ANALYSIS?

The Enactment of Accountability Study tried to do more than just describe what was seen and heard during handovers and multidisciplinary meetings. Analysing data in a focused ethnographic study demands that the researcher engages in an iterative and self-reflective process as preliminary interpretations are challenged and data are continually revisited. This is to plan for further data collection to generate new insights into the data (Pope, Ziebland & Mays 2000; Higginbottom 2004). By drawing out the themes in observation and interview data a richer and more meaningful picture of accountability enactment could emerge. Thematic analysis can be used to make sense of seemingly unrelated material. It was

helpful to analyse qualitative information and to systematically gain knowledge about the participants and their interactions, thoughts and feelings. The systematic approach for analysing ethnographic data, as outlined by Roper & Shapira (2000) was followed and amended with elements from Dey's (1993) and Saldana's (2009) systematic analyses.

4.6.2. A PROCESS OF THEMATIC ANALYSIS

Thematic analysis can be undertaken by using a computer software program or equally appropriate a manual process. I commenced using the QSR International NVivo 10 software to organise, store, retrieve and manage data but the electronic coding program limited my perspective on the data, a perspective which is necessary and that can contribute to a more conceptual and theoretical view of accountability enactment. Through a step by step process and manual coding I got an increased understanding and more of a 'feel' for the connections between the various codes and sub codes. It proved to me that no computer software package is capable of providing a link between theory and data or defining an appropriate structure for the analysis of such qualitative data (Pope, Ziebland & Mays 2000).

Thematic analysis has been extensively discussed in the literature but I decided to use Roper and Shapira's (2000) systematic and practical approach as they clearly outline the steps. I have also used suggestions and ideas from other authors such as Saldana (2009) and Dey (1993) and I integrated them to suit the analysis of the data. Figure 4.1. outlines in detail what was involved in each phase of analysis. The initial coding was a line-by-line process, at times a word by word process. This first level of coding helped to reduce the data to a more manageable size. I commenced by coding for descriptive labels and grouped

words into categories of descriptive labels, then organised them to compare, contrast and identify patterns. This resulted in 12 very broad categories.

In subsequent levels of analysis, I split and spliced the descriptive labels under axial codes. For instance, the label of '*the holisticness gets lost in the routine'* which in First Level Analysis was part of a broad category of '*staff and culture'* was split further into a Second Level Analysis category '*work practices'* which in Third Level Analysis was split into '*viewing nursing as task oriented'.* In Fourth Level Analysis this was spliced with other labels and eventually formed part of the theme *'Dissatisfaction'.* The same process of splitting and splicing categories continued to Third and Fourth Level Analysis until I commenced to formulate themes that describe the enactment of accountability by mental health nurses regarding the care plan.

This process did not however initially provide a sense of possible connections between the information. (Roper & Shapira 2000). To overcome this impasse, my supervisors suggested I commence writing reflective assignments using the literature related to theory and the theoretical framework. This assisted me in starting to make sense of the data. The combination of categories and subcategories, possible themes and subthemes with the available literature and the process of writing facilitated my reflection. This process helped me to make sense of all the complex data and more deeply understand their relationships (Roper & Shapira 2000). The last step was about connecting the findings to theories that make sense of the rich and complex data. This step was concerned with generalising findings about the cultural world of study, finding linkages between the emic meaning and worldview of study participants and my etic interpretation of these meanings and then constructing theoretical understandings that take both of these perspectives into account (Roper & Shapira 2000).

Figure 4.1: Phases of thematic analysis used in this study and adapted from Dey 1993; Roper and Shapira 2000; Saldana 2009).

Phase	Description of the process
1. Becoming familiar with the data	Data are transcribed. This includes interview data, notes to self, observations and initial ideas. Collect quotes that could be significant. Read and re-read the data.
2. Formulation of basic domains	Basic domains can categorise a broad range of phenomena for example setting, types of activities, events, relationships, social structure, strategies, process, meanings and repeated phrases.
3. First level coding and axial coding	Coding of the data in a systematic fashion across the entire data set. Reviewing aims and objectives of the research. Axial coding through identifying relationships between original codes.
4. Sorting for patterns	Written words must be grouped into meaningful categories or descriptive labels, then organized to compare, contrast and identify patterns. Sorting or grouping the descriptive labels into smaller sets: the subcategories. Splicing of subcategories into overarching categories. To commence developing themes from those groupings and a sense of possible connections between the information in the categories and subcategories.
5. Identify outliers	To identify cases, situations, events or settings that do not 'fit' with the rest of the findings.
6. Making con-nections: generalising of constructs and themes	Patterns or connected findings are related to theories in order to make sense of the complex data collected.

7. Defining and naming themes	Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells. Naming the themes.
8. Writing the findings chapters	The final stage of analysis. Selection of extract examples, final analysis of selected extracts. Linking the analysis of the research questions and literature. Scholarly report of the analysis

Themes were developed as part of the process of data analysis. I analysed the data from the interviews separate from the data obtained through observation and field notes. I then synthesised and identified similarities and differences between different data sets. An initial read and re-read of the interview transcripts identified common experiences and thoughts and a variety of expressions used to describe these experiences. The initial coding and re-coding and subsequent axial coding resulted in the formation of categories and sub-categories. Second Level codes could be grouped under broad categories such as **nurse practices, leadership, nurses' professional identity, relationships, risk and safety, work pressure, discontent.** In Second Level Analysis the initial First Level Analysis was further refined and collated into potential themes until major themes became explicit in the third or fourth level analysis. For instance, in Second Level Analysis a subtheme within the **nurses' professional identity** category was '*self-esteem and confidence'*. In subsequent analysis the theme of **expectation of reactive care** eventually formed part of the final theme **role and identity** (Appendix 9.3). Likewise, in Second Level Analysis a subtheme within the **risk and safety category** was *'managing risks in the unit'*. In subsequent analysis the theme of **risk management and recovery** eventually formed part of the final theme **finding a balance: therapy and control** (Appendix 9.3)**.**

4.6.3. RIGOUR OF THE RESEARCH PROCESS

Rigour is defined *as 'the strictness in judgment and conduct which must be used to ensure that the successive steps in a project have been set out clearly and undertaken with scrupulous attention and detail'* (Roberts & Taylor 1999). Credibility, transferability and confirmability are the elements of qualitative research rigour. Credibility is a criterion for evaluating data quality in qualitative studies and refers to the confidence in the truth of the data (Moon et al. 2016; Korstjens & Moser 2018). In other words the researcher needs to link the study findings with reality to demonstrate the truth of the research findings. Strategies to ensure credibility are prolonged engagement, persistent observation, triangulation of data sources and member checks (Korstjens & Moser 2018). Fittingness implies the degree of transferability of findings, the degree of congruence between the research sample and another group or setting (Korstjens & Moser 2018). To ensure transferability thick description is required to describe not just the behaviour and experience but the context as well so that the behaviour becomes meaningful to an outsider (Moon et al. 2016). Thick description was utilised in the analysis of the data in the findings Chapter 5 and 6. Auditability is important as it allows other researchers to follow a qualitative researcher's steps and decisions and arrive at similar conclusions. To this end a clearly articulated decision making trail with rationales for decisions and responses is outlined.

In chapter three it was identified that reflection and reflexivity is a key component of ethnographic research. Data collection processes were continually critiqued through a process of reflection and consultation with supervisors, other doctoral students and colleagues with expertise in the area of mental health nursing and quality of care. I examined my own conceptual lens and my explicit and implicit assumptions, preconceptions and values and how these impact on the research

decisions in all the stages of the research process. Member checks were undertaken to ensure credibility of the study. I solicited study participants' reactions to preliminary findings and interpretations. Member checking was carried out both informally as data were being collected and more formally after the data had been collected and analysed. In addition, two participants returned to me shortly after the interview and wished to explore the topic under investigation some more to clarify their contribution which added to the credibility of the study.

Confirmability was established through strategies such as cross checking data sets (observations, interviews, journal entries and field notes) and a step-by-step description of methods employed to conduct the research. As outlined before, member checking by a number of the interview participants was also completed to confirm the accuracy of the transcripts. When appropriate, the use of direct quotes to represent the participants' voices as also used to promote confirmability of these data. In addition I kept a reflective journal throughout the research process.

In seeking to ensure rigour it was decided that in addition to obtaining experiences of participants via interviews, data from field observation were also obtained. In addition, analysis of the template of the NCare Plan, reports and policies in South Australia would add to the overall understanding of the phenomena.

Triangulation is the use of multiple methods, investigators, theories or data sources to collect and interpret data about a phenomenon (Polit & Beck 2012; Carter et al. 2014). Triangulation has been found to be beneficial in providing confirmation of findings, more comprehensive data and enhanced understanding of the study phenomenon (Casey & Murphy 2009). Data source triangulation,

which was utilised in the present study, provides a more complete picture of study variables, thus helping researchers better understand the truths about particular phenomena. The comparing of data can lead to an iterative process whereby phenomena are explored more deeply, it can result in enhanced understanding of the context of the phenomena and can enhance trustworthiness of findings (Carter et al. 2014). Triangulation benefits research because it enhances a study's rigour through the collection of data from multiple sources (Moon & Wolf 2019). There are however some concerns as well. Walsh (2013) cautions researchers assuming that utilising triangulation prevents errors in data collection and/or analysis. If all the collected data are incorrect, no amount of triangulation will correct the problem. Furthermore, researchers need to be aware that data and triangulation findings can both be wrong for different reasons. For instance incorrectly collected data that appear to triangulate with an inappropriate methodology are still not accurate data (Walsh 2013). Despite these concerns, I decided to utilise triangulation of data sources as it can check the consistency of findings while it can also can play an important role in helping to alleviate the concern of identifying data that do not fit the expected outcomes. These unexpected findings frequently help identify other aspects that were not previously considered regarding a clinical question (Moon & Wolf 2019).

4.7. SUMMARY

This chapter has outlined the methods used to conduct the study on accountability and care planning in a mental health unit. It describes ethical issues, the study setting, the selection of participants, data collection as well as data analysis and research rigour within a qualitative methodology. The chapter showed that the links between paradigm, methodology and methods are interdependent.

The qualitative paradigm was most suitable to investigate a concept which is complex and multifactorial. The enactment of accountability was explored through observing practice by mental health nurses and other health professionals in real time and gathering nurses' opinions, experiences and feelings in regards to their practice of accountability with relation to the care plan. The use of triangulation and the observation data to check the consistency of interview data as well as the analysis of policy documents assisted in gaining an in-depth understanding of the workings of accountability in this inpatient unit.

Chapter five describes the increased acuity and unpredictability of the inpatient unit and the resulting discontent amongst nurses and the potential impact of these two factors on accountability enactment.

CHAPTER FIVE FINDINGS: PLANNING OF CARE IN A MULTIDISCIPLINARY TEAM

> *'The problem is that those multidisciplinary team meetings are actually not team meetings at all because each faculty of the team works very exclusively'* (Denise)

5.1. INTRODUCTION

This chapter and the following chapter report the results of thematic analysis of the data. It considers data collected from semi-structured interviews with mental health nurses in one inpatient unit and observations of multidisciplinary team meetings and clinical handovers. Within this chapter and the next chapter the data are grouped in broad categories resulting from data analysis (Figure 5.1.). Chapter five focuses on the activity of planning of care in the context of the multidisciplinary team and how the work environment influenced the development of care plans by mental health nurses. The inpatient unit and the entire multidisciplinary team as well as developments in the wider context of the Local Health Network (LHN) impacted on nurses' practice and how they enacted their accountability in decision making on are planning activities. Chapter six discusses more specifically findings related to the role and identity of the mental health nurse and the accompanying complexities of accountability enactment.

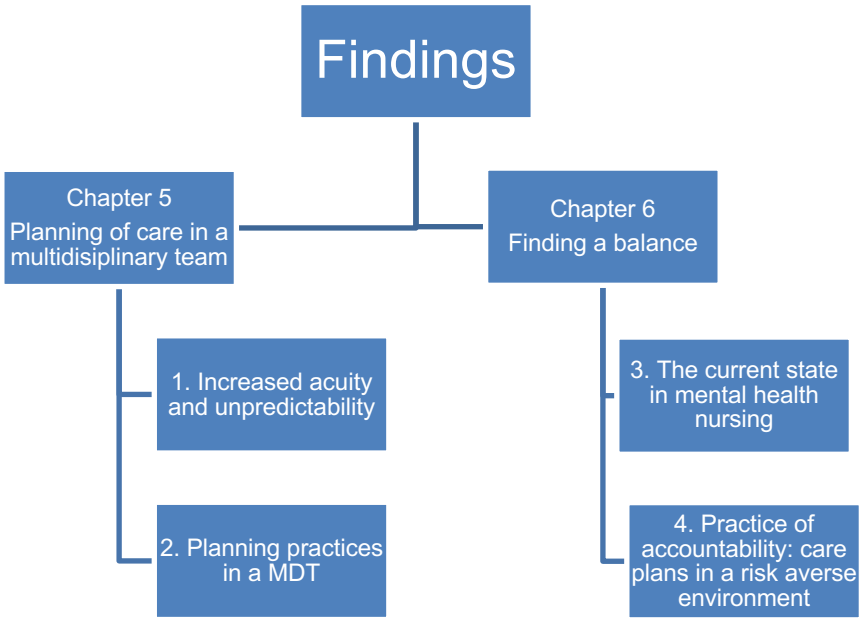


Figure 5.1: Findings of the study

5.2. PARTICIPANTS

As outlined in Chapter four, 12 nurses participated in semi structured interviews and multidisciplinary team meetings and another 23 health professionals from other disciplines participated in multidisciplinary team meetings and clinical handovers (Figure 5.2. and Figure 5.3.).

Figure 5.2: Participants in-depth interviews and observation in MDT meetings

Name	Details Employment	Gender	Years of experience
RN1: Denise	RN mental health	F	➢ 30
RN2: Marion	RN mental health	F	➢ 30
RN3: John	RN mental health	M	20-25
RN4: Suzanne	RN mental health	F	➢ 30
RN5: Karen	RN mental health	F	25-30
RN6: Andrew	RN mental health	M	➢ 30
RN7: Wendy	RN mental health	F	➢ 30
RN8: Sam	EN mental health	F	20-25
RN9: Mark	RN mental health	M	20-25
RN10: Gloria	EN mental health	F	10-15

RN11: Simon	RN mental health	M	➢ 30
RN12: Joseph	RN mental health	M	20-25

Some nurses who attended the multidisciplinary meetings did not participate in interviews but all nurses who participated in interviews were involved in the multidisciplinary review process on one occasion of more.

Figure 5.3: Participant details of health professionals in MDT meetings

Health professionals	**Gender**
Psychiatrist 1 blue team	F
Psychiatrist 2 blue team	F
Psychiatrist 3 red team	F
Psychiatrist 4 red team	M
Psychiatric registrar 1 blue team	M
Psychiatric registrar 2 blue team	M
Psychiatric registrar 3 red team	F
Psychiatric registrar 4 red team	M
Medical officer 1 blue team	F
Medical officer 2 red team	M
Occupational therapist	M
Psychologist	F
Senior psychologist	M
Social worker	F
Senior social worker	M
Aboriginal Mental Health Worker	F
Pharmacist	F
Clinical Practice Consultant (2 acting CPC's over that period of time)	F and M
Team leader 1 Red team (2 different team leaders)	F and F
Team leader 2 Blue Team (2 different team leaders)	F and M

5.3. OVERVIEW OF MAIN RESULTS

Chapter five describes the findings in the context of the planning of care in a multidisciplinary team and how practices in the unit were impacted upon by circumstances in the state and the relationships between health professionals. Themes are outlined that provide a rich and detailed picture of the previously unexamined aspect of accountability and the creation of a care plan. The major themes identified include:

1. Increased acuity and unpredictability

- Altered focus of care

- Dissatisfaction and projection

2. Planning practices in a multidisciplinary team

- Perceived power differentials

- Clinical leadership

5.4. THEME 1: INCREASED ACUITY AND UNPREDICTABILITY

This study aimed to explore ward practices and how the environment impacts (or not) on nurses' practice and care plan development with consumer involvement. Under this theme, a changed policy direction in the state and the Local Health Network (LHN) will be discussed in the context of the inpatient unit after which the changed focus of care and the resulting discontent amongst participants will be explored (Figure 5.4.). I will show that the existing culture in the inpatient unit was embedded in the broader LHN and the health organisation and was impacted upon by a policy direction which was characterised by a top down approach. Senior management initiated and championed changes influenced by budgetary constraints. The acute inpatient unit showed evidence of increased unpredictability and acuity which impacted on work routines and nurses' practice.

Observation and interview data revealed feelings of discontent amongst mental health nurses who attempted to provide quality care. This influenced how nurses saw themselves, their practice and their role in the inpatient unit. Consequently this impacted on nurses' accountability enactment which included care plan development and how this was undertaken.

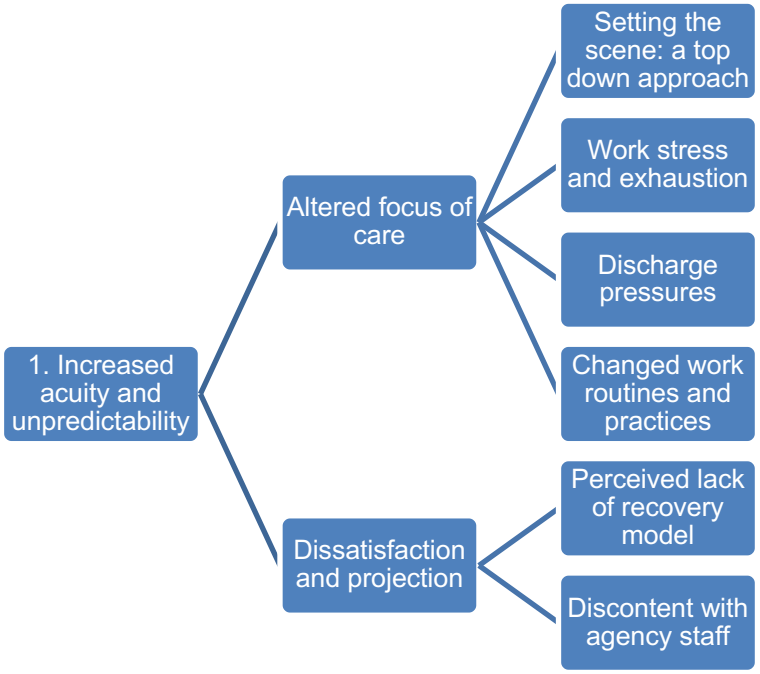


Figure 5.4 Summary of subthemes under Theme 1: Increased acuity and unpredictability

5.4.1. Subtheme: Altered focus of care: 'flow is the big word at the moment'

5.4.1.1. Setting the scene: a top down approach.

The research and data collection took place from August 2015 to the end of January 2016, a time of transition in health services in the state where the research was undertaken. The background to this transition was the National Health Reform Agreement (NHRA) which the Australian Government initiated to

restructure the health system (Council of Australian Governments 2011). The aim of this restructure was to increase local ownership of health services and to promote access, efficiency, accountability and funding transparency (Commonwealth of Australia 2011). The NHRA committed the Commonwealth state and territory governments to implement new health system funding arrangements, including the establishment of Local Health Networks. In the state where the Enactment of Accountability Study was undertaken 5 LHNs had been established under the Health Care Act of 2008. These LHN's were accountable to the state government for performance management and planning.

In the context of the restructure of health services, the state department of health engaged KPMG in 2015 to review the metropolitan adult mental health service. KPMG reported that there were blockages to consumer flow processes that needed to be identified. The report indicated that mental health consumers stayed too long in the Emergency Departments (ED) waiting for an acute care bed. The issue had progressively worsened since 2011 with an average length of stay in ED for mental health consumers in 2013-2014 of just over 13 hours and an average of 36 consumers staying longer than 24 hours in ED every week. The acute inpatient unit length had increased slightly as well to over 14 days (KPMG, 2015).

The KPMG (2015) report identified that the centralised Bed Allocation System that was used in the state had become a largely administrative system which reduced the level of ownership, accountability and responsibility of consumer flow at local levels. There seemed to be a lack of recognition of the clinical urgency to address the problem of prolonged ED stays for very disturbed consumers identified as needing a Psychiatric Intensive Care Unit bed or other high support bed (KPMG, South Australia Health 2015). The report concluded that a system whereby the next consumer admitted was generally the person who had been

waiting the longest in ED, acted as an incentive for mental health consumers to present to the ED even though they did not clinically require ED care (KPMG, South Australia Health 2015). Mental health consumers were motivated to present to the ED as they knew they were going to be assessed which often resulted in an admission if they waited long enough, something that was not guaranteed if they presented to the community mental health team or a GP.

Recommendations of the report included that accountability for outcomes should be placed at each of the LHN's. Other recommendations were an increase in consumer flow through re-invigorating clear escalation plans to avoid consumers staying in the ED longer than clinically required. It was acknowledged there was a need for a so called 'whole of service approach' to improve consumer flow matching capacity via improved discharge planning and follow up. Another recommendation was to increase the linkages between the inpatient unit and community mental health and to build staff competency in crisis and acute community management (KPMG, 2015). My PhD was undertaken against the backdrop of these developments and recommendations. A changed focus of care with an emphasis on discharges impacted on nurses' decision making and how they enacted accountability with regard to consumer involvement in care planning.

5.4.1.2. WORK STRESS AND EXHAUSTION

> *'The staff are burnt out, exhausted and completely traumatised'* (Wendy)

The impact of the KPMG (2015) report, which recommended an increase in consumer flow, could be observed as I visited the inpatient unit to introduce the Enactment of Accountability Study. During the first visit to the unit, the unit Nurse Manager complimented and thanked nurses in the staff meeting for their hard

work as the number of discharges had increased and length of stay had decreased (Field notes, 29/07/2015). The increased focus on flow and discharges was also confirmed by observations in one of the multidisciplinary team meetings two months later when the Clinical Director walked in and explained to all the staff present that from that week onwards there would be daily 'huddles' at 14.00 for the senior nurses and medical staff (Field notes, 29/09/2015). The Clinical Director explained it was anticipated that the sharing of information in the middle of the day would facilitate discharges. He did not present any evidence for this but argued that this was the only practice not performed that set this particular unit apart from all the other metropolitan inpatient units and that therefore it was thought this played a role in the slightly shorter length of stay in the other mental health units (Field notes, 29/09/2015).

During my observations in that same meeting I noticed written information on the white board in the handover room on the average length of stay in the inpatient unit which was now updated on a daily basis. A scheduler with planned discharges for the next two weeks was also visible on the white board. The aim was to pencil in at least two discharges a day and during the meetings a mental health nurse usually filled in the schedule (Field notes, 29/09/2015). These developments can be viewed as a reflection of the developments within the LHN and at a larger scale in the health service in the state.

Mark, a nurse who at times took on an acting position as the Clinical Practice Consultant (CPC), mentioned the extreme attention that was paid to flow and the impact this had on care plan development.

> *I think a lot of that [care plan] is affected by the pressures on the unit at the present. With the element of, 'flow'. Flow is the big word at the moment. The flow is not going. We need to improve the flow. And that certainly has an impact on the level and the quality of care*

> *and the risk assessment. It has a big influence. I would like to see 'this is the care plan, that is where we go'. But I think it is more like 'I have got 4 more clients to look after, we'll take it as we go'. Certainly that is something that can be improved upon significantly* (Mark, Interview 9, line 105-111).

Mark referred here to increased acuity resulting in ad hoc care planning and care provision rather than a well thought out care plan driving the care.

As a result of the push to clear out the EDs in the large hospitals, pressures were felt in the inpatient unit. Denise described how she noticed that consultant psychiatrists were pushed to follow guidelines developed by policy makers while feeling under pressure.

> *I can see that some of the senior consultants are burnt out with the whole system. This is a quote: 'I suppose I'll be disappearing from your roster because I'm not keeping up with the discharge rates'* (Denise, Interview 1, line 148-150).

It is telling when a psychiatrist makes a comment like this. What impact might this have on other health professionals in the room as Denise links these remarks to possible burnout?

Gloria, another nurse, elaborated how she could hear exhaustion in a nurse's voice when talking on the phone.

> *Recently when I rang you could tell the exhaustion in the [nurse's] voice….I could nothing but feel for the person. You could tell it was 21.00 at night and they were exhausted (Gloria, Interview 10, line 71-73).*

Marion one of the shift leaders, expressed her concerns about staff members.

> *I've got responsibility to staff because staff are exhausted, burnt out. Every day there is something……...The staff are burnt out,*

exhausted and completely traumatised (Wendy, Interview 2, line 161-163).

These are serious concerns as burnout can have far reaching consequences and potentially impact on the quality or care provided and health outcomes. Employee burnout is related to job dissatisfaction and low morale of employees (Stalker & Harvey 2002; Acker 2011; Green et al. 2014). Participants described a situation of extreme pressure to discharge and increase the flow. This impacted on the care provided and accountability enactment and how staff made their decisions regarding priorities in care provision. Care plan development with consumer involvement was not regarded as a major concern.

5.4.1.3. DISCHARGE PRESSURE

'Quick, quick, get him out of here' (Denise)

The inpatient unit cannot be seen in isolation and must be viewed in the context of the entire LHN the unit provides services for. Consumers from various backgrounds where admitted to the inpatient unit including consumers from rural and remote areas of the state where there are often limited services. This creates challenges in the discharge process as services that are considered standard in metropolitan areas are not available in the rural and remote regions. For instance, some of the services unavailable include 24-hour crisis teams, emergency housing, detoxification facilities and certain therapies, especially group therapy, are often difficult to access.

The challenges encountered in the discharge process which were often related to the limited services in rural communities were now exacerbated by discharge pressures. With few services available in rural and remote regions and a long way from the metropolitan area, discharge pressures and a high demand for beds caused situations where consumers were discharged while a discharge plan was not completely finalised. This was a cause of frustration amongst some

staff members. Denise, an experienced nurse, described in detail the discharge process of two consumers and the complexities involved.

> *'He can go today, right, get him out today' and never mind we actually planned for tomorrow and it's already one o'clock, we don't know if there's a bus to the ferry to X Island, 'oh right we'll find out, yes there's a bus, quick order a taxi, oh whoops the taxi is late, oh my God he's missed the bus, he's at the bus station in town, send another taxi'. This happened last week or the week before. So there we are at, what time was it, the bus had gone, we didn't know whether the patient was on the bus and I thought 'dear God, what am I going to do?' I rang X Island, I rang the team and told them what happened. It's most embarrassing, not to mention you're frantically worried about this poor bloke who lives on X Island, he's got chronic mental illness, he's wandering around the CBD, what's he going to do…..So I rang somebody on X Island, they rang Z and anyway somehow a miracle had occurred, another taxi driver had whizzed him to A and he got on the bus there so he got home* (Denise, Interview 1, line 152-163).

> *I'll give you another example of that sort of mismanagement, complete lack of accountability. I was shift coordinator, shit coordinator I call it, the CPC was on that day. The poor registrar or junior doctor whoever he is, lovely chap, young chap, he was given orders to get this Aboriginal person up to X, he was actually from Y or something, but they were packing him off to the unit at X. So I'd been frantically faxing and emailing information up to them to make sure that they would pick him up from the bus stop because this boy was still really mad, very delusional and he'd been smoking dope on the unit* (Denise, Interview 1, line 164-170).

> *He'd been smoking dope, you'd go out there and they're all smoking and I went out looking for him, this was the day before he was supposed to go home and there he is with another lad, they're giggling their heads off and I needed to sign the 'permission for follow up phone call' form, he couldn't even sign his name, he*

thought it was hilarious, the pair of them (Denise, Interview 1, line171-174).

JR: And this is on the premises of Z unit?

*Yes, Cracking up, everything was just….off their faces they were. So we got a bus ticket for him (*Denise, line 175).

JR: To X?

To X, A was involved in this plan which I just thought was disgraceful to be sending this lad who's as mad as a cut snake on public transport on his own with me hoping that somebody at X is going to pick him up at the other end. And I had a day off the following day. Anyway when I came back to work first thing I did was say 'what happened?' Oh they came in the morning, the medical team, and somebody decided, somebody over-rode the decision. He was still on an ITO when his plan was being put in place, they decided they couldn't lift the ITO after all. I thought there is a God. But you know that's what they were going to do and it was just 'quick, quick, quick get him out of here'. It's awful……(Denise, Interview 1, line177-185).

These issues are not new and were extensively described by Rhodes (1991) who provided a picture of an emergency psychiatric unit where involuntary and voluntary psychiatric consumers were evaluated for either discharge or referral for continued inpatient or outpatient care, which was usually not readily available. The staff in the study by Rhodes (1991) struggled to discharge consumers quickly while also managing to treat them adequately.

The discharge pressures and complexities that need to be dealt with to complete a discharge as soon as possible inadvertently leads to less attention to consumer involvement in the development of a care plan. Consumer involvement in therapeutic engagement takes time, which is not available under these kind of circumstances. In nurses' decision making on care delivery, care plan development was a lower priority. Moreover, a consumer may indicate they do

not wish to be discharged, but ward pressures dictate otherwise which impacts on health professionals' decision making and results in overriding consumer concerns.

Andrew also thought some consumers were sent home too early and viewed the increase in discharges as an internal competition between medical staff. He also felt consumers were discharged while being unwell.

> *I don't think the nursing staff have much to do with it really, it's to do with the doctors, It's like competition. I reckon, it's see how many you can get out. They clear ED but they're taking up beds here, there aren't actually enough beds really. So a lot of people they go home, they're still unwell* (Andrew, interview 166-169).

Bed shortages led to discharge pressures and doctors discharging consumers who had not completely recovered. Discharge pressures appeared to have reached such high levels that a nurse like Andrew perceived the number of discharges as competition between medical staff.

Denise thought that the discharge pressures impacted on the nursing staff and their practice.

> *So all that pressure filters down, nursing staff are just run ragged, absolutely run ragged on the unit…*(Denise, Interview 1, line 149-151).

Marion also mentioned the discharge pressures and the impact on the culture in the unit and consumer care.

> *I do believe that with all the current political pressures of this place, the bed flow issues, the length of stay issues, we run all day every day pretty much. We haven't got the time to sit down and reflect and do things as they should be done and that's using a reflective sort of practice model* (Marion, Interview 2, line 65-69).

The policy to reduce the length of stay exacerbated the existing challenges resulting from limited services in rural and remote areas in the LHN which was noticeable in the inpatient unit. The push to discharge put the pressure on nurses and medical staff impacting on the care provided and how accountability was enacted as care needed to be prioritised. Discharges were at times insufficiently prepared and this changed the culture and focus of care which put a large emphasis on length of stay and less attention was paid to care plans.

Observations confirmed that not many voluntary consumers were present in the inpatient unit. Nurses presented me with a consumer list during my observation sessions which revealed that the majority of consumers were admitted on an involuntary basis. An inpatient unit in a LHN which was already challenged by its specific circumstances now experienced more pressure. The increased acuity was evidenced by difficulties I encountered in finding voluntary consumers to consent to their care plan being examined by me. The planned viewing of care plans or observation of care plan development proved to be a challenging exercise as at any given time only 3 or 4 of the 24 consumers in the inpatient unit had been admitted on a voluntary basis. The few voluntary consumers who were available were deemed ‘not suitable’ or ‘too complex’ by the mental health nurses to ask for informed consent to look at their plan. Moreover ethics approval to view consumer files was only granted given that consumers should remain completely anonymous to me. To achieve this the nurse would chose the care plan for viewing from a large number of consumer files belonging to consumers who had consented. As a result of the limited number of voluntary consumers there were never sufficient files for the nurse to make a choice which could ensure anonymity of the consumer. The absence of voluntary consumers was an indication that as soon as consumers were voluntary they were discharged to go back to their community. The result was an inpatient unit where the majority of

consumers were acutely unwell and therefore placed on Inpatient Treatment Orders (ITO). The culture in the unit could be characterised as increasingly unpredictable and acute which impacted on mental health nurses' practice. Participants expressed the view they did not have the time to sit down with consumers to discuss a care plan. Nurses regarded consumer involvement in care plan development as a lesser priority than other aspects of care which could accelerate a discharge.

5.4.1.4. CHANGED UNIT ROUTINES/PRACTICES:

> *'Now it's all paperwork….I spend very little time with my four clients'* (Andrew)

The amount of paperwork that needed to be filled in by mental health nurses had grown as a consequence of increased discharge numbers. The focus on admissions and discharges was reflected in the unit routines as less attention was paid to face to face consumer care and more time was spent behind the computer taking care of the required documentation.

Andrew voiced his frustrations and described how he thought activities with consumers had changed over the last two decades and how consumers were increasingly left to their own devices.

> *Now it's all paperwork. If I look at my twelve-hour day, I spend very little time with my four clients, very little when I look at it (*Andrew, Interview 6, line 19-20).

Andrew thought that nursing was increasingly a profession occupied with admitting and discharging people and he recalled the number of discharges over the previous weekend.

> *It always used to be a very practical oriented profession, where now people are more interested in getting people admitted and discharged than actually fixed. We had five discharges on the*

> *weekend and three on Friday and two on Thursday, that's nine in four days and it just seems a constant push* (Andrew, Interview 6, line 52-55).

Marion expressed discontent with care provision including her own practice as a result of discharge pressures. She used the term 'Band aid stuff' and referred to hasty care which covers up the symptoms but does little to mitigate the underlying problem.

> …..*you know you're just in crisis mode on the unit, you're just trying to get through the day and I think that's really sad I think that's the whole system with mental health. We're into band aid stuff aren't we, especially the ED's and the units (*Marion, Interview 2, line 69-71).

Denise used the similar terminology when describing comments made by the medical staff.

> *One senior consultant referred to cosmetic psychiatry or band aid psychiatry* (Denise, Interview 1 line 149).

Nurses noticed a change in care, which according to them, was the consequence of a relentless need to prioritise care on a daily or hourly basis. Aspects of care such as care plan development were not at the top of the list. Denise, who I spoke to in the nurses' station, commented to 'not blame the nurses' for anything (Field notes, 19/01/2016). She argued that what is happening on the unit is related to the broader political climate with a push for a reduction in length of stay. Suzanne, who was shift leader that day, also mentioned 'not to blame the nurses' if the plans were not completed (Field notes, 19/01/2016). She explained she was not happy with current practice and the lack of care plans, but that the push for discharges came first. She said there were priorities that needed to be looked after and that care plans were just not on top of the list at this stage. She maintained that this inpatient unit was the last inpatient unit in the state to focus

on flow and discharges and that this consistently took higher priority than care plans. Suzanne put forward that she sometimes felt consumers were doing better than nurses who felt pressured and stressed and were pre-occupied with completing paperwork. *'Something is not right then'* she said while pointing to a pile of paperwork (Field notes, 19/01/2016).

How the care plan could play a role in improving the quality of care and the discharge process was not considered. Nurses appeared to have good insight into the consequences of recent policy directions, but seemed powerless to challenge this. The main concern was to satisfy management and to assist psychiatrists in an effort to reduce the length of stay. Mark explained that the care plan was not prioritised and that information was a cut and paste as a result of the increased flow.

> *I think to some degree there is a lot of cut and paste element where it is not proactive enough. This is the plan they came in with, oh we will review it once in a while, rather than, right where is this client's plan of care, what are we looking for. Where is that drive, how do we get there? And I think a lot of that is affected by the pressure on the unit at present (*Mark, Interview 9, line 182-185).

Also Denise mentioned the aspect of cutting and pasting as a result of time constraints.

> *Yes, everything is cut and pasted because…….we are run off our feet for eleven hours and forty-one minutes. I have never been so frantic in my life, you walk your legs off very fast* (Denise, Interview 1, line 284-286).

Marion explained how time pressures reduced the nurses' ability to tailor care plans to the specific needs of consumers.

> *So we thought 'okay that makes it really easy to copy and paste it over' and that saves laborious typing of it* (Marion, Interview 2, line 113-114).

Sam stated that because plans were copied, not many nurses or other health professionals looked at the content of the care plan.

> *I think that's probably for me one of the frustrating things that people just add one or two things in there and that's all they do and they just copy it and don't really look at what's in the plan* (Sam, Interview 8, page 100-102).

In the decision making process on priorities during their working day nurses did not think that developing a care plan was as important as other aspects of care. The decision making by nurses was informed by messages sent by the leadership group who argued the length of stay needed to be reduced. Accountability to senior leadership and psychiatrists and a focus on paperwork and discharges appeared to take priority over individual professional accountability and accountability to consumers. The ward environment and culture impacted on decision making in accountability enactment and whether or not to develop a care plan with or without consumer involvement. Nurses observed how management decisions impacted on consumer care but did not overtly question management decisions they did not agree with.

5.4.2. SUBTHEME: DISSATISFACTION AND PROJECTION

5.4.2.1. PERCEIVED LACK OF RECOVERY MODEL

> *'I'm always pulling the doctors back to try and be a little bit more recovery focused'* (Marion)

The heightened acuity and unpredictability in the inpatient unit as a result of the increased discharge focus led to discontent with practices on the unit and participants mentioned different aspects they were unhappy about. Dissatisfaction with work can lead to increased staff turnover, reduced

productivity and performance and increased risk to consumers with reduced quality of care (McHugh & Byrne 2012, Laschinger & Fida 2014; Kaschima et al. 2015).

Marion was discontented with the apparent lack of use of the recovery model by the medical staff

> *I am talking about medical people really to be honest who are just real clinically focused, 'let's just go and do our medical model' and as nurses I'm always pulling the doctors back to try and be a little bit more recovery focused. What does the client want, have you talked to the family about what they want, have we had a conversation with a community mental health worker, have we looked at what's happened before and what works. I think there are time restraints that clinicians have got that they're just going, nah, this is what we're going to do* (Marion, Interview 2, line 58-64).

Karen believed that senior staff should lead by example through their use of recovery based language and the provision of high quality care.

> *I think that leaders and senior staff need to use language that is recovery focused…..*(Karen, Interview 5, line 140-141).

Recovery is defined as a process of personal growth and development which can lead to regaining control of one's life and enjoying a sense of fulfilment, but does not necessarily require symptom remission (Rickwood 2004; Davidson et al. 2005; Commonwealth of Australia 2013;; Field & Reed 2016). My observations suggested, however, that the focus of the medical staff was dominated by discussions about medications to reduce symptoms as soon as possible to facilitate a discharge (Field notes, 17/08/2015, 01/09/2015, 14/09/2015, 22/09/2015, 29/09/2015, 13/10/205, 27/10/2015, 24/11/2015, 30/12/2015). A lack of recovery focus in the inpatient unit was viewed as the result of time constraints and the push to discharge within a certain period of time which automatically

shifts the attention to Community Treatment Orders and medications to be able to manage unwell consumers in the community. This is linked to comments by Andrew about the changed nature of the work of a mental health nurse and his unhappiness about not being able to spend more time with consumers as a result of documentation requirements. Andrew looked back and had fond memories of mental health nursing more than 20 years ago which he described as the '*golden years of mental health nursing'.*

> *If you had some older clients they'd be able to tell you, in those golden years they were inpatients but they weren't here much they were out of hospital, they used to sleep here…..No we took them out, not for coffees and lunch and things like that, it was all to do with resocialisation, education, resourcing things, such as where they're going to buy cheap food and cheap cigarettes, all that sort of gear* (Andrew, Interview 6, line 37-42).

From Andrew's description it appeared that the care provided by the nurses had changed and that in the past attention was payed to gradual re-adjustment to living back in the community, in contrast to the current focus on discharge at all costs.

The impact on Andrew was that he did not enjoy the work anymore as is now thinking of retiring.

> *I'm actually thinking of retiring……*(Andrew, Interview 6, line 13).
> *Even though this is on tape, I must admit my heart's not in it, I'm burnt out, you know what I mean, it's a real struggle for me to come in here* (Andrew, Interview 6, line 16-17).

Andrew's account demonstrated the impact the discharge focus and resulting work pressures had on mental health nurses. It was encouraging that some participants at least observed this change in the lack of the use of the recovery model in care provision. It proved however to be challenging to change this care

focus in the very acute environment with pressures to discharge to reach the desired average length of stay and satisfy senior management. The observation of the lack of the recovery model in the care provided by medical staff was possibly also a reflection on how nurses felt about their own work as they were not able to use recovery oriented practice either. Practices by other health professionals in the inpatient unit who were perceived not to be working within a recovery model impacted on nurses' actions and their decision making on involvement of consumers in care plan development.

5.4.2.2. DISCONTENT WITH AGENCY STAFF

> *'Forget the agencies because they don't work'* (John)

Some unhappiness was specifically directed at agency staff who were hired during almost every shift as not enough permanent nursing staff were present in this acute inpatient unit. Marion thought that agency staff were not part of the team which could impact on care provision as they did not work well together with the regular staff.

> *I think the challenges that we have on the unit are with agency staffing. Not saying that they're not great clinicians, but if you work with a group of agency nurses and you work with a group of regular nurses it's completely different….If you're working with regular people who know each other we know how each operates and we understand each other and we're sort of on the same page. Where if you're working with agency and casual nurses, everyone's on different pages all over the place and that's not saying they're bad clinicians, it's just that they're not gelled as a team so that can be difficult* (Marion, Interview 2, line 197-203).

John put forward that he believed that agency staff did not do their job with regard to the care plan.

> *What the nurses should be doing is looking at the care plan or looking at the journey board or the journey paper and find why the care plan is not there, some people just let it go. Agencies wouldn't even be bothered….*(John, Interview 3, line 107-109). …..*Forget the agencies because they just don't do the work, they do very little in fact* (John Interview 3, line 120).

Wendy one of the senior nurses who at times acted as Clinical Practice Consultant (CPC) also voiced her frustrations with the agency staff impacting on the culture.

> *But if you get either infighting, too many different views or a culture where morale is low and people don't care so much, particularly if there's a lot of agencies where people are just coming 'I am here for the shift, I'll do my work and go', so that all has an impact on accountability* (Wendy, Interview 7, line 187-190).

Some nurses believed the use of agency staff had an impact on the culture and quality of care in the inpatient unit. There appeared to be a perception that agency nurses were not as capable or accountable which might have been related to the pressures nurses were experiencing. High turnover of nursing staff had an impact on the culture and morale in the inpatient unit as illustrated by some of the comments which revealed underlying frustrations. The environment influenced how nurses felt about their workplace as they expressed unhappiness about care provision in general which may impact on their own accountability enactment. In this highly stressful environment the agency nurse was singled out and blamed for contributing to the perceived reduced accountability and the lack of up to date care plans. It became clear that a lack of accountability or the lack of care plans was projected onto agency nurses.

5.5. THEME TWO: PLANNING PRACTICES IN A MULTIDISCIPLINARY TEAM

In this section I will explore how planning practices in the inpatient unit are influenced by relationships between health professionals and leadership in the

multidisciplinary team (Figure 5.5.).

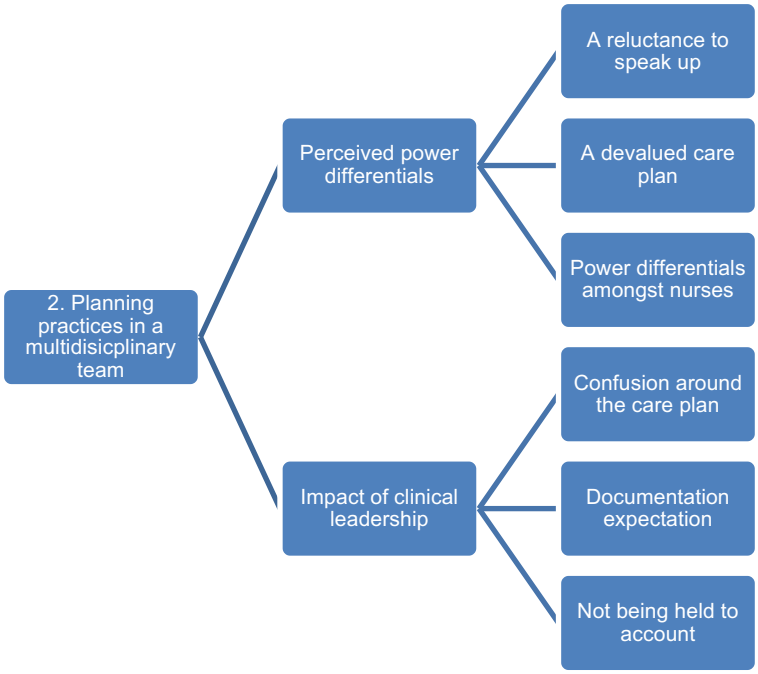


Figure 5.5 Summary of subthemes under Theme 2: Planning Practices in a Multidisciplinary Team

5.5.1. SUBTHEME: PERCEIVED POWER DIFFERENTIALS

5.5.1.1. A RELUCTANCE TO SPEAK UP

> *'Because I said to them 'make sure you sit at the table and say this is where the person is at'* (Karen).

The mental health nurses were under-represented in planning of care forums such as the multidisciplinary team meetings which played a key role in the inpatient unit. Consumers were also absent during these meetings. The nurse remained in the background while other health professionals had a larger input in care discussions (Field notes 17/08/2015, 24/08/2015, 01/09/2015, 14/09/2015, 22/09/2015, 29/09/2015, 13/10/2015, 19/10/2015, 24/11/2015. 30/12/2015). Two nurses in particular were discontented with the role of the nurse in the inpatient unit while most other participants expressed discontent with some of the processes in relation to care planning. Yet, during the important multidisciplinary team meetings and clinical handovers the nurse remained in the background which appeared to go against the nurses' wishes to increase their role in the unit

and improve and include Consumer Plans. One nurse observed that nurses' contributions were minimal during the multidisciplinary team meetings.

> *And so in terms of putting together the mental health care plan and you've sat in our unit rounds and you've heard the nurses give their handover of how the patient slept and behaviours and that is all that is required (*Denise, Interview 1, line 104-106).

> *The problem is that those multidisciplinary team meetings are actually not team meetings at all because each faculty of the team works very exclusively. There is a liaison between allied health and the medical teams and the medical team defers to the allied health team…..*(Denise, Interview 1 line 120-123).

Denise observed that contributions were minimal and thought that this occurred partly because the requirements were such that the handover would be minimal. She observed the fact that nurses were often excluded from care discussions and used the word 'defer' to describe this. The term 'defer' refers to accepting another person's opinion because one respects the knowledge or experience of that person more than their own. The interview revealed that Denise believed the medical staff respected the allied health staff more and they relied on their expertise.

Interactions between various health professionals and how this occurred shaped what some nurses perceived as power differentials amongst the staff. The interplay amongst the health professionals developed and determined the input of the nurses in care discussions. Nurses kept their contributions to a minimum and delivered very brief handovers (Field notes 17/08/2015, 24/08/2015, 01/09/2015, 14/09/2015, 22/09/2015, 29/09/2015, 13/10/2015, 19/10/2015, 24/11/2015. 30/12/2015). Consequently, the influence of the nurse in the negotiations on how to proceed with consumer care was reduced which impacted on how nurses perceived their own status in the inpatient unit.

Observation data indicated the atmosphere in the room was generally collegial and friendly and various staff members were given the opportunity to speak without being interrupted (Field notes 17/08/2015, 24/08/2015, 01/09/2015, 14/09/2015, 22/09/2015, 29/09/2015, 13/10/2015, 19/10/2015, 27/10/2015, 24/11/2015, 30/12/2015). Usual procedure during the multidisciplinary team meetings was that for every consumer the responsible nurses were asked for their handover. There appeared to be an expectation that nurses need not use the formal handover tools as they were not criticised for not doing so. While the Clinical Services Coordinator (CSC) and the Clinical Practice Consultant (CPC) informed me during informal discussions they would like to see the nurses use the ISBAR (Introduction, Situation, Background, Assessment, Recommendation) format, they did not challenge them during the multidisciplinary team meetings. Research has shown that using a standardised format can assist the transfer of information, particularly when there are time constraints. ISBAR is such a tool. ISBAR organises a conversation into the essential elements for the transfer of information form one source to another (Hill et al. 2007; Government of South Australia, Clinical Handover Policy 2015; Government of South Australia, Clinical Handover Guidelines 2015). Its effectiveness has been demonstrated in both clinical and non-clinical situations of communications transfer (Government of South Australia, Clinical Handover Policy 2015; Government of South Australia Clinical Handover Guidelines 2015). An effective handover is vital as poor communication can harm consumers.

The medical staff did not question the minimalistic handovers or ask the nurses to clarify their handovers. Using the ISBAR format ensures, however, that all aspects of the consumer's life and situations are covered and provides structure and thoroughness as details of the consumer's mental state are discussed. Utilising the ISBAR format ensures an interview with the consumer during the

shift has taken place to update information. An interview with the consumer is an appropriate occasion to check whether a care plan is still relevant. Nurses who at times openly criticised the standard of the handover did not initiate an improvement in practice through handing over information in a more formal or comprehensive format such as the ISBAR.

Observation and interview data suggested that the multidisciplinary team meeting was the most important meeting of the week. Multidisciplinary team meetings were held twice a week on Monday and Tuesday mornings, Monday mornings for the blue team and Tuesdays for the red team. As outlined earlier, health professionals from a variety of disciplines attended the meetings. Multidisciplinary team meetings are central to the management of chronic disease including mental illness. Their purpose is to optimise decision making and improve outcomes (Campbell 2001; Raine et al. 2014). Key features of a psychiatric multidisciplinary team meeting include being held once a week at a predetermined set time, the presence of the consumer (with the right not to attend) and with the array of health professionals represented (Fiddler et al. 2010). Research into critical factors which impact on the multidisciplinary team effectiveness identified clear leadership, (Fay Borroll & Amir 2006; Lamb, Brown & Nqpal 2012) explicit shared outcomes, (Fiddler et al. 2010) and positive team atmosphere (Gonzalez-Roma & Gamero 2012).

The multidisciplinary team meetings on the unit had a high status which was evidenced by the fact that all health professionals were expected to attend and important decisions were often made during the gathering. Observation data suggested the clinical decision making rested with the psychiatrist and consequently they were viewed as the leaders of the multidisciplinary team. It appeared that as a result of this leadership the care that was planned during the multidisiplinary team meetings often had a biomedical focus and discussions

frequently revolved around medications or change in medications in consultation with the pharmacist, electroconvulsive therapy, inpatient treatment orders and community treatment orders. Other aspects that were discussed were relationships with family or accommodation and potential physical health issues. The consumer, who was not invited to the multidisciplinary team meeting and thus was absent, and their input in the Consumer Plan (figure 5.3) were not visible or discussed during the meeting.

Nurses' reluctance to speak during multidisciplinary team meetings was also visible when they generally did not sit at the table with other health professionals which might have been an expression of perceived power differentials (Field notes 17/08/2015, 24/08/2015, 01/09/2015, 14/09/2015, 22/09/2015, 29/09/2015, 13/10/2015, 19/10/2015, 27/10/2015, 24/11/2015. 30/12/2015). This behaviour influenced care planning practices as the presence and input of the mental health nurse was reduced. The shift coordinator was usually present during the whole meeting and sat at the table. Karen who was an experienced nurse and who acted for a while as the CPC on the unit, acknowledged the issues of nurses not sitting at the table during the multidisciplinary team meeting.

> *Because I said to them 'make sure you sit at the table, you lead and say this is where the person's at…..and then you get the medical and pharmacy and other components, social work added components….*(Karen, Interview 5, line 211-213).
>
> JR: Why do you think that it is that the nurses are reluctant to speak up during those meetings?
>
> *Some have said that they have felt put down or they're just not confident….*(Karen, Interview 5, line 226).

This indicated Karen thought it was possible for nursing staff to have input and that nurses should contribute to the meeting and sit at the table along with other health professionals. She acknowledged that leadership by nurses in care

planning was important and in order to make this happen the nurses need to sit at the table to reinforce their presence.

Also Denise thought that nurse leadership was needed which could then raise the profile of the mental health nurse.

> *So those ground rules if you like about multi-d team meetings, they really need to be put in place by people in the leadership team, and I don't mean this as a criticism to the current CPC and CSC,* (Denise, Interview 1, line 260-261).

The fact that the majority of nurses did not aspire to increase their contribution to the meetings unintentionally led to the absence of Consumer Plan discussions. Limited accountability enactment for the Consumer Plan took place as a result of a reluctance by the nurses to speak up and express an opinion, impacted upon by perceived power differentials.

5.5.1.2. A DEVALUED CONSUMER CARE PLAN

> *'They're not asking for it, maybe that where it's been devalued as well'* (Karen)

As outlined above, nurses viewed themselves as lower in rank than other health professionals and in particular doctors, which had an impact on the care plan. Some nurses thought that doctors requesting the Consumer Plan was necessary for the care plan to have value.

It was apparent that they perceived the doctors as being at the top of the hierarchy holding most power and responsibility. Karen thought by not asking for the plan doctors contributed to devaluing of care plans.

> *And also I think that's' where the doctors need to speak the language and walk the talk as well. That they say 'okay where's the care plan, I'd like to look at the care plan because they're not asking*

> *for it. Maybe that's where it's been devalued as well* (Karen, Interview 5, line 160-163).

Karen pointed out that doctors' not asking for a care plan sent a message to nurses that the plan was not worthy of discussion and that therefore the quality of that care plan or even the existence of that plan did not matter.

Wendy and John stated that medical staff did not ask for the Consumer Plan except in certain circumstances.

> *I don't think it gets talked about enough in the meetings. The doctors use it more for hearings, GSB hearings, the Guardianship Board always ask for a copy of that* (Wendy, Interview 7, line 130-131).

> *We only do that when it's really, really necessary, GSB, if they go to EICC (Eastern Intermediate Care Centre) or WICC (Western Intermediate Care Centre) it has to be done (*John, Interview 3, line 59).

The view that a doctor or the Guardianship Board needed to ask for a care plan as an incentive for that plan to be created or regarded as important is a reflection of where the nurses saw themselves in the inpatient unit. Karen who was an experienced and confident nurse viewed herself as subservient to the medical staff who gave directions. It is implied here that by doctors not asking for the plan then these plans do not have value. They did not see that the nurse can emphasise the value by putting the consumer care plan at the forefront of discussions. It is the nurse who has an opportunity to make the consumer care plan count by including it in all handovers. Perceived unit hierarchy impacted on the development of the Consumer Plan as nurses thought that medical staff needed to ask for it.

5.5.1.3. POWER DIFFERENTIALS AMONGST NURSES

> '*A nurse with a bigger voice, someone who's been in that shift coordinator role for a long time'* (Denise)

Exchange of information and care planning also took place via informal channels which was an opportunity for the nurse to contribute and ensure the consumer care plan was included. Different health professionals were observed to have smaller meetings in one of the rooms in the corridor of the inpatient unit. Sometimes these meetings were planned but at times they were spontaneous when different health professionals had the opportunity to discuss a consumer's progress. Informal discussions between health professionals could be observed frequently in the unit corridor or the handover meetings. Karen commented how she organised or sat in during unplanned meetings which indicates that confident nurses used these ad hoc opportunities to put their opinions forward.

> *..I mean I've sat on reviews where I've done them kind of impromptu, you get the pharmacist, the doctor, nursing staff, the client and we're all sitting around the table and you can actually debate what's going on* (Karen, Interview 5, line 54-56).

The language Karen used indicate that she felt self-assured and the word 'debating' implies she thought she had something to contribute to the discussion and to the care planning in general. Mark who at times acted in a leadership role, described how care was planned using daily interaction between health professionals

> *Usually there are daily reviews and feedback between the nursing, consultants, junior doctors, occupational therapists, social work, psychology……. that happens on a daily basis. So that plan is developed and input from each team is fed into that plan of care* (Mark, Interview 9, line 84-87).

These two staff members appeared comfortable with their role and place within the team as they described the informal meetings they were part of. Denise on the other hand commented on the ad hoc nature of these meetings and that she was not always informed and therefore unable to attend.

> *It really depends [that the doctors] …come and get the nurse, if you are not taken if you're not part of the interview process with the patients that's when you get a lot of information. If you are not included in that process and some of the consultants will just waltz past you and they couldn't care less whether you come or not and so you just don't know what the plan is, so then you have to try and read their writing. And if you were to say 'how did that family meeting go?', you get a look as much as to say, 'why are you asking me that question', it's almost as if 'how dare you', I'm busy and I'm important and you're not* (Denise, Interview 1, line 292-300).

Denise did not feel part of the care planning meetings and she felt that consultants bypassed her and so she was sometimes unaware of the meetings occurring. She appeared disillusioned and felt resentful regarding the psychiatrists when she commented how she literally had to 'try and read their writing' (referring to psychiatrists' notoriously illegible handwriting). She hypothesises what the psychiatrist would say if she were to ask for clarification regarding a family meeting and stated that the psychiatrist would probably think she should not ask any questions. These comments are a reflection of how Denise felt about not being valued. There is a tone of discontent with her role in the inpatient unit.

Denise who often fulfilled the role of team leader in the unit described how some staff members who had been in longstanding leadership roles and who were known to the medical staff appeared to have more input.

> *But then somebody will come along that they [medical staff] may know, a nurse with a bigger voice, somebody who's been in that shift coordinator role for a long time, for example somebody like X or another member of the lead nursing team, they're people who are listened to (Denise, Interview 1, line 244-247).*

Through this remark Denise implied that she did not have such a voice.

Comments by Denise demonstrate that the higher the nurses felt they were placed in the formal and informal nursing hierarchy in the inpatient unit, the more they believed they were part of the care panning process and felt included. The confidence and role of the nurse appeared to determine how much involvement they had in care plan discussions. Experience did not appear to play a role as all participants had been a mental health nurse for 10 years or longer. Interview and observation data suggested nurses perceived a hierarchy, which impacted on their contribution to care plan discussions. These perceived power differentials were probably less prominent during informal meetings as these were situations when nurses had more of an opportunity to have input and to raise their profile as fewer other health professionals were present. Only a few nurses, however, seemed able to use these informal situations and enact accountability for the Consumer Plan.

5.5.2. SUBTHEME: CLINICAL LEADERSHIP

5.5.2.1. CONFUSION AROUND THE CARE PLAN

> *'It's hard to know whether the client's component is the core component or sometimes the service part'* (Karen)

Interview data revealed there was uncertainty and lack of understanding on the structure of the multidisciplinary care plan and what the content of the plan should be (figure 5.3.) A discussion commenced between staff members during my second visit to the inpatient unit about the purpose of the care plan (Field notes 05/08/2015). One nurse believed the multidisciplinary care plan for the inpatient unit should be different from the community team's plan as there was a different focus. He mentioned the example of the care of pets during the hospital admission which was a topic in many inpatient Consumer Plans. The acting CPC, on the other hand, commented the inpatient unit and community multidisciplinary care plan should be similar. She explained that multidisciplinary care plans are

living documents and should develop over time, from community to inpatient unit and vice versa. The CPC added it would be good for consumers to keep the care plan as a document which they could carry with them. From this discussion it was clear there was no consensus about what the care plan is or should be and staff members had differing perspectives.

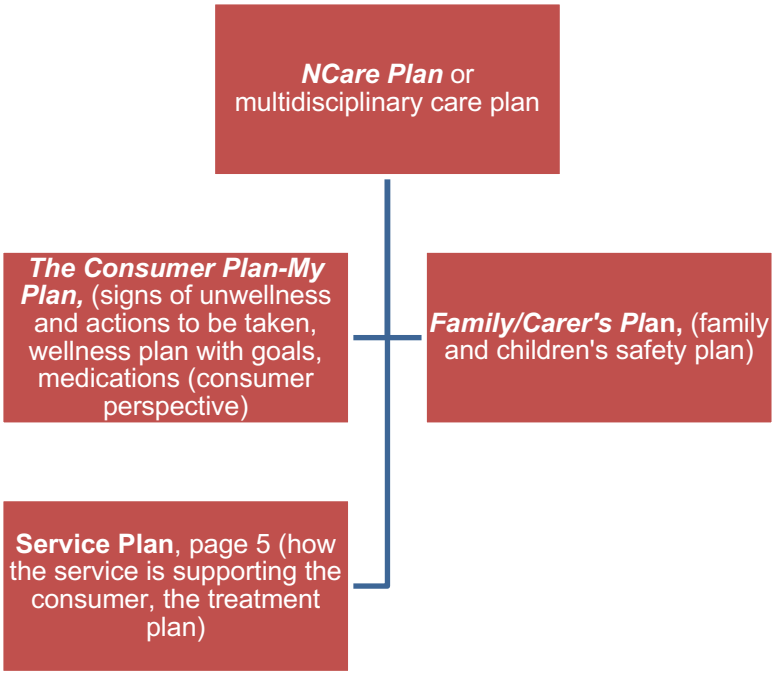


Figure 5.6. Structure of the NCare Plan

There was no common understanding of the purpose of the care plan or the processes around it which resulted in ad hoc planning. Some nurses referred to the multidisciplinary care plan as the NCare Plan (Figure 5.6.) which was the official name for the plan used in mental health services in the state. Others mentioned the Wellness Plan while some spoke about the Service Plan.

> *The management plan, yes you've got the Consumer Plan. Now the Consumer Plan, we have the Service Plan, which is more the management plan which the consumer needs to know. But then we have the Consumer Plan. The consumer care plan we tend to call our Wellness Plan on the unit and that is usually either given to the client to fill in because they choose to fill it in* (Wendy, Interview 7, line 94-98).

Andrew referred to the Wellness Plan.

> *Now the Wellness folder, that's different…..Well it is, but the wellness is actually what they want to get out of it* (Andrew, Interview 6, line 111).

Denise implied that the only part of the care plan that was important was the Service Plan as this part of the plan was asked for or requested by various health professionals.

> *But the guts of it is when you get to page 10 and it's a summary, the Service Plan, that's what everybody wants, the Service Plan* (Denise, Interview 1, line 118-119).

The multidisciplinary care plan used in this mental health service incorporates the Consumer Plan, the Family/Carer's plan and a Service Plan (figure 5.3.). The Consumer Plan is supposed to be the core of the multidisciplinary care plan and outlines consumer goals and benchmarks. It also includes an advance directive, a wellbeing matrix and wellbeing plan to explore past and future treatment, a physical wellbeing and wellness plan and medication information. The Consumer Plan was however seen and referred to as a somewhat separate plan. The multidisciplinary team meeting focused on the doctor's treatment plan which was later cut and pasted into Service Plan, the last page of the multidisciplinary care plan. The Consumer Plan was expected to be developed between the mental health nurse and the consumer. This was a source of confusion and it was not clear to team members how the three plans (Consumer Plan, Family and Carer's plan and Service Plan) could be integrated or who is responsible for doing this.

Karen mentioned the potentially different functions of the various parts of the multidisciplinary care plan.

> *It's hard to know whether the client's component is the core component or sometimes the service part because it depends on*

> *where they're at in their mental state I suppose (*Karen, Interview 5, line 30-31).

Karen believed that the various parts of the plan had a different purpose and implied that at a certain stage during the admission when the consumer was unwell, the plan formulated by the treatment team in the Service Plan was the most important part. Adding to the confusion was the fact there was a perception that health professionals including nurses did not read the documented multidisciplinary care plan in the electronic system, which confirmed its lack of relevance. Nurses just changed the dates in the care plan to create an illusion that work had been undertaken.

> *A lot of people do not read what's in it and when I go in there I will make a point of reading it and its quite obvious a lot of people never read it because…..[all] they've done is change the date [of the care plan]* (Sam, Interview 8, line 91-93).

Karen acknowledged the multidisciplinary care plan was not used correctly and believed that education was needed. She focused on the document and how it was used and thought that through education or adding small headings nurses could be persuaded to complete the plan.

> *But I've seen a lot of care plans and in the Service Plan there might be reams and reams of information and people are reluctant to delete it because there's been a lot of work put into it. So perhaps it's the Service Plan that staff need to be educated on, how to use it. And then in there, do we have then prompts like we do in other modules…….so that the right thing goes in there* (Karen, Interview 5, line 35-38).

A lack of leadership was apparent on how to coordinate the care and combine the Consumer Plan, the Family's Plan and the proposed Service Plan by the multidisciplinary team. The fact that the multidisciplinary care plan including the Consumer Plan were not read or used by different health professionals sent a

message to the nursing staff that the Consumer Plan was not a priority. As a result of the lack of leadership on the structure, content and coordination of the multidisciplinary care plan, mental health nurses (and other health professionals) were not held to account.

Clinical leadership is important in a hospital setting such as the inpatient unit. The importance of effective nurse leadership in ensuring a high quality health care system that consistently provides safe and efficient care has been reiterated in the literature. Clinician engagement and clinical leadership are critical to achieving and sustaining improvements to care, quality and patient safety. Good clinical leadership can ensure a common understanding of the procedures in the hospital units. (Sorensen, Iedema & Severinsson 2008; Havig et al. 2011; Ezziane 2012; Finkelman 2013; Daly et al. 2014; Chavez & Yoder 2014). With regard to Consumer Plan clinical leadership appeared to be lacking to the detriment of the quality of the multidisciplinary care plan. Although there appeared to be clarity and a common purpose on increasing the number of discharges, there was no such understanding of the structure and content of the multidisciplinary care plan.

5.5.2.2. DOCUMENTATION EXPECTATIONS

> *'A lot of duties do fall on nursing staff'* (Wendy)

The perceived power differentials contributed to a unit environment where nurses believed there was an expectation that they compiled and documented treatment decisions into the Service Plan in the electronic system without the nurses overtly asking questions about this routine. After the treatment plan was decided upon at the multidisciplinary team meeting, the plan needed to be entered in the electronic system along with the Consumer Plan which should have been created by nurses in collaboration with the consumer. Other health professionals

contributed to hand written notes in the consumer's paper file but nurses were expected to maintain the documentation in the electronic system. This job was viewed as an administrative task and some participants gave reasons why they thought nurses were responsible for the compilation of the Service Plan. Mark thought that nurses needed to keep track of the different requirements in terms of reviews and the multidisciplinary care plan was part of this.

> *I think that it [the care plan] is developed comes down to the nursing staff. Because they are the instigators and the reminders of the time prompts. So there is a 90-day review, a monthly review or a review as a result of risk or an event which indicates risk. Does the care plan need to change and how does it need to change, because it is a fluid document? Does it change with the changing risk, the risks that affect that document and vice versa?….*(Mark, Interview 9, line 25-29).

Wendy on the other hand, pointed out that that the compilation of the documented Service Plan was a task that should be able to be carried out by all health professionals and not only nurses.

> *I think it's really, it's all of us, the whole health care team but in saying that there's a lot of duties that do fall on nursing staff and I can only probably compare it to risk assessment which we were told that….They're supposed to be done as a team, but nurses do it every shift independently which wasn't really what it was developed as (*Wendy, Interview 7, line 135-138).

Karen agreed with this and thought that the Service Plan should be a collaborative attempt. She added, however, that nurses are best suited to document and compile the Service Plan because they spend more time with the consumer and are involved in all aspects of care.

> *Definitely collaboratively, but I think nurses are in the best position because we can assess right from the medication through to you know the social components* (Karen, Interview 5, line 158-

160).....*Hopefully quite often the nursing input is closer to the mark because they literally seem to have more time with the client* (Karen, Interview 5, line 158-160).

Denise pointed out that the nurses had the lowest standing in the unit and were the professionals who were expected to fill in the Service Plan which she saw as a discrepancy.

> *In terms of values, so what I think I've been saying is that nursing as a profession is not valued, is not valued as a profession on an equal standing as allied health and yet nurses are expected to fill in the plan and social workers are not, there's huge discrepancy there* (Denise, Interview 1, line 259-162).

Denise explained she thought that for the plan to have validity all health professionals needed to document in the electronic system.

> *Unless it has been a collaborative approach then accountability is lacking, the responsibility is always delegated to the nurse to make sure that the care plan is on CBIS because allied health do minimal CBIS* (Denise, Interview 1, line 196-198)……*I think for that NCare Plan to have validity…it needs to be a collaborative attempt* (Denise, Interview 1, line 206-207).

Marion, a shift leader, thought there was a policy which outlined that all health professionals should be involved in the Service Plan, but she felt unsure about the documentation of it.

> *Yeah, every member of the multidisciplinary team is supposed to be involved in the care plan. Nurses are the only ones that do it and that's just the way it seems to be and it's something that we've struggled with for a long, long time, but nurses do the care plan* (Marion, Interview 2, line 102-103).

Marion said that she had tried to include other health professionals but that this initiative had been abandoned.

> *The original format that we actually did was [to have as] a heading for occupational therapists, a heading for medical, a heading for whoever else, social worker, put their spiel underneath it. And we did this big educational thing for people to, even if it's just a paragraph like just put any medical specific stuff in there, but they don't do it and that's probably their own time constraints* (Marion, Interview 2, line 115-120).

Hence the treatment plan that was decided upon during the MDT meeting, which had input of all health professionals, was documented by the nurses which meant that nurses were expected to carry out electronic documentation for other health professionals. Regardless of unit policies about care plans, all health professionals need to document their health care activities which constitute their part of the care plan. Consumer records are central to all health facilities. Ethically and legally all types of health care professionals have a responsibility to maintain an accurate record of health events for their consumers (Australian Government, Department of Health 2016). Consumer record keeping is an important part of any type of quality health care. Health professionals are obligated to make records for each of their consumers. The primary use of these records is for the treating practitioner and other health care professionals to ascertain the consumer's medical history and identify problems and patterns that may help determine the course of health care that should follow. The consumer health record is a legal document that records events and decisions which help the practitioner manage consumer care (Australian Government, Department of Health 2016). Taking this into consideration, there is an issue with health professionals not documenting their part of the electronic care plan, even if some documentation is present in the form of hand written progress notes.

The current practices with regard to the care plan in the inpatient unit might be related to the history of care plans. More than two decades ago it was the mental health nurse who was responsible for the development of the 'nursing care plan'

in inpatient units. The plan was developed in order to ensure continuity of care and communication across and between parties involved in providing care to individuals and their families. Nurses had a professional responsibility for the planning process. The nursing care plan was used as a legal record of an individual's care (Tunmore 2000; Townsend 2011).

Over the last two decades, changes have taken place in mental health services and the nursing care plan was replaced by the multidisciplinary care plan across all mental health services, including inpatient units. As a result of the consumer movement, consumers are more aware of their problems and diagnoses and today consumers and carer involvement is an accepted approach. An individualised plan needs to be completed by the multidisciplinary team in consultation with the consumer (Anthony & Crawford 2000; Crawford et al. 2000; Australian Government 2010; Bee et al. 2015b). The multidisciplinary care plan exists to assist a consumer with recovery and to facilitate the consumer, the service providers and the family and carers to work towards desired outcomes and increase self-esteem (Crawford et al. 2002; Australian Government 2010; McHugh & Byrne 2012; Bee et al. 2015; Grundy et al. 2016).

A multidisciplinary care plan needs the input of consumers, carers, the nurse as well as other health professionals to ensure a comprehensive plan. The mental health nurse was however regarded as the responsible person for the compilation of the entire plan. There was a lack of clinical leadership regarding issues of documentation and staff members, although expressing their discontent, did not formally challenge this situation.

5.5.2.3. NOT BEING HELD TO ACCOUNT

> *'The care plan doesn't get done, that's not SLS'd'* (Denise)

A lack in clinical leadership or leadership which did not focus on care plans, was also apparent when nurses or other health professionals were not held to account for absent Consumer Plans. First of all, the absence of the Consumer Plan in the multidisciplinary team meeting meant that nurses were not held to account for the existence or the content of the Consumer Plan. In addition, it was not clear who was responsible for checking the Consumer Plan and whether it had been completed according to an acceptable standard. There was not a generally accepted policy on how to report a substandard Consumer Plan and/or multidisciplinary care plan. There was no protocol that an absent or substandard multidisciplinary care plan would be notified through a Safety Learning System (SLS) report. The SLS user guide, outlines that the SLS system is an application that enables staff and the service to record, manage, investigate and analyse patient and worker incidents as well as consumer feedback. Mark explained the purpose of the SLS and how it should be used.

> *The Safety Learning System is not punishment, it is that learning system. It needs to be used as a system's approach to see why things were not done* (Mark, Interview 9, line 173-174).

The overall impression by the staff was that incomplete or out of date multidisciplinary care plans were not incidents and therefore need not be reported. Denise explained how other missed aspects of care were however entered into the SLS.

> *If you make a medication error there's a possibility that someone will write an SLS, put in, lodge an SLS, however if the care plan doesn't get done that's not SLS'd if that's the term. So that seems to indicate something about the perception of accountability involved in care planning, that's kind of 'oh well we've got to do that*

care plan, oh whoops, page 10, cut and paste' (Denise, Interview 1, line 223-226).

The lack of policy or protocol to notify an absent or substandard multidisciplinary care plan sent a message that the care plan was not a priority. It demonstrated that a care plan was not an aspect of care that needed to be worried about. The perceived widespread use of 'cut and paste' to complete such an important document is quite concerning as it indicates that health professionals think of accountability as a cut and paste exercise to feed the electronic system and meet basic requirements.

Power differentials and inter professional relationships led to documentation and compilation of Service Plans without direct written input from the various health professionals. This practice was reinforced by a lack of leadership as the practice of nurses documenting for other health professionals was not questioned. Leadership was also lacking in regard to accountability for the presence and quality of the Consumer Plan. Insufficient clinical leadership reinforced partnerships between health professionals which did not resemble best practice and contributed to substandard multidisciplinary care plans.

5.6. CONCLUSION

This chapter provided the results related to a practice of planning of care in one inpatient unit influenced by both the wider background of service directions in the state and the relationships within the multidisciplinary team. It was shown that the publication of a report and resulting government policies changed unit practices with regard to consumer care. A push to discharge and the increased acuity in the inpatient unit that followed, had an impact on the work morale of mental health nurses. The focus on discharge also led to a reduced priority for care plan development. Aspects of care that could result in an early discharge were viewed as more important. Nurses expressed dissatisfaction but were reluctant to speak

up in the formal and informal meetings as a result of perceived power differentials amongst nurses and staff members from other disciplines. As a consequence, perceived power differentials indirectly played a role as nurses did not include the consumer care plan in their limited handovers or introduced them in multidisciplinary team care discussions. Perceived power differentials impacted on nursing practice influenced also by a lack of clinical leadership with regard to the care plan. The lack of leadership was reflected in confusion about the content of the care plan and documentation expectations. This lack of clarity about the planning of care and its responsibilities had an impact on the care planning activities of mental health nurses.

The next chapter will examine the mental health nurses' role and identity and how this is played out in a practice of accountability in a unit environment with an overarching focus on risk aversion.

CHAPTER SIX FINDINGS: FINDING A BALANCE

'I've decided to send her to a closed unit to protect other patients…..however it's not going to do anything for her' (Marion)

6.1. INTRODUCTION

The accountability relationships that govern the lives of health professionals are complex because they must answer to a variety of stakeholders under an array of ground rules (Lerner & Tedlock 1999; Bergsteiner 2011). Accountability relationships are fluid and dynamic. As each party to the accountability relationship learns to anticipate the reaction from the other, subtle patterns of mutual adaptation can be observed (Lerner & Tedlock 1999). In this way the culture in an inpatient unit impacts on accountability enactment. Accountability was enacted by nurses as a result of distinct relationships amongst and between health professionals from various disciplines and as a result of accepted values in the organisation as a whole and the community.

6.2. OVERVIEW OF THE MAIN RESULTS

This chapter presents the findings in relation to the role and identity of the mental health nurse and how nurses attempt to find a balance in making accountability decisions. Therapeutic engagement in consumer care plan development mostly depended on expectations or situations that demanded or required reactive care which rendered the therapeutic encounter as a lower priority. The nurse was often seen as an extension of the medical staff which had an impact on practice and reduced opportunities for care plan development and therapy. Mental health nurses regarded the concept of accountability as closely linked to safety and had individual views on what constituted risk. Risk management and a risk averse environment influenced the enactment of accountability as staff practiced precautionary care which could restrict consumer's freedoms and consequently

lead to increased risks in the long term. In an environment preoccupied with risks most participants felt more comfortable with informal learning than with learning from mistakes via the formal Safety Learning System (SLS). This could lead to defensive practice. Accountability enactment for the consumer care plan confirmed an emphasis on avoidance of perceived errors and in attempting to circumvent adverse events. Aspects of care such as therapeutic engagement in Consumer Plan development had lower priority. In this complex milieu the mental health nurse tried to find a balance between the expectations of recovery oriented care and the requirements of the highly acute, medicalised unit environment.

The major themes identified include:

3. The current state of mental health nursing
    - Mental health nurse practice
    - Role and identity

4. Practice of accountability: care plans in a risk averse environment
    - Precautionary care
    - Finding a balance: therapy and control
    - Organisational learning

6.3. THEME 3: THE CURRENT STATE OF MENTAL HEALTH NURSING

The theme of the current state of mental health nursing explores the fact that the lack of inclusion of the Consumer Plan in team meetings was also influenced by well-intentioned paternalistic care and an assumption that unwell consumers did not have the capacity to be involved in care plan discussions. Furthermore, an exploration of the role of the nurse revealed a perception amongst some nurses that the provision of formal therapy was not supported by management (Figure

6.1.). This resulted from a culture in the inpatient unit with expectations that nurses took care of crisis management, which was now more visible in a highly acute inpatient unit. Mental health nurses were regarded as an extension of medical staff as they followed directions in the care of consumers and executed their treatment plan.

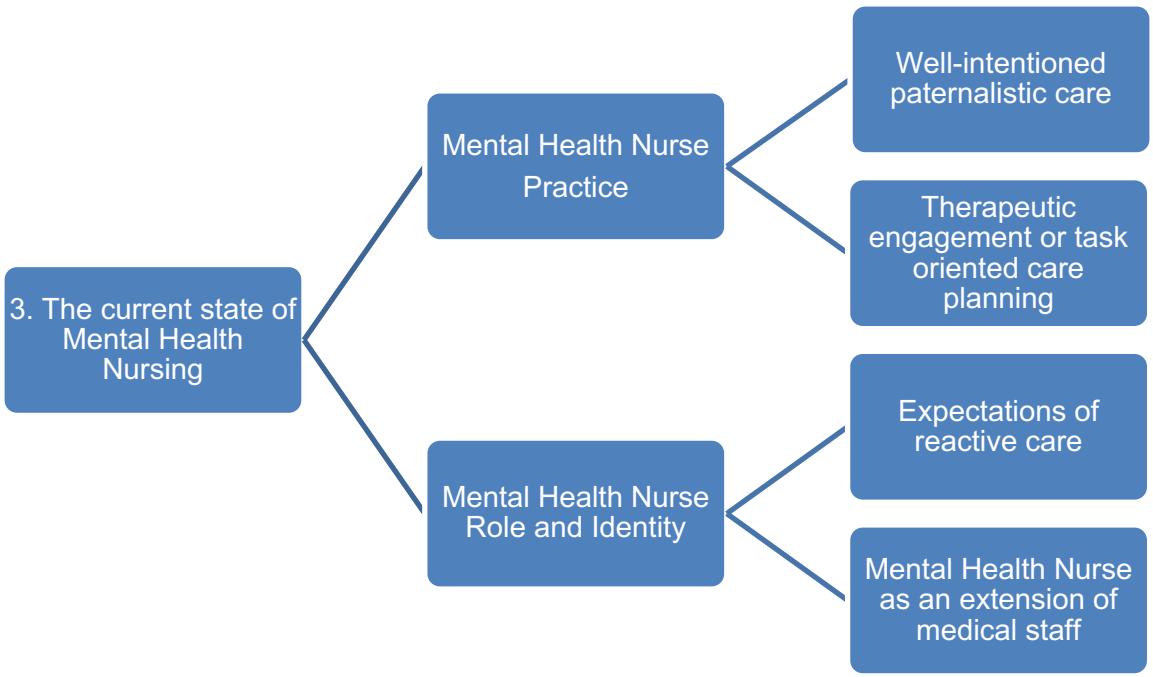


Figure 6.1 Summary of subthemes under the Theme 3: The current state of mental health nursing

6.3.1. SUBTHEME: MENTAL HEALTH NURSE PRACTICE

6.3.1.1. WELL-INTENTIONED PATERNALISTIC CARE

> *'It's really unfair to conduct a care plan for somebody who is unwell'* (John)

As outlined in Chapter five, the limited input of mental health nurses in care discussions in the multidisciplinary team meeting was the result of perceived power differentials and insufficient clinical leadership. The degree of nurses' contribution to multidisciplinary team meetings was also a reflection of the ambivalence of mental health nurses regarding the involvement of unwell consumers in the care plan and the perceived usefulness of care plan

interactions in those circumstances. This played a role in the nurses' reluctance to speak up in the multidisciplinary team meetings and insist on discussing the Consumer Plan. Interview data with two participants suggested that they were unsure about engagement with unwell consumers and how to negotiate a Consumer Plan (figure 5.3.).

John suggested a Consumer Plan should not be developed until the consumer was voluntary.

> *Well to me they are detained for a reason and it just tells me that the capacity and understanding or insight to mental illness is variable and I feel as though a care plan should not be done until a patient becomes voluntary* (John, Interview 3, line 61-63).

Marion questioned whether the inpatient unit was the right place to create a Consumer Plan as consumers tended to be unwell

> *I am not convinced that an acute inpatient unit is the right place to do it, I'm not sure. Sure I really struggle with that, like the consumers' sort of perspective of it because we do it with clients who are often really unwell and it's gobbledygook* (Marion, Interview 2, line 36-38).

I decided to explore these views further the next day when I saw John in the inpatient unit. Field notes (02.12.2015)

> JR: Would you think that the consumer is always able to participate in the care plan process?
>
> John: *No and I say this. When a patient comes from ED and comes into the unit, they are very unwell and we can normally see that whenever they come on the unit, trying to sit down with a patient who is quite psychotic is quite unrealistic. And trying to conduct a care plan, I feel as though that to me, I don't know, I don't know about anybody else I find it, it might be a little time consuming. Because the next day you have to go back and keep on going back.*

The patient might eventually say to you 'so why did you conduct a care plan when I was unwell? And the nurse would reply, 'obviously the answers you gave me indicated you were unwell'. And today, it could be different that's why some nurses keep participating with the same client every day to try to get enough for the care plan.

But I find that people who are quite psychotic get distracted, they become quite restless, they become quite angry, they become verbally abusive, and you could be in the way of being assaulted. I think it is really, really unfair, to conduct a care plan on somebody that is unwell. Somebody with depression, you may be able to do that, but especially people with paranoid schizophrenia I feel as though it should not be conducted as I feel they will become extremely paranoid about the questions you are asking and in fact what will happen….instead of you trying to be the primary nurse and looking after the patient, the consumer might say: now I don't want you because he starts getting paranoid. And you want to try to have a relationship. I find that you can also lose that therapeutic relationship with a paranoid schizophrenic. That's my take on it anyway. I don't know what other people think.

JR: When you say unfair, do you mean unfair for the consumer or for you as a nurse?

John: Unfair for the consumer as they are not fit enough to conduct an interview.

JR: You don't think that any client has a right to a care plan? Whether they are well or unwell?

John: I am not saying that. What I am saying is that it is really unfair to conduct a care plan for somebody who is unwell. For me and that is only me, it is really unfair. I don't want to be in harms' way of getting slogged by a patient. For example if it does happen and I am sitting there and trying to write something and it is not making sense. I find that……..I would say two days after consumers come in, you might see some sort of result where the patient is starting to be a lot more calmer and is able to do a care plan but not when they first come in. You may be able to do with some patients but not all.

On the one hand, John described the practice of continued engagement with the consumer and amending the care plan on a daily basis. He also acknowledged care plan discussions can help in determining how unwell the consumer is. On the other hand, John believed he would lose the therapeutic relationship if he attempted to develop a consumer care plan with a consumer who experiences psychosis which he views as unfair to the consumer. He is afraid this could lead to rejection by the consumer later down the track. In addition, John relates psychosis to restlessness, anger and verbal abuse and thinks there is a chance of being assaulted. Violence can be a presenting sign of consumers with psychosis in the development of aggressive behaviour especially in patients with first episode schizophrenia (Latalova 2014; Hodgins & Klein 2017). John's judgement on consumers who experience psychosis stood sometimes in the way of care plan discussions in the early stages of an admission. It is important for consumers with psychosis that health professionals maintain a personal rather than diagnostic approach, to be empathetic and authentic and to create a safe and supportive environment while supporting the consumer's autonomy (Green et al. 2012).

Developing a plan with an unwell consumer can build rather than destroy a therapeutic relationship. As the consumer recovers he or she knows the health professional is there to support them, regardless. The balance of power between the nurse and consumers shifts according to the degree of illness in a dynamic (therapeutic) process (Laugharne et al. 2011). There is a need to balance therapy and control and move from one to the other as the situation requires and John did not always feel comfortable with this. John implies he does not think he can successfully negotiate with a very unwell consumer.

Previous research demonstrated that consumers want to actively engage with treatment and regard the sharing of decisions with clinicians as a dynamic

process (Laugharne et al. 2011). Not all consumers are identical and would like to have the same level of input but encouraging consumers who want to actively share in decision making helps them to engage with services (Dwight-Johnson et al. 2001; Priebe et al. 2005). The balance of responsibility for decision making in the therapeutic relationship needs to have dynamic flexibility, taking into account the consumer's current condition while considering their experience (Laugharne 2011).

A form of well-intentioned paternalistic care could be observed which may limit autonomy or be contrary to the consumer's wishes. Two participants overtly discussed the topic of consumer involvement and engagement when unwell and thought that unwell consumers should preferably not be involved in the creation of their care plan. This might have resulted from these experienced participants having observed numerous unwell and psychotic consumers over the years. This resulted in a tendency to assume responsibility for the consumer and their wellbeing and to provide good care to promote mental health (Horsfall, Cleary & Hunt 2010; Pelto-Piri, Engstrom & Engstrom 2013). These mental health nurses believed that high risk consumers needed to be protected from themselves which included not being exposed to potentially challenging situations such as the process of care plan development. Consumers were expected to comply with decisions despite the fact that the mental health nurse might not have taken into account her/his specific needs and preferences.

6.3.1.2. THERAPEUTIC ENGAGEMENT OR TASK ORIENTED CARE PLANNING

> *'Nutting things out together'* (Karen)

Nurses had different opinions on the care plan development process and demonstrated a variety in skills and knowledge when they described how they

created a care plan. Without a *care plan* there is no *plan of care* resulting in a lack of consensus on the pathway to recovery. Health professionals, consumers and their carers need to be in agreeance and have knowledge on the purpose of treatment, what the aims and goals are and where the consumer's journey is heading as they move from illness to wellness.

Karen used the phrase 'nutting things out together' to describe consumer care plan development which implies that something challenging or a problem is resolved with everyone involved.

> *Definitely at the start of the admission, at the start of the presentation and if it's not literally done then I think there needs to be times where you're doing clinical reviews and you're sitting down with the client and another clinician so that you can really nut things out together* (Karen Interview 5, line 49-52).

Some participants struggled however to describe how exactly they developed a Consumer Plan with the consumer and how they engaged with consumers as they led the discussion while developing the care plan. At times remarks implied the consumer might not be involved in the first stages of the development of the Consumer Plan.

Andrew described how the Consumer Plan was handed to the consumer to have a look at. He indicated that consumers would fill in the plan by themselves and that the nurses' role was mainly an administrative one and consisted of typing the plan in the electronic system.

> *So what they do is they [the consumer] go through it [care plan] first, they don't all do it but most of the time because they haven't really got much to do here they'll actually cooperate. And they [the nurses] type it all up on CBIS and give them [the consumer] a copy* (Andrew, Interview 6, line 112-113).

JR: So they do the hand written plan first and then you type it up?

> *I've got to type it up. Sometimes you've got about sixteen pages and then after that you give them a copy, like when they go home* (Andrew, Interview 6, line 117-119).

John had similar views and left care plan creation to the consumer.

> *I'll give it to the patient, I would assess them but I let them try and do as much as they can. But I feel as though not many nurses encourage people to do care plans on the ward. I don't know, maybe it's too hard, time consuming, because what we do is give them the pack, we just give them the admission pack which involves quite a bit of paperwork but in there is the care plan and we just say 'forget the charts, just fill it out'. Well you know, we should be assisting them I feel if they've been detained, but I don't know what it is, it's part of an admission pack. We should be assisting patients in doing that but we just don't seem to do it'* (John, Interview 3, line 43-49).

John's implied he viewed the care plan as a task that needed to be completed as part of the admission process. He acknowledged the plan should be developed with the consumer but described a culture where because of a variety of reasons the nurses did not assist consumers who were left to develop their own plan.

Suzanne explained the care plan process and content is related to assessments including a risk assessment and ongoing evaluation which guides the consumer care plan. The consumer appeared to be absent in this process which was presented by the nurse as a series of tasks.

> *On admission, on the very first clinical assessment with a comprehensive assessment there's a risk assessment that goes in there that's an evaluation, a mild evaluation process and there's the very first guidance of what the plan is, and that then becomes part of the ongoing risk assessment* (Suzanne, Interview 4, line 68-70).

One participant stood out and demonstrated his skills as he described how he created a care plan with the consumer. Simon, who worked in the community as well as in the inpatient setting, described how a care plan could be developed but

that time constraints prevented him from doing this in the inpatient unit. His insights led to further discussions on the challenges of developing a plan in the inpatient unit for a consumer who is unwell.

> *When I am doing a care plan [in the community setting] I try to ignore the diagnosis as much as possible and ask them how are you, what are you about, what are the difficulties you know of, what would make life better for you and what would make life easy, do you understand that you have problems that with treatment could be improved and try to work within that* (Simon, Interview 11, line 52-55)..*I mean as far as really sitting down one on one and spending an hour or so with a patient to really get them to open up to you [in the inpatient setting] just haven't got the opportunity because there is always somebody else and that's frustrating for them and for me (*Simon, Interview 11, line 69-73).

JR: So when that's so difficult how do you then develop a care plan?

> *I try to be involved with every aspect of the treatment plan as it is, as in unit rounds and so forth when they're discussing that's one thing here in particular the unit rounds are quite good because you have all the disciplines all here together* (Simon, Interview 11, line 74-76).

JR: How do you involve the consumer when they're not present during the unit rounds?

> *That's a difficult one, it varies from person to person obviously….So you're not only looking at somebody who's got an illness but you're looking at what's their attitude, their attitude towards treatment, their attitude towards things that are happening, people around them, circumstances and do they have any sort of belief system that given the right opportunity, the right treatment and so forth life can be better. I mean that's the ideal and it can be rare to find but if you've got somebody, who has insight and that willingness to work and to trust and to do things a bit differently, then you can sit down and say right let's look at everything and what can we do to make it better*

> *for you. But a lot of the time you don't have that, a lot of the time particularly in a place like this, they don't want to be here…..*(Simon, Interview 11, line 83-93).

JR: So how do you get it right then doing a care plan for someone who is mentally unwell?

> *You have to just go by what you have seen work for other people, you have to know that if their lifestyles and behaviour are causing them difficulties and it's clashing and causing illness to become worse then you have to try and get them understand that, and then it also comes down to trust also, even if you're establishing a care plan with somebody who's not willing are they at least willing to say well alright I'll give it a go or are they just going to reject it* (Simon, Interview 11, line 97-101).

Simon acknowledged the restrictions of developing a care plan in the inpatient unit but continued to involve the consumer. He tried different approaches to maintain consumer participation and recognised the importance of trust in the therapeutic relationship between the nurse and consumer.

The purpose and the focus of the multidisciplinary care plan and the way the consumer is involved will vary but a care plan with consumer involvement is vital on the path to recovery (Laugharne et al. 2011). There was variety in the level of knowledge which may be a result of the quality of training on this aspect of consumer care. As mental health nurses go through their training, not a lot of attention is paid to the creation of meaningful care plans and practice on how to do this (Mc Hugh and Byrne 2012; Bee et al. 2015b; Simpson et al. 2016). Previous research supports the view that there are deficiencies in the educational preparation of mental health nurses generally (Fisher 2005; Stuhmiller 2005; Usher 2006; Happell 2009; Fisher 2014). If basic training in care plan development is absent in post graduate curricula at Universities, it will be challenging to acquire this skill later in the reality of the work environment. This

was demonstrated by the participants in this study who were all experienced mental health nurses, yet knowledge on care plan creation varied. The absence of training in care plan development also sends a message that perhaps this is not such an important aspect of consumer care in mental health services.

Therapeutic engagement and developing a Consumer Plan were seen by some as separate activities. This became apparent when Denise, one of nurses, commented on the fact she was not allowed to use her therapy skills in a formal way in the inpatient unit.

> *It doesn't matter what skills you have as a nurses working in a psychiatric unit, in…..you are not able, it is not acceptable for you to use them. Because you know I've done narrative therapy level 1 and 2 and I've done a bit of CBT…..*(Denise, Interview 1, line 211-213).

This quote indicates Denise did not see a connection between her knowledge of narrative therapy and therapeutically engaging with the consumer in the creation of a Consumer Plan. Care plan creation would be a suitable moment for Denise to utilise all the skills she acquired. It can also be argued that there is less focus on therapeutic engagement which leads to less therapeutic practice. The role of the mental health nurse appears to have shifted from interpersonally relating with consumers to a role which is dominated by excessive paperwork, patient observation, custodial care and risk management (Slemon, Jenkins & Bungay 2017). This had an impact on Consumer Plan development.

In summary, nurses who were expected to enact individual accountability accepted substandard Consumer Plans which was partly a reflection of their ambivalence about involvement of unwell consumers in their care plan. This ambivalence can be explained by a tendency to enact paternalistic care to protect the consumer and a lack of understanding of possibilities of therapeutic

engagement in care plan development particularly with consumers who were unwell. This became more apparent in an increasingly acute unit environment. In addition, the care plan was not always viewed as an important aspect of care provision which resulted partly from a lack in education and limited understanding that therapeutic skills are required and need to be utilised in care plan development. A lack of training may also communicate the idea that care plan creation is unimportant and result in an undervalued part of care provision.

6.3.2. SUBTHEME: ROLE AND IDENTITY

6.3.2.1. EXPECTATION OF REACTIVE CARE

> *'I thought you've got some skills but she is only allowed to use them in an ad hoc way'* (Denise)

While exploring the context around care plan development participants shared their impression of the position of the nurse in the mental health unit. The role of the mental health nurse, including the nurses' perception of their role, defines and influences their identity (Hurley, Mears & Ramsay, Hurley 2009). Participants spoke about the position of the nurse as someone who is preoccupied with reactive care rather than including therapy in daily work activities.

Denise described the role of the nurse and explained that health professionals had 'discreet roles' and that the role of the mental health nurse in the inpatient unit was not around therapy, despite the education and training they might have undertaken.

> *So everybody has very discreet role, nurses have a role and so the nurses themselves, their identity is around what they do on the unit and because a lot of them have never done anything else, they don't see outside that. They wouldn't think 'oh Denise got a Masters in music, she could run a music and relaxation group', and they wouldn't be supportive of me doing that because then they would*

> *have to look after my group [of patients] and that would be a nuisance. That would be a burden on them, because it's not supported by management, it's not supported by the people that make the rules, the politicians. Because I really think that the system that we're working in at the moment is run by politicians and the clinicians including senior medical staff are really just puppets and the decisions that they make as far as I am concerned, some of them lack accountability* (Denise, Interview 1, line 126-135).

Denise explained how the majority of mental health nurses had been pre occupied with general care provision for most of their careers and therefore found it challenging to imagine themselves in the role of therapy provider. In addition, Denise believed that colleagues would not support her doing group therapy as this would result in the need for another nurse to care for her consumers during that time. This, however, is directly related to the actions of management. Senior management play a crucial role in facilitating therapy through accommodating this by employing sufficient staff members thereby creating availability of time and opportunity. The responsibility for the provision of psychosocial interventions is therefore mutual and both managers and mental health nurses have a role to play (Mullen 2009; Fisher 2014).

Mental health nurses were often at the forefront and dealt with crisis situations which resembled reactive practice. An example was given by Marion who described very challenging circumstances the nursing staff had to deal with.

> *So we had a fire on the unit last night with a client (K) with borderline personality disorder who also has got schizophrenia. Sometimes she is psychotic, sometimes, she's not. Sometimes she's very borderline. She lit a fire last night. We are trying to discharge her at the moment and we are specialling her by sending her to a closed unit. I know that specialling her is going to make her worse and is not going to achieve anything in the long term trajectory of her mental illness and her borderline structure. However, I'm*

> *accountable to other clients and she actually burnt a huge hole in a floor last night and the whole building had to be evacuated. So what happened was she locked herself in the bathroom, she lit a fire just inside the bedroom door, the nurses had to go into a smoke filled room with fire and extract her from the bathroom, because she refused to come out. They [nurses] put themselves at risk in terms of smoke inhalation, they're okay but they put themselves at risk. Other clients were traumatised because they were woken at 11:30 at night with a fire alarm and they knew it was a real fire because they could see smoke and flames and there's a lady on the unit at the moment who is here pre-dominantly from post-traumatic stress from the recent fires up North* (Marion, Interview 2, line 141-156).

This description of an acute and unpredictable unit environment demonstrated how there were few opportunities for the use of formal therapy by mental health nurses. Best practice guidelines for consumers, who experience emotion dysregulation and have a diagnosis of borderline personality disorder, indicate very short hospital admissions, preferably not lasting more than 24 hours and therapy (McMain et al. 2009). However, as a result of the increased acuity in the inpatient unit there was limited scope for the health staff to look at different options. The role of the mental health nurse consisted of custodial and reactive care to limit and reduce risks and keeping staff and consumers in the inpatient unit safe but left little room for formal therapy. This testimony also demonstrates the dilemma Marion struggled with as she was aware that she is accountable for all consumers in the inpatient unit and therefore had to forego appropriate treatment for the consumer with borderline personality disorder.

The expectation that mental health nurses undertake reactive care, which often meant dealing with crisis situations at the forefront, appeared to be firmly established in the inpatient unit. Circumstances and culture in the unit informed the outcome of dilemmas nurses dealt with, as seen in the example above where Marion decided to 'special' a consumer with borderline personality disorder

although this is not the preferred treatment for consumers with this diagnosis. Some participants such as Marion felt powerless to break the cycle. This impacted on how mental health nurses saw themselves and to some nurses this led to an unfavourable opinion of the profession of the mental health nurse as was illustrated by the earlier comments made by Denise.

6.3.2.2. MENTAL HEALTH NURSES AS AN EXTENSION OF THE MEDICAL STAFF

> *'I'll just use the word drone, we are the drones'* (Denise)

As nurses focused on and provided what appeared to be mostly reactive care they concentrated on tasks and ensured they were completed. Denise described how she believed that all the tasks in the end filtered down to nurses who were expected to deal with anything that came their way.

> *But because the nurses are at the bottom, no patients are at the bottom of the hierarchy, but the nurses are on the second bottom rung and so all the jobs filter down to them* (Denise, Interview 1, line 208-2011).

Denise saw mental health nursing as a profession entangled with other professions. This resulted in an expectation that nurses act as a 'jack of all trades' as they employed many different tasks ranging from medication administration and computer work to dealing with crisis situations and giving out meals

Participants described their role and function on the unit as being engaged with the execution of the treatment plan created by the medical staff. Sam described her daily routine from the moment she started her 12 hour shift.

> *Before 7 am you get in there and have a look at who you have got. Generally the handover starts to happen so then I'll spend a bit of*

> *time having a read about people and certainly if there's someone I don't know. But then often that's about 07:30, then I'll try and have a look if any of my clients are up and about. Then go up to breakfast and generally that's when the medications are given…..So in this ward I give my own medications* (Sam Interview 8, line 42-47). *…then there'll be the handover at 09:00, so depending on where you are it means you need to plan if one of your clients have got any appointments. They've got to go off somewhere or they're going to ECT, you need to be mindful of that (Sam, Interview 8, line 50-52). ….you're never quite sure how the day's going to pan out. I generally try and organise an activity in the afternoon, often I do the hand cream or I might take a group for a walk* (Sam, Interview 8, line 56-58). *…most of the doctors have gone by the afternoon so there's bit of a lull there* (Sam, Interview 8, line 60). *….I always try to get the paperwork done, the computer work done which is often hard to do because there's only a few computers* (Sam, Interview 8, line 64-66).

This account of the day in the inpatient unit suggested the mental health nurses' role revolved around medication administration, assisting in daily tasks and keeping appointments, paper and computer work and surveillance of consumers with varying degrees of mental illness. Nurses dealt with and executed the management plan mainly laid out by the medical staff. Sam's observation that after the medical staff left the unit there was not much happening, which she described as 'a bit of a lull', is quite revealing as it suggests that only activities provided with medical staff needed everyone's attention and therefore added to the overall busyness of the unit.

Mark confirmed a close alignment with the medical staff as he explained how it was up to the nurses to enforce the treatment plan if the consumer did not agree.

> *But again we have got clients here who don't agree, who don't take medications, would abscond and would be a risk to themselves and*

> *others so sometimes it has to be 'this is what you are going to do. This is what is going to be'….*(Mark, line 68-71).

He pointed out how the nurse at the coalface had to take charge and carry out a plan developed by the medical staff sometimes against consumers' wishes. The nurse needs to carry out treatment determined by someone else which can cause dilemmas if the nurse questions the decisions made. The nurse is at the forefront of care provision and deals with the consequences of medical decision making.

The fact that the mental health nurse was expected to deal with administrative aspects of inpatient unit admissions also contributed to the impression that the mental health nurse's job was an extension of the medical staff. Psychiatrists decided on admissions and discharges which resulted in computer and paperwork which mental health nurses were expected to complete. Medical staff sometimes did not have access to the electronic system to complete this themselves.

> *I've come across instances where doctors don't even know how to get into the electronic systems, so they haven't got a password and I think everyone needs to access regardless of whether you're a social worker or the registrar or the consultant* (Karen, Interview 5, line 164-166).

It is telling how some of the medical staff were allowed to work in an inpatient unit without access to the electronic systems. This is an indication how much the medical staff relied on mental health nurses to ensure the necessary computer documentation had been completed.

Andrew described how the job of the mental health nurse had become a largely administrative job.

> *It's just repetition, you know the admission sheet used to be one sheet, one page and everything was on there, including MSE that you did yourself as nurses. Well now it's all CBIS, it's just huge amounts of typing and carrying on, …and not everyone uses it that's the other issue (Andrew, Interview 6, line 22-25). …..They do here but a lot of other places don't use CBIS so there's a lot more photocopying, faxing, all this sort of carry on where it just takes hours. The actual procedure to be in contact and the observations etcetera, it takes about five minutes, but CBIS takes a long time especially if it's the first one [admission]* (Andrew, Interview 6, line 26-30).

JR: So why do you think that this has happened? Why do you think there's such a focus on paperwork?

> *Well I don't know. I think it's nursing in general. It just seems to have gone that way* (Andrew, Interview 6, line 46).

Andrew's insights about the increased paper and computer work pointed towards a shift in the role of the nurse from mainly interpersonal activities relating with consumers towards one dominated by excessive administrative tasks.

The dependant role of the mental health nurse became self-evident when Denise described the nurse as a 'drone'.

> *How can I put his, as nurses we understand what we are accountable for, but we operate, I'll just use the word drones, we are the drones and other people, other members of the multi-d team would see their accountability as more important* (Denise, Interview 1, line 230-232).

A drone is an unmanned aerial vehicle operated by a controller and that is how Denise viewed the role and identity of the nurse, as a health professional who is directed and steered by other health professionals. Denise had undertaken studies in CBT and had acquired a masters in music and relaxation and she recognised other nurses who she thought had done the same. However, it will

take more than individual nurses acquiring training to enable them to use the skills and knowledge required for therapeutic interventions. As long as the model and processes of care provided in the inpatient unit supported the view that nurses are attached to and complementary, but subservient to medicine (Barker 1989; Buchanan-Barker & Barker 2008; Hurley 2009), it is likely the role of the nurse will remain largely around crisis intervention and supporting the medical staff in enacting treatment plans.

6.4. THEME 4: PRACTICE OF ACCOUNTABILITY: CARE PLAN IN A RISK AVERSE ENVIRONMENT

Under this theme the practice of accountability is explored in the context of consumer care plan creation (Figure 6.2.). The concept of accountability was closely related to safety, as enacting accountability was thought to enable the consumer's security through risk prevention. Awareness of accountability obligations as well as the notion of accountability was viewed as a safeguard. There is however a subtle distinction between adhering to standards and policies and therefore facilitating consumer safety on the one hand, and the provision of care that resembles restrictive practice on the other hand. Increasingly it is argued that restrictive interventions may not be safe and inflict harm (Brady et al. 2017; Slemon, Jenkins & Bungay 2017).

Participants believed that safety was related to care provision while risk was viewed as originating from the consumer. To mitigate risk mental health nurses provided precautionary care but in the process demonstrated a potential to restrict consumers' freedom which could lead to excluding consumer from the care planning process. Consequently, the delivery of 'safe care' could lead to increased risks in the long term as consumers' skills were not developed to deal with challenging situations in the future. In an environment preoccupied with risks

originating from the consumer, only one participant viewed the Safety Learning System as an opportunity for nurses to learn from mistakes and consequently reduce risks in care provision. Other participants did not feel confident with the concept. A focus on consumers' safety was observed in an environment where nurses did not feel safe themselves to learn from errors. Not feeling comfortable with learning from mistakes can lead to an overarching focus on avoidance of errors or adverse events and the use of risk management strategies. This in turn can result in restrictive care and exclusion of consumers in care plan creation.

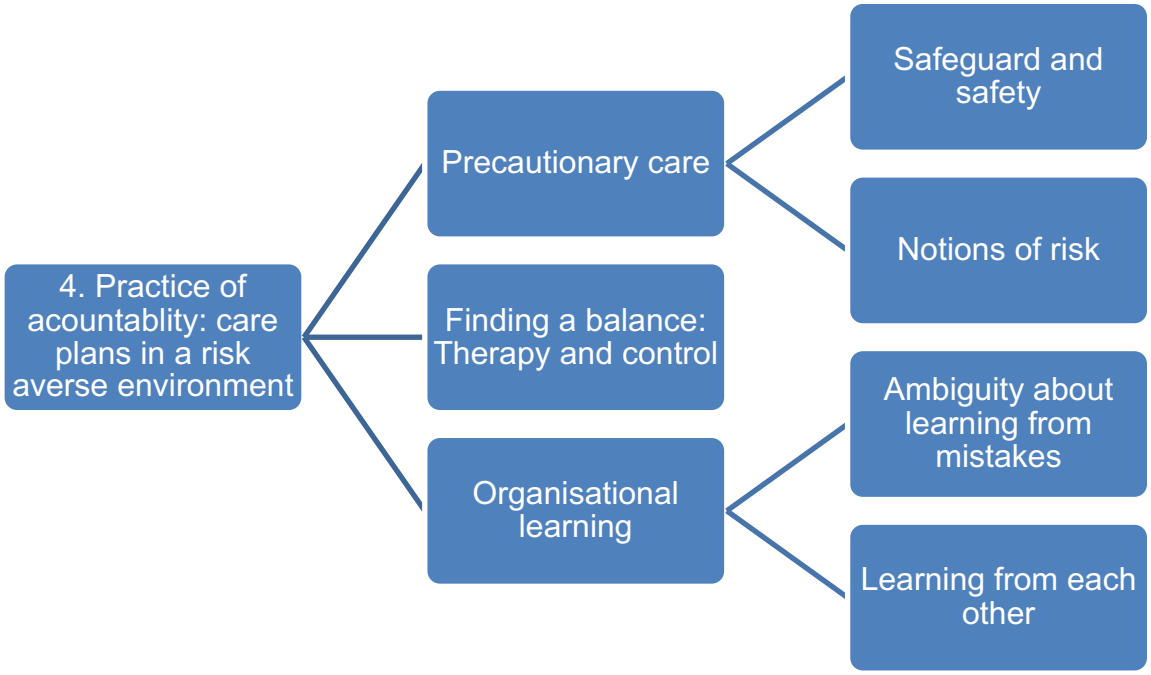


Figure 6.2 Summary of subthemes under the Theme 4: Practice of Accountability: Care plans in a risk averse environment

6.4.1. SUBTHEME: PRECAUTIONARY CARE

6.4.1.1. SAFEGUARD AND SAFETY

'It's about doing the right thing' (Karen)

Accountability was regarded in the context of standards and the need to follow standards to ensure the execution of accountability. Participants thought that accountability was linked to the provision of high quality care which was facilitated by following all the relevant guidelines and standards.

> *It's complicated isn't it, it's complicated but it's simple……..I suppose for me in a nutshell what accountability means is that there are professional standards to which I adhere that make me answerable for the decisions that I make about the care of another person and it means that I am accountable……*(Denise, Interview 1, line 186-189).

In the context of standards of care, consumers' safety was on participants' minds when they spoke about accountability. Ensuring the safety of consumers was viewed as an accountability obligation.

> *And can I say this because in my experience over the last fifteen, twenty years of working in highly acute units we have an accountability to keep clients safe* (Suzanne, Interview 4, line 195-196).

Sam also spoke about the pressure to determine the safety of a consumer when she discussed accountability.

> *It means that I've looked after somebody, I could be asked why did I make a decision to do something or was I aware that this person wasn't safe to go out. That I can justify what my actions were. Like you say it's something we talk about, but what do you really mean by it. I guess that I could justify whatever my actions were or whatever at any time that I've been there, be able to say what I've done and why I've done it, you need to be able to say why you've done something and the reasons for it* (Sam, Interview 8, line 143-148).

Simon views the notion of accountability and mental health nurses' awareness they are going to be held to account as a safeguard for quality care.

> *I think it's a safeguard for the patient and for everyone…that people are aware that they are going to be accountable for what the outcome is and if anything goes wrong then human nature is that if we realise that that is the case then we are going to do a better job because of that. I mean that shouldn't be what drives a person to do their work but it's certainly a safeguard that certain protocols and procedures will be done the way that they should be done* (Simon, Interview 11, 140-145).

He regards the concept of accountability as an incentive for nurses to improve their practice. Accountability is regarded as a safeguard that certain procedures and protocols are adhered to as required as nurses' provision of care will be measured against this.

Karen displayed similar beliefs when she mentioned that accountability is all about 'doing the right thing'.

> *I think it's about doing the right thing, that's one of the first things. It's about doing the right thing for the consumer, doing the right thing against your professional standards and the organisation, you know the Nurses' Board and so on* (Karen, Interview 5, line 144-146).

Awareness that mental health nurses are held accountable in the case of an adverse event may however lead to practice that is focused on avoiding mistakes and a tendency to be overly cautious which impacts on consumers' care. An overarching focus on safety to protect the organisation and its employees from litigation can lead to conservative or defensive practices and a restriction of consumers' freedom to avoid blame if something untoward were to happen. This might reduce health professionals' anxieties but is perhaps not beneficial to a consumer and their treatment (Mullen; Admiraal & Trevena 2008; Slemon, Jenkins & Bungay 2017).

Asking the right questions about 'safety' and whether planned treatment is justified can therefore be regarded as part of accountability enactment. Mark

explained this further when he said accountability can mean disagreeing with everybody else. Doing this and speaking one's mind in the face of recovery might enable safe care.

> *Accountability is at times standing up for the patient and disagreeing despite what everybody else says. Or you have an opinion which needs to be put forward. It's an opinion, it's about not being a shrinking violet, it's about 'okay I need to say this'. It may get overruled, but I need to say this. And then it needs to be recorded. It is part of that care* (Mark, Interview 9, line 162-165).

Mark believed it was vital to express an opinion in the context of accountability enactment even if others would disagree. This ensures discussions and the inclusion of everybody's knowledge in the decision making. Nurses need to be accountable and act in the consumer's interests and need to be able to explain and justify why (Walsh 2000) and this sometimes means disagreeing with other health professionals.

Accountability was viewed in the context of safety as participants thought that enacting accountability would facilitate safety for the consumer and accountability itself was viewed as a safeguard. Practices underpinning the value of safety using risk management strategies as the guideline in nursing care can however result in restrictive practices such as involuntary treatment, seclusion and restraint. These strategies can possibly resemble unsafe care as consumer perspectives have demonstrated harm (Leamy et al. 2011; Slemon, Jenkins & Bungary 2017; Australian Institute of Health & Welfare 2018). The dominance of the safety discourse obscures the often physically and/or psychologically harmful nature of nursing practices designed to maintain safety (Valenti, Giacco, Katasakou & Priebe 2014; Slemon, Jenkins and Bungay 2017). In this context it is important for mental health nurses to be assertive and challenge controversial decisions if they believe consumer safety is at risk. Providing safe care and

enacting accountability is then about being courageous and voicing an opinion. This can be challenging and at times uncomfortable especially if senior staff, management or medical staff do not agree. Within the inpatient unit nurses can use recovery-oriented approaches to support consumers in increasing responsibility for self-management of medications and symptoms thus facilitating long term safety (Leamy et al. 2011). What will increase safety is connecting and collaborating with the consumer, assisting them to develop coping and problem-solving skills, increase hopefulness while strengthening interpersonal connections (DeSantis et al. 2015). This can occur in care planning activities. Hence, decisions on consumer safety can be controversial and mental health nurses must not take this lightly.

6.4.1.2. NOTIONS OF RISK

> *'It's that thing of the Mental Health Act of client of risk to themselves or others'* (Mark)

Closely related to safety was the notion of risk and then mainly risks originating from or created by the consumer, not risks linked to the care provided by the health professional. Participants did not pay attention to risks in terms of adverse events in care such as poor communication, medication errors, or the side effects of psychotropic medications but focused on possible harm originating from the consumer such as harm to self or others. Suzanne discretely assessed consumers in the context of risk and safety from the moment she entered the inpatient unit.

> *Well for me I believe, certainly assessments are happening on different levels all the time and from the moment I walk in the door there's a radar going on, not fully out of control but sensing the status quo, receiving information, seeing people that maybe I haven't met before and being aware and having knowledge base to know this doesn't look safe then there's an accountability straight*

> *away. So there's a level of assessing all the time on different levels so the accountability is certainly not going past something that I perceive as being unsafe or compromising to other people or the client* (Suzanne, Interview 4, line 174-179).

Managing unsafe situations in terms side of effects of pharmaceutical treatment or communication errors was not part of Suzanne's assessment of risk.

Likewise, according to Mark, accountability was linked to the Mental Health Act and the risks the consumer posed to themselves or the public.

> *The accountability for the client, those around them, yourself, in some cases the wider public, depending upon risk. It's that thing of the mental health act, of client of risk to themselves or others. That is the main driver for somebody being detainable as well as mental illness there. We have to look at the whole structure how we provide that care. That accountability is what we do as practitioners to provide appropriate care, safety, planning, for the client family or self, the services, the general public. It's the key thing of keeping overall practice up to date* (Mark, Interview 9, line 115-122).

Mark's idea of accountability revolved around the legal aspects of care and in particular the mental health act as he referred to consumers creating risks to themselves or others. Risk was regarded as originating from the consumer while safety was linked to care provision.

The fact that Mark believed he is accountable for the safety of the public demonstrates his perception on the far reaching consequences of accountability enactment. Unlike other hospital environments, within mental health inpatient settings consumer risk is perceived as affecting not only the individual but also other patients, staff and the general public which widens the sphere of risk (Slemon, Jenkins & Bungary 2017). It is often the wider public who worry about the risks involved with mental health consumers which impacts on nurses as they do risk assessments. The public are however often unaware of the fact that

medications and hospitalisation do not cure mental health problems and that coercive interventions can only be a measure of last resort (Wand 2017). Restrictive practices are known to have detrimental effects on the mental health and wellbeing of the consumer and are therefore potential risks in themselves. They have the potential to build resentment towards mental health services (Wand 2017).

The impact of a risk aware and adverse environment was also apparent when Marion demonstrated she was preoccupied with emergency situations, risks and maintaining safety.

> *If there's an emergency situation I'm accountable, being shift coordinator I've got the responsibility to manage the situation but I'm also accountable in terms of, I'm accountable to the other patients to make sure they're all safe. I'm accountable to the staff members to make sure that I've covered the organisational risks and responsibilities, I'm accountable to myself to make sure I'm okay. Yeah, it's just how I sort of see it like in a way the buck stops with me. It doesn't really because I've got people above me but you still like the buck stops with me. I can't actually just ignore anything I've got to tie it all together and make sure it's all done* (Marion, Interview 2, line 131-138).

Marion saw herself as being accountable for managing emergency situations as she explained how she had to maintain safety for consumers. Carrying responsibility for the safety of consumers and the organisation weighed heavily on her mind. She felt she carried ultimate responsibility if something untoward were to happen in the inpatient unit and that everyone would look to her for a correct judgment and action.

As Marion pointed out, mental health nurses in leadership positions feel pressure to make decisions which ensure the wellbeing of everyone. Sam referred to what

could happen if negligence had occurred in the eyes of the organisation and the wider community.

> *And as happened a person went home and no one really realised how sick that person still was, he committed suicide. Well see there's a whole group of them now going to have to go to the Coroner's Court because nowhere in there it is documented that anyone thought this person was at risk. Lots of people thought he was, but it wasn't documented anyway, it was verbalised but not documented because I guess nobody wanted to take responsibility* (Sam, Interview 8, line 163-167).

Sam spoke about the consequences of failing to document risks. It is interesting Sam believes that staff failed to document the fact that the person was at risk because they did *not* want to take responsibility. This could be linked to Sam's appreciation of an organisational culture of fear and blame and a perception that if the level of risk was documented and an adverse incident were to happen the finger would be pointed to the person who was responsible for the risk documentation or whoever was responsible for the discharge. Although a 'no blame' policy is in place in public mental health services in Australia (Government of South Australia, SA Health 2017) it appears a culture of blame exists around the assessment and management of risk in mental health services. Perceptions of failure and criticism from the media and the general public impact heavily on decision making by individual nurses and the organisation resulting in high levels of risk adversity that can be harmful to both clinicians and consumers (Morgan 2007). There is a widespread fear and anxiety about the wider consequences of a negative consumer outcome (Krawitz & Batcheler 2006) and mental health nurses and clinicians are fearful of legal reprisal and of being called to appear at a Coroner's inquest (Wand 2017).

Wendy pointed out that the risk assessment and management was a task the whole team should take responsibility for, but which was now generally viewed as an activity primarily undertaken by mental health nurses. This had consequences for the role of the nurse in the recovery model.

> *But in saying this, there's a lot of duties that do fall on nursing staff and I can only probably compare it to risk assessments which were tools that were brought on, which were supposed to be done by the team. …[However] nurses do it every shift independently, which wasn't really what is was developed as. Ideally again, everyone should be looking at….seeing it and bringing it up* (Wendy, interview 7, line 135-139).

This demonstrates how the role of the mental health nurse in the inpatient unit was shaped and how nurses were expected to deal with care and risk at the coalface, while being supportive of decisions made by the medical staff. The mental health nurse in the role of consumer advocate in the recovery model was however responsible for surveillance and weighing up risks through their role as risk assessor. A 'high risk' assessment could potentially reduce the freedom of consumers, therefore impacting on recovery.

Nurses undertaking constant observation of consumers assessed as being at risk often do this to protect themselves against legal action in the event of an adverse outcome (Mac Kay, Peterson & Cassels 2005; Slemon, Jenkins & Bungay 2017). Close observation can be regarded as a defensive practice in itself with the goal of maintaining physical safety of the consumer and protect the nurse from litigation as opposed to promoting therapeutic engagement or addressing the underlying suicidality (Cutcliffe & Stevenson 2008). This detracts from meaningful treatment and consumer care planning. Mental health nurses felt pressured to eliminate risk, which resulted in limiting the freedom of the consumer to the point that appropriate treatment was not prioritised.

This is exemplified by Marion who described her dilemma in caring for the earlier mentioned consumer with Borderline Personality Disorder.

> *So with L who I know, I've actually specialled her at the moment and she's on the list for a closed bed, it's not going to do her any good, however I've got a responsibility to other patients to make sure that they're safe…So yeah this is complex, like I have decided to special her, I've decided to send her to a closed unit to protect from other patients, to protect staff, however it's not going to do anything for her, [but] on balance that was the decision that was made, so yeah, it's complex* (Marion, Interview 2, line 163-165).

Marion felt the need to initiate a transfer of the consumer to a closed unit to protect other consumers and staff. She acknowledged this move would be counter therapeutic and would not assist in the consumer developing skills as part of the consumer journey. Priority was given to containment and the overall running of the unit to the detriment of the consumer who might have benefitted from therapy, given her diagnosis of borderline personality disorder (McMain et al. 2009).

In summary, nurses provided precautionary care in accountability enactment. A safety discourse however had the potential to obscure and lead to harmful risk management strategies. A focus on risk originating from the consumer and fear for adverse incidents and negative consequences led to pressures to eliminate all risks which can resemble unsafe care. It is an accountability obligation for nurses to be assertive and challenge each other on potentially harmful practices.

6.4.2. SUBTHEME: FINDING A BALANCE: THERAPY AND CONTROL

> *If the care plan is coming from the client's side and from the services side, those points don't always agree* (Mark)

Care planning and therapeutic relationships might also have been influenced by a tension between therapy and control which is part of daily practice of the

mental health nurse. With an increased focus on discharge, increasingly consumers in the inpatient unit were detained under the Mental Health Act which resulted in a higher level of control exercised by health professionals. The challenge was then to provide therapeutic care for consumers who did not believe they needed to be in hospital. In an increasingly acute and unpredictable inpatient unit with more detained, unwell consumers, it was a challenge for nurses to balance therapy and control.

> *If the care plan is coming from the client's side and from the services side, those points don't always agree and there is negotiation that needs to be there as well. Again the care sometimes needs to be ….dictated, for example if someone is on a CTO [Community Treatment Order] and lack of insight, a lack of ability to comply is here and the risks and the safety of others in there (Mark, Interview 9, line 17-21).*

Negotiating and dictating appear to be in contrast with each other and demonstrate the difficult position the nurse is in and the dilemma this sometimes creates. The mental health nurse who is expected to negotiate with consumers in therapeutic engagement is also cast in a role where they must enforce care. Partnerships between the mental health nurses and consumers can form the basis of the care provided and will work well if they can discuss the various options and decide together on a course of action. This consensus is not always easily achieved in the acute inpatient unit. There are times when consumers are denied a choice and are told they must comply with nurses or the multidisciplinary team's decision they might not agree with. In such a situation the possibility of consensus in the relationship is precluded.

There appeared to be a tension between nursing duties and responsibilities in relation to compulsory care facilitating consumer involvement with choices documented in a Consumer Plan (Cleary 2003). On the one hand, nurses are

expected to enforce aspects of care while on the other hand they should advocate for consumer presence and collaboration in the multidisciplinary care plan development. The nature of mental illness means that it is nurses who at times override consumer's wishes in accordance with nurses' responsibilities (Crowe et al. 2001; Cleary 2003). Nurses work at the coalface of mental health services in an inpatient unit and the mental health nurse needs to enact treatment sanctioned by the Mental Health Act and initiated by the psychiatrist.

Achieving the therapeutic balance between beneficial intervention and consumer choice is the basis of many ethical tensions in mental health nursing. In this environment, with ethical issues in mind mental health nurses are expected to sit down with consumers and collaborate on consumer care plans. For nurses balancing therapeutic obligations with the requirement to maintain institutional order and control provides a challenge (Cleary 2003; Stevenson et al. 2015). These two functions are however not mutually exclusive and nurses' attempts to maintain consumer's safety against their wishes can be more acceptable to the consumer when they involve a respectful conversation on an equal level (Cleary 2003). On the continuum between illness and wellness health professionals and consumers can work together and move from less consumer control to more consumer control while collaborating each step of the way.

There are two things happening here simultaneously. On the one hand, Consumer Plans which should have been developed between the nurse and the consumer, were not discussed in the multidisciplinary team meetings. This was not challenged by nurses. On the other hand, it was in the multidisciplinary team meeting where decisions were made on a treatment plan for consumers with a (co created) heavy input from doctors, who relied on nurses to enforce this treatment. Because of the nurses' continued presence in the inpatient unit, nurses needed to execute control when consumers displayed high risk

behaviours. Nurses needed to use control and power to put into practice the decision often made by other health professionals. In this environment it is a challenge for nurses to provide choices when control needs to be exercised or to spend adequate time with consumers to explore alternatives (Kuzub & Skidmore 2001). Nurses needed to balance accountability to other health professionals when care needed to be dictated with accountability to the consumer and their wishes. In an increasingly acute and medicalised environment nurses perceived psychiatrists' decisions as all important as unit expectations informed that psychiatrists' treatment plan needed to be executed. Nurses viewed themselves as lower in rank and sometimes found it difficult to take the therapeutic relationship into account when control needed to be exercised

Observations during multidisciplinary team meetings and clinical handovers confirmed that care was focused on symptom management and reduction and risk minimisation. The Mental Health Act, the use of inpatient treatment orders and application for community treatment orders (on discharge) were the topic of conversation during all meetings to assist psychiatrists in the treatment of consumers who were refusing medications or other treatment (Field notes, 17/08/2015, 01/09/2015, 14/09/2015, 22/09/2015, 29/09/2015, 13/10/205, 27/10/2015, 24/11/2015, 30/12/2015). Medications compliance was often debated and during one of the multidisciplinary meetings a mental health nurse stated:

> *'I told her we were going to jab her if she would not take the orals* (Field notes 14/09/2015).

This can be interpreted as a mental health nurse supporting treatment decisions made by the medical staff and aligning with psychiatrists by using a verbal threat. In addition, electro convulsive therapy was discussed during most meetings as an option for consumers. Even if consumers did not agree to this treatment (Field

notes 01/09/2015, 14/09/2015, 22/09/2015, 29/09/2015, 13/10/2015, 27/10/2015, 24/11/2015).

The processes around the introduction of the antipsychotic medication clozapine was also a regular topic of conversation. Clozapine is currently prescribed to consumers who have failed to get adequate benefit from at least two trials of other anti-psychotic medications. Clozapine is a third resort because of concerns that the use as a first-line agent would lead to greater mortality, mainly through agranulocytosis (Wang et al. 2004; Stroup et al. 2016). Medical staff regularly considered clozapine, as this could assist in managing negative symptoms of schizophrenia. Research showed that the introduction of clozapine can result in a reduction of hospital admissions which was a relevant issue, given the local health network policy of reduction of length of stay and keeping hospital admissions to a minimum (Stroup et al. 2016; field notes 14/09/2015/19/10/2015, 24/11/2015).

Discussions in the multidisciplinary team meetings and clinical handovers suggested a strong focus on diminishing symptoms according to a medical model to facilitate discharge. As the medical staff developed treatment plans with a strong focus on symptom reduction and discharge then the mental health nurse automatically became part of this plan. This caused a dilemma, when on the one hand the mental health nurse needed to be a consumer advocate and include the Consumer Plan development, while on the other hand the nurse felt compelled to follow directions by the medical staff. Finding a balance between the medical model and the recovery model of care was part of the role of the mental health nurse and complicated accountability enactment.

Some nurses had commented on the lack of the use of the recovery model by the medical staff. The question can be asked, to what extent can the mental health

nurse facilitate recovery and the recovery model given their alignment with medical staff and psychiatry in general, and how does this impact on nurses' practice and their role in the formulation of a care plan? This alignment was reinforced by the directions of senior management and the goals of state policies to reduce the length of stay. The existence of a meaningful care plan was complicated from the start, as a result of the culture and processes followed in the mental health inpatient unit. The care plan requires genuine involvement of the consumer, while simultaneously mental health nurses were expected to follow instructions from the medical staff which included treatment to reduce symptoms to which the consumer did not agree. This caused a conundrum for the mental health nurse as they tried to find a balance which impacted on consumer care and the creation of a consumer care plan.

6.4.3. SUBTHEME: ORGANISATIONAL LEARNING

6.4.3.1. AMBIGUITY ABOUT LEARNING FROM MISTAKES

'People wanting to dob each other in if there's any errors' (Sam)

In the milieu of the inpatient unit there were concerns about potential blame in the organisation which leaves limited opportunity for learning from mistakes (Brady 2013; Castel et al. 2015). Through defensive practices the goal was to prevent any potential errors in judgements or deficiencies.

Sam regarded reporting on errors as 'wanting to dob each other in'.

> *In the last eighteen months or so there's been a big push about medication and people wanting to dob each other in if there's any errors. I mean you should always report it but there seems to be a heightened thing about it…....Whether something's happened specifically, but it [care plans] should be as accountable. I mean it's a bit like with behaviours, some people will SLS all sorts of behaviour, other people just wipe it off and say 'that's what they're*

> *like all the time', so again it's about what's important to you, what you think is worth making sure is recorded because at the end of the day if anything happens…*(Sam, Interview 8, line 154-163).

The Safety Learning System (SLS) enables the health service in the state to record, investigate and analyse consumer and staff incidents. Sam believed that notifications in the SLS became a higher priority to staff members including herself when an adverse event had taken place. Sam stated that health professionals entered SLS reports depending on what they thought was important which was an indication of a lack of leadership as outlined in chapter five. The fact that Sam regarded documenting an SLS report as 'dobbing each other in' revealed Sam was not entirely comfortable with this process.

Unlike Sam, John thought it was odd to complete an SLS report for a missed care plan.

> *…..because people don't think of that or it doesn't appear to be an issue I guess. Because it would be pretty strange to do an SLS report on the primary nurse not doing a care plan. It's unheard of, I've not heard of it, somebody getting reprimanded for not doing a care plan but I guess they will be reprimanded if something goes terribly wrong with the patient* (John, Interview 3, line 130-137).

John linked SLS reports to being criticised or even punished which is a potential issue as this can prevent documentation of deficiencies in care which results in a missed learning opportunity and managers not having a realistic big picture understanding on which to base decision making for the service.

Mark was the only participant who spoke about learning from omissions in the context of accountability and using the SLS as an opportunity for learning.

> *The SLS, Safety Learning System is not punishment, it is that learning system. It needs to be used as a system's approach to see why things were not done. That is, a care plan was missed because*

> *of a lack of training. Like this person I spoke to yesterday, it was a substandard risk assessment because of a lack of training I can acknowledge, so that can now be addressed. That can only be addressed if we know about it. It is to find deficiencies or mishaps so you can look at the wider picture to provide that accountability, that care, that appropriate interaction with the client. So again it is not to say your area is at fault or you have done wrong, it's why did that happen? It's that system's approach of, that happened what can we do to make it stop happen again. We need to put something in place. That should be an SLS* (Mark, Interview 9, line 173-182).

Mark understood how the organisation can learn from errors which can prevent the occurrence of similar deficiencies next time. He believed that an investigation as a result of an SLS report can reveal systemic issues that may need to be dealt with.

To Mark it was not clear why medication errors were documented in the SLS system and missed care plans were not.

> *There should not be any difference in accountability between care planning and medications. If they are missed, there is an oversight, a lack of care, missing accountability. The care plan can be more important and should be at times more important than the medication. If the care plan is not there and someone kills themselves. Why was there not a care plan in place, why wasn't there something in place? Somebody misses a dose of medications, something minor and then something unfortunate happens, okay it would have an effect, unless the care plan would have been done, it would have an effect on that person. Taking it to the nth degree for example but the bottom line is that an SLS should be done. I can't see why that is not happening.* (Mark, Interview 9, line 183-191).

Mark referred here to learning from mistakes and that the SLS system is not punishment but an opportunity for learning. Clinicians need to be able to learn in

a safe environment without fear of punitive action if for instance a risk had been misjudged.

Both John and Mark thought that the existence of a care plan or lack of it would be important if something untoward had happened to the consumer, although John thought that documentation of the omission in the SLS system was not necessary. How the existence of a care plan or any other meaningful documentation could become more pertinent the moment something went wrong or could go wrong was described by Simon.

> *I worked Sunday and Monday. A patient came in Saturday evening from X hospital and had only been there [mental health inpatient unit] for a matter of two or three hours and he left the unit and didn't come back overnight. And so then looking in the notes as to the assessment that had been done there were some notes from the hospital X but not all of the necessary notes and documentation was there. So it was a bit late so we don't know enough about this person to know everything that's involved with him and what should we be doing and so therefore it was a matter of ringing up the hospital X to try to get more details. The duty doctor who had seen the patient when he arrived on the unit had written up, based as best as she could on what she got from the notes of the X hospital. But it was a little bit late, there were so many things involved…..Overnight they said that a missing person report had been completed etcetera and a complete search of the grounds and everything had been done but he didn't come back and he came back voluntarily the next day, midmorning. But then it was like rushing around, hang on we need to know more about this person, we don't know what could've happened and it did become quite complex ……..*(Interview 11, Simon, line 204-217).

The lack of documentation on the consumer was an issue from the start but suddenly became more problematic in the eyes of Simon and the other health professionals when the consumer went missing and not enough information had

been gathered on him. Most participants did not believe an SLS was necessary for missing care plans, but Simon's record of events, illustrated that with the prospect of a missing consumer who might get into harms' way care documentation including care plans increased in importance and health professionals were rushing around for information.

Mark was the only participant who viewed the SLS reporting system as a learning opportunity and thought that health professionals could learn from mistakes. Errors are not synonymous to negligence and by systematically exploring errors health professionals could be looking at multiple contributing factors which can be resolved only by improving systems (Johnson et al. 2007). If an SLS report is not entered in the system an opportunity for formal learning has been missed. The correct use of effective reporting systems such as the SLS encourages and supports transparency and should be free from punitive action, allowing health professionals to feel comfortable and empowering them to speak up (Harper & Helmreich 2005; Johnson et al. 2007). Fear of negative consequences can lead to reporting errors only when a consumer is harmed or when the error could not be covered up (Cook et al. 2004). It can be concluded that there are varying opinions on what constitutes an error and what information needs to be reported. Differing definitions of errors and near misses as well as differences in reporting make it difficult to act to prevent similar errors.

Comments such as 'dobbing each other in' or being 'reprimanded' point towards a culture where health professionals might not always feel safe. Thus, the organisation's culture shaped by management, staff and consumers is a critical consumer safety factor as it encourages learning which improves nurses' skills (Wolf & Hughes 2008; Kanerva, Lammintakanen & Kivinen 2016). A supportive culture with effective leadership and collaboration enables the delivery of safe care through shared values and norms, creation of trust and the consistent

delivery of high quality care (Weaver et al. 2013; Kanerva, Lammmintakanen & Kivinen 2016). When individuals and organisations are able to move towards a culture of safety, where blame of errors is eliminated, organisations are able to increase reporting of all types of errors including missed and incomplete care plans (Stump 2000; Force et al. 2006). In a culture of safety, open communication facilitates reporting (Henry 2005). In this study, however, an overall focus on care provision to ensure consumers' safety was undertaken in an environment where nursing staff might not have felt sufficiently safe themselves to learn from mistakes.

6.4.3.2. LEARNING FROM EACH OTHER

> *'People raising things you can't see, 'have you thought about this, have you thought about that'* (Mark)

Overall participants felt more comfortable with the concept of learning from each other than learning via a formal SLS system. They explored how they were influenced by good and bad practice in the inpatient unit hence experiences which directly impacted on their sense of accountability.

Mark described how the team impacted on the quality of care provided.

> *Yeah because you got that team support it effects how you work as a practitioner, but also how you work as a team. It is the ability to be able to work with and raise things you can't see. People raising things you can't see: 'have you thought about this have you thought about that'. That is seeing what is going on.* (Mark, Interview 9, line 244-247)*……..I certainly have a different approach. A lot of people have been there for many years. I am sort of quite fresh and have a different approach to care or different experience so that feeds into the mix of accountability as well. It's that ability to not work in isolation within the team itself that team cohesion. To work in an accountable manner. Not just the nursing team. The OT, the physios, the consultants, the team at a wider level really…….you*

> *need that wider team education and understanding that its everybody's business* (Mark, Interview 9, line 251-256).

Mark viewed accountability as closely related to team work and explained that the whole team impacted on individual accountability as the team supported each individual health professional. Although Mark valued the SLS reporting system, he also regarded the team and the interaction within the team between all health professionals as an opportunity for education and exchange of information.

Wendy focused on the influence of other mental health nurses and in particular more senior nurses and acknowledged the positive and less favourable impact of colleagues.

> *If you can get a group of senior nurses together that promote excellence in nursing that can feed in because they can set a benchmark standard and that can filter down, but if you get infighting, too many different views or there is a culture that morale is low and people don't care so much particularly if there's lot of agencies where people are just coming 'I'm just here for the shift, I'll do my work and go'. So that all has an impact on accountability. So it can work for and against, depending* (Wendy Interview 7, line 185-190).

Wendy outlined the important role of senior nurses and that when they lead by demonstrating excellent practice, this is followed through by junior staff members. She acknowledged however that the opposite can happen. When a majority of staff members do not strive for high quality care and have a narrow focus on the shift at hand without taking into consideration the more far reaching consequences of care provided, this can result in a lack of accountability and substandard care.

Likewise, Sam identified two different nursing cultures on the unit which impacted on her own practice.

> *So I can certainly see where I would have times when I probably don't document enough and then I think about it when I've gone home 'I should've put this down, I should've put that down' but because of the culture and the feeling in the office you just don't want to be in there. So you tend to rush what you record rather than if it's more relaxed and you feel you can talk to the person next to you and bounce off them. If you bounce off some ideas you'll write so much more or put so much more into the care plan because you've asked questions* (Sam, Interview 8, line 200-206). *…..There's two quite distinct teams down here, so one you feel comfortable with and you know no matter what happens you'll work through it, and another one you just never know what it's going to hold….*(Sam, Interview 8, line 203-206).

Sam considered how engagement with some staff members and exchanging ideas had an impact on her practice including care plan development. With another group of colleagues this interaction did not take place, which had the opposite effect. She believed that feeling awkward with other health professionals impacted on her willingness and ability to ask questions and learn in the process.

Wendy, on the other hand, was unsure about learning from other health professionals in the team.

> *I think the more people share the load so to speak means there's less people accountable. There's always someone to say 'what about this person what about that person'. So it's hard to pinpoint a person who's accountable which again is probably why a lot of these things have fallen on nurses because they're the common people that are on the unit twenty-four hours a day* (Wendy, Interview 7, line 176-179)*…….It tends to be certain people who are very dedicated and they'll take on that and they'll do a brilliant job and there's others that can be very lackadaisical and get away with it purely because they can and that's unfortunate really. Whereas many years ago I think those people might have been pulled into line a lot quicker because there were more consequences* (Wendy, Interview 7, line 180-184).

Wendy believed that the larger the team the less accountability would be present. She viewed accountability as a commodity that was more thinly spread amongst a larger team with negative consequences in relation to consumer care. She did not think that substandard care was being dealt with sufficiently via informal or formal learning and that inferior care did not have any ramifications.

Most participants felt more comfortable with the notion of learning from interaction with colleagues than through the formal learning system to maintain and enact accountability. A systematic investigation via the formal systems can however prevent future adverse events (Cerbigilia-Lowensen 2015). Informal learning does not provide this systematic approach and might even reinforce damaging practices. When a mistake or error is identified, nurses tend to think about the potential loss of professional registration, job or colleagues' respect, as well as how the mistake will affect the consumer concerned (Berman 2006). The creation of non-judgmental working cultures allows for the open admission of errors that can reassure staff that mistakes will be dealt with sensitively and effectively (Brady 2013). This will help in the prevention of a 'blame culture' and create an environment in which health professionals can learn from their mistakes (Philipson 2011).

6.5. Conclusion

In summary, this study found that a change in state policies had altered the focus of care and practices in an inpatient unit. An increased focus on discharges and acute care had an impact on the care plans which were now regarded as low priority. Nurses perceived themselves as lower in rank and were ambivalent about involving unwell consumers in care planning and therefore were reluctant to speak up and include the care plans in team and care discussions. This reinforced a lack of collaboration amongst different disciplines also influenced by a lack in leadership. The increased unit acuity also highlighted dilemmas mental

health nurses encountered as they needed to find a balance between the medical model and the medicalised care which complicated accountability enactment.

Nurses' descriptions of accountability enactment demonstrated a strong emphasis on perceived safety and risks (more noticeable now in this highly acute unit) and how to avert these risks. As a result of this overarching focus on risks in accountability enactment, other aspects such as therapeutic engagement were not at the forefront of care and were rarely mentioned in the context of accountability.

CHAPTER SEVEN DISCUSSION: DEMONSTRATING ACCOUNTABILITY

7.1. INTRODUCTION

The development and use of a multidisciplinary care plan in collaboration with the consumer is a vital part of consumer care in mental health units. Exploring how care planning is used in practice will assist in understanding how accountability is executed in the reality of the work environment (Australian Government, National Standards of Practice 2010; Australian Government, National Practice Standards for the Mental Health Workforce). The aim was to uncover how mental health nurses enact accountability through the creation of a care plan and the involvement of consumers in the process and if the work environment influenced this. While previous research investigated the potential barriers to the creation of the care plan (Anthony & Crawford 2000; Crawford et al. 2002; McHugh and Byrne 2012, Bee et al. 2015a; Bee et al. 2015b; Grundy et al. 2017) there is no understanding of the relationship between mental health nurses' accountability enactment and consumer involvement in care planning. Other studies investigated ways to enable accountability, but few have considered how accountability is executed and played out in the reality of the work place in mental health services.

Key findings of the Enactment of Accountability Study are discussed using a framework based on the research literature regarding accountability, the care plan and consumer involvement and the role of the mental health nurse in inpatient units. The unit environment and culture played a vital role in the decision making process of mental health nurses. Pressures informed by the acute unit environment and a focus on discharges to meet the State's KPI's

regarding length of stay determined nurses' decision making and whether to create a care plan and involve the consumer in the process. In a highly acute environment the necessity to deal with crises took over all other aspects of care delivery. Even though standards and policies require that nurses create meaningful care plans with consumer involvement, the reality of the work environment forced nurses to provide reactive care (Figure 7.1). The work culture had a dominant impact on the decision making process of the mental health nurse, regardless of government policies. The culture with a focus on risks determined nurses' decision making as it was they who were responsible for the risks assessments. In the accountability decision making process of the nurses it was the focus of care in the work environment and the work culture that determined how care planning was conducted and not the nurses' knowledge of standards and policies that require the involvement of consumers in care plan development (Figure 7.1).

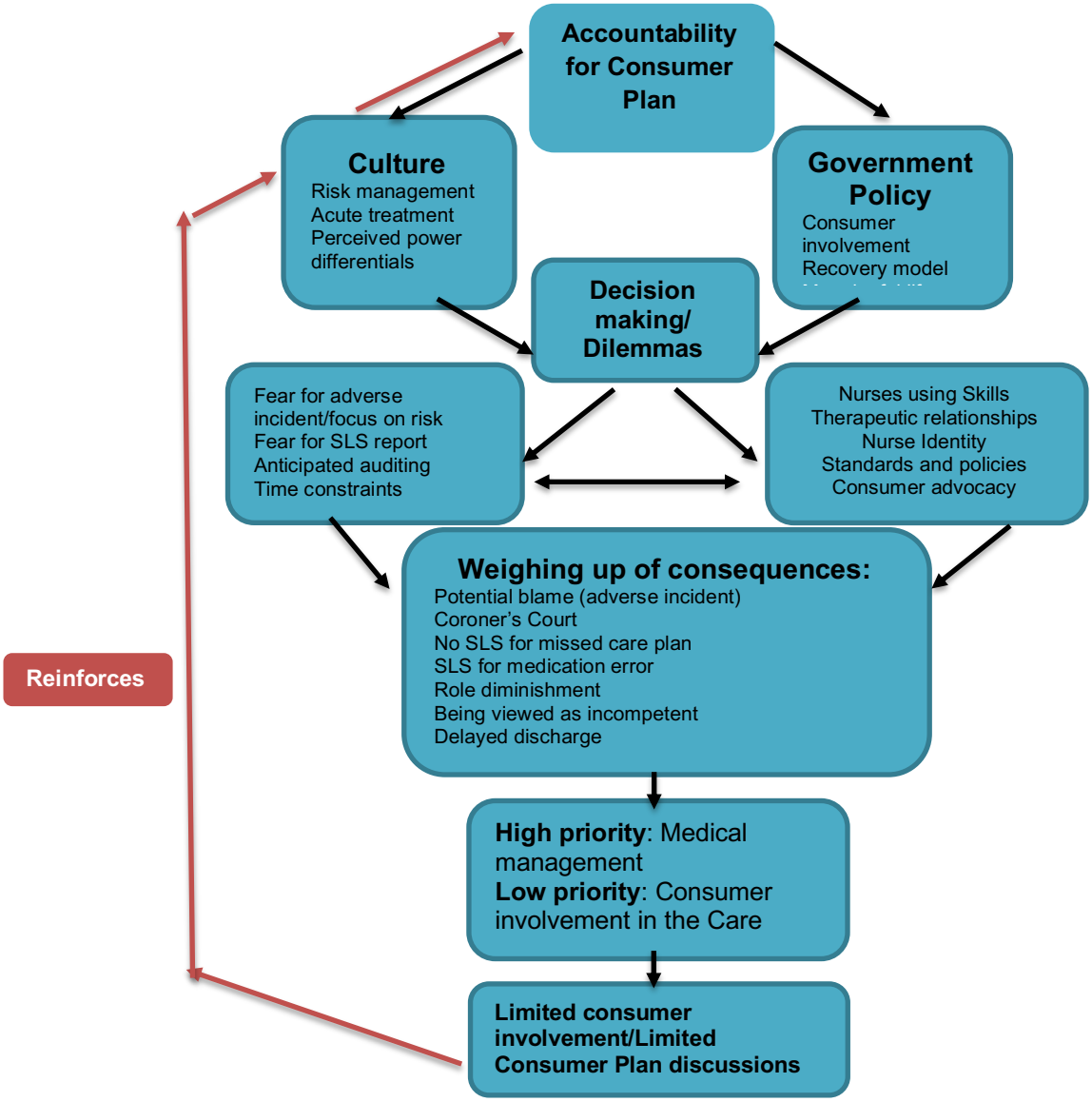


Figure 7.1. Synthesis of findings

This chapter will examine the synthesis of the findings (Figure 7.1) in relation to existing literature and how the culture in the inpatient unit was the main determinant in nurses' decision making on consumer involvement in care planning. I argue that it is when nurses spend time with the consumer, engaging and being completely present that the core of accountability is enacted. While clinical audits and service accreditation processes are used to assess and report on organisational accountability, these do not ensure that that accountability occurs between a consumer and a nurse in the moment of daily care provision.

A care plan in the background which was not utilised by other health professionals had an impact on nursing practice and obscured accountability obligations. Nurses' perceived lack of control as well as reduced role identification with a covert use of skills and diminished self-esteem was accompanied by a perceived lack of recovery oriented care. In the real life work environment with its specific requirements to manage a highly acute inpatient unit, the culture had an overarching influence on accountability enactment as nurses weighed up consequences and demonstrated accountability (Figure 7.1). The focus on risk was paramount which led to a neglect of therapeutic engagement in care planning.

In the following sections organisational circumstances and the work culture are considered in how these influenced the decision making process of the nurse. The chapter structure is as follows:

7.2. A Consumer Plan in the background

7.3. Mental health nurse covert use of skills

7.4. Demonstrating accountability

7.2. A CONSUMER PLAN IN THE BACKGROUND

In this study, nurses expressed frustration with a perceived contradiction between expectations to develop the Consumer Plan with consumers and the inpatient unit focus on documentation in the electronic consumer record and a reduction in the length of stay. This underpins previous research by Hercelinkskyj et al. (2014) who found that the role identity of the mental health nurse was seen in their daily interactions with consumers while the organisational identity was driven by the requirement to push discharge so as to vacate a bed for another consumer who was deemed to be more unwell. In the current study, even though

policy expectations were to include consumer involvement in care planning, nurses felt there was insufficient time and opportunity to engage with consumers to discuss the plan.

Nurses did however frequently engage with consumers while assisting them in completing tasks even in a work context of reactive care. During these interactions with consumers they discussed aspects of care that could have been related to the content of a care plan. For instance, nurses assessed and discussed consumers' physical health while doing physical observations, or they discussed consumers' ability to care for themselves while assisting them in activities of daily living. Hence in an informal way consumer involvement in their care did take place, but not as a formal session of therapeutic engagement. In previous studies this 'invisible' practice was described when mental health nurses undertook a variety of roles which had a background nature (Cleary 2004; Fourie et al. 2005; Deacon and Fairhurst 2008). This background nature relegated nursing activities to the status of menial rather than being seen to be therapeutic. In Fourie et al.'s (2005) study nurses viewed tasks such as 'kitchen duty' as non-nursing and regarded these as interfering with the registered nurses' roles. Cleary (2004) suggested that the challenge is to make visible what the nurse does to create a therapeutic atmosphere. For instance, 'kitchen duty' can give nurses the opportunity to observe how the consumers interact with each other and to assess the appropriateness of those interactions (Fourie et al. 2005). Without providing formal therapy, a therapeutic atmosphere can be created with the consumer.

If the content of these informal interactions between the nurse and the consumer is documented either in the progress notes or the electronic care plan, the issue is then not about the creation of the Consumer Plan but rather in making it visible to other health professionals. Documentation was rarely an issue in the inpatient

unit as the organisation put an emphasis on creating reports about the presence of care plans in the electronic system. This could include a care plan that was created and updated using 'cut and paste' text. During audits, the measurement outcome was that a care plan was documented in the electronic system. The nurses in this study saw accountability as the documentation requirements and so they focused on filling in the fields in the electronic care plan as the priority rather than on the quality of what was written. This supports Bee et al.'s (2015b) argument that care plan success is defined primarily in terms of the derivation of this plan rather than the quality of the process through which this is achieved.

A documented comprehensive Consumer Plan is meaningless if it is not discussed in the multidisciplinary team. The Consumer Plan needs to be a regular agenda item during the multidisciplinary team meetings and clinical handovers. A systematic synthesis of research on consumer led care planning outlined specific communication failures that were identified between in-patient and community staff and between mental health nurses and psychiatrists (Bee et al. 2015b). My study found that the invisibility of the Consumer Plan occurred because the medical staff and other health professionals did not ask for it. The Consumer Plan was not discussed at the multidisciplinary team meeting and staff did not request to view the plan unless they needed to present a case for an Inpatient Treatment Order or Community Treatment Order in front of the Guardianship Board who required a multidisciplinary care plan. When contributing to the clinical handover they did not use the Consumer Plan as a basis for this contribution. The Consumer Plan remained 'invisible' as no one took responsibility or felt accountable to place the plan at the forefront of handovers and discussions. This meant that there was no formalised communication process through which to take into account the wishes of the consumer. The most important stakeholder in care provision and planning was

ignored as a result. Good care planning, however, necessitates interactions between different stakeholder groups and the context of the quality of these interactions may directly impact the way in which the meaning of the care planning event is construed (Bee et al. 2015b).

An exchange of information during care plan discussions can also be regarded as a form of clinical handover. Previous research found that an apparent lack of overt and observable responsibility with accountability being transferred between practices in the handover process can have detrimental consequences as clarity is needed on accountability obligations (Chin et al. 2012; Crotty 2013). If the Consumer Plan is not discussed, valid concerns expressed by the consumer during interactions with the nurse can be missed. The absence of the Consumer Plan during clinical handovers obscures accountability obligations with regard to the content of the Plan.

7.3. MENTAL HEALTH NURSES' COVERT USE OF SKILLS

Nurses utilised skills that they perceived as invisible and felt they had insufficient control over the process of consumer involvement in care planning as a result of organisational pressures. It was difficult to identify the role of the nurse as they took on a wide variety of roles. This wide variety of task did however provide flexibility which could be helpful in complex and ever changing health organisations. Because there were few opportunities to engage in formal therapeutic engagement with consumers some nurses had a diminished sense of confidence. This influenced their perception that the mental health nurse was not as significant as others in the team which led to their lack of contribution to the discussions in the multidisciplinary meetings.

7.3.1. PERCEIVED LACK OF CONTROL

The struggle of some of the nurses in the study with the role of the mental health nurse had resulted in them searching for increased knowledge and skills to gain job satisfaction and increase control and autonomy over their practice. Nurses who had done so, however, stated that their knowledge and qualifications in psychological therapies were not valued in the work environment and that there was no opportunity to use these skills. Nurses believed that increased acuity forced them to engage in reactive care which left little time for formal therapeutic engagement. Organisational pressures have also been found in previous studies to prevent mental health nurses fulfilling their own expectations for professional nursing practice (Hummelvoll & Severinsson 2001; Cleary 2004; Tee et al. 2007; Deacon & Fairhurst 2008; O'Donovan 2008). In Cleary's (2004) study nurses expressed concerns about the increased workplace demands. They referred to the unpredictability of the unit which impacted on their practice as they dealt with unexpected and challenging consumer behaviours. Competing demands placed considerable pressure on nurses as nursing practice was characterised by a lack of control in the workplace. Hummelvoll & Severinsson (2001) found that the acute environment led to nurses' acceptance of therapeutic superficiality while in O'Donovan's (2007) research nurses believed they offered little therapeutic care and that the therapy that was provided was fragmented.

The new knowledge the current study adds is to show how the existing service approach influenced mental health nurses' decision about their accountability enactment. Control over care plan creation and if and how to utilise therapeutic engagement was influenced by the existing culture in the inpatient unit. Accountability, responsibility and control over practice are interrelated concepts and it is necessary to have autonomy and control over practice to be held accountable and to enact accountably (Sorenson et al. 2009).

An empowered work structure and having a feeling of control is recognised as a key contributing factor to the provision of high standards of safe quality care to consumers (Spence, Laschinger & Wong 1999; Sorenson et al. 2009; Twigg & McCullough 2014). Moreover, access to senior staff, efficient flow of information and shared decision making is considered critical to a culture of empowerment (Spence, Laschinger & Wong 1999; Cleary 204; Sorensen et al. 2009). In this Enactment of Accountability Study there was a reduced sense of responsibility for the Consumer Plan and low emphasis on the need to develop this in formal consultation with the consumer. Nurses did not feel in control over their practice and did not engage in autonomous practice, but they felt they were directed by other health professionals who they thought did not value the care plan. The lack of autonomy and limited decision making impacted upon by the culture left nurses with a reduced sense of empowerment which directly influenced accountability enactment. It led to a decision to abstain from or give lower priority to developing the plan through formal therapeutic engagement as nurses were influenced by the perceived expectations of other health professionals.

Study participants felt they had insufficient control over the process of consumer Plan creation and discussion although they were expected to develop one. Systems and processes in the inpatient unit kept nurses preoccupied with other aspects of care delivery although they did not realise these were opportunities to utilise engagement in care plan creation. As the Consumer Plan was not used in discussion with other mental health professionals then this led to nurses' perception that the Consumer Plan was not viewed as a valuable document. The combination of under-utilisation of the care plan and the perceived lack of control to formally use therapeutic skills, frequently caused by time constraints, determined how accountability was enacted. It resulted in care plan creation with

consumer involvement being rated as a low priority on the list of accountability obligations.

7.3.2. ROLE IDENTIFICATION

The existence of the multidisciplinary team in this study did not provide a guarantee that interventions and planned treatment would be multidimensional in nature. There was limited input by mental health nurses about their role that involved care plan development in the team meetings. The nurses had a continuous presence in the ward and were expected to assist other health professionals especially the medical staff. This supports previous research where nurses felt they had a pivotal resource role as an ancillary support to enable others in the team to fulfil their roles and where they believed that practice was driven more by the needs of the organisation than the consumer (Fourie et al. 2005).

In the Enactment of Accountability Study, the mental health nurse executed various tasks initiated and prescribed by the doctors. These activities varied from medication administration and monitoring for side effects to physical observation and risk assessment and management. Nurses, more than any other occupational group, have played an instrumental role to medicine and nurses are the health professionals who put into practice the treatment that is prescribed (Lakeman & Molley 2017). In this milieu it is challenging for the nurse to demonstrate his or her own niche in consumer care.

It became apparent in the study that the capacity to identify and communicate the role of the mental health nurse was challenging as a result of the nurses' alignment with the medical staff. This was highlighted by the acuity in the inpatient unit with a strong focus on medication management to stabilise consumers' mental state. As a result of budgetary constraints with a focus on

reduced length of stay the attention in the inpatient unit had shifted to admission and discharge. This defined and reinforced the position of the medical staff who usually took charge of admission and discharge decisions. In other words, the acuity of the inpatient acted as a variable in balancing potential interprofessional collaboration with the dependence on medical management .

Although it is challenging to identify and communicate the role of the mental health nurse because it is not easily visible, (Hercelinkskyj et al. 2014) in the Enactment of Accountability Study it was the mental health nurses who worked 12 hours shifts and who were the most visible and accessible team members. They frequently worked across occupational boundaries to ensure that activities were taken care of. This role blending was exacerbated when pressures for discharge increased, or during weekends and after hours when allied health professionals were not available. Other studies have also reported that nurses find it difficult to articulate a distinct role for mental health nursing and oriented themselves more towards mental health practice in general rather than the nursing profession (McCrea et al. 2014). Participants in McCrea's et al. (2014) study presented mental health nursing as an interpersonal therapeutic activity and did not identify with general hospital orderliness.

In the same context Deacon and Fairhurst (2008) found that mental health nurses took responsibility for unusual kinds of work that did not belong to anyone else which demonstrates the flexibility of the mental health nurse within an increasingly complex environment and the social organisation of healthcare settings. It is this flexibility which suggests a potential to grow and develop the profession of the mental health nurse. This can include opportunities for consumer involvement in Consumer Plan discussions.

In a work culture described in the Enactment of Accountability Study with an increased focus on reactive care, the development and use of the Consumer Plan appeared destined to fail. It is however during episodes of reactive care that the mental health nurse could engage with the consumer and information obtained during these interactions could be utilised in care plan development. In this study some nurses perceived their role as invisible but their presence in the unit was evident as they were the core of service delivery. Participants in the study were not always aware that they were the health professionals who had the most extensive knowledge of the consumers' wishes as a result of the fact that they took care of such a wide variety of tasks. This is an ideal position to advocate for consumers and involve them in the creation of their own care.

7.3.3. COMPROMISING BETWEEN RECOVERY AND MEDICALISED CARE

Nurses in the Enactment of Accountability Study tried to work with expectations regarding consumer involvement and medical instructions which impacted on the creation of the Consumer plan. Regardless of whether the plan had been developed with or without consumer involvement, the other health professionals did not consider this plan in multidisciplinary meetings. Mental health nurses who spoke about the lack of the use of the recovery model by the medical staff compromised between the requirements of the recovery model and the reality or the unit environment which provided medicalised care. This mirrors similar findings of Cleary (2004) that nurses negotiated contradictory expectations and conflicting demands of therapeutic and institutional considerations.

Research by Cusack, Killoury and Nugent (2017) found that nurses perceived the main inhibitor to the recovery approach was a symptom-focused to mental healthcare delivery and the medical format of documentation used within mental health services. In the Enactment of Accountability Study there was limited support from the medical profession for nurses to engage in formal therapy with

consumers in order to produce an individual assessment and recovery oriented Consumer Plan. Although consumer involvement can take place in other ways, this lack of support for the mental health nurse created a disjunction between expected care development by mental health nurses and the care creation by medical and other professionals in a treatment plan.

Consequently two separate entities, the Consumer Plan and the Service Plan (treatment plan) (Figure 5.3.) were created which had an impact on Consumer Plan development and utilisation. Nurses tried to compromise and created a multidisciplinary treatment plan in the electronic system and documented the care that had been developed by other health professionals in an attempt to fulfil one aspect of the requirements of recovery oriented care provision. Insufficient support however from other health professionals for the nurses' role in the creation of the Consumer Plan impacted on nurses' decision making and practice. It led to nurses not feeling confident to speak their mind during the multidisciplinary team meetings which resulted in the absence of the consumer voice in these forums.

7.3.4. DIMINISHED CONFIDENCE AND SELF-ESTEEM

Caught up in a conflict between the existing care focus in the inpatient unit and the recovery approach was the mental health nurse. They were expected to create the Consumer Plan without the supporting processes in place such as sufficient time to engage in therapy or genuine care plan discussions in the multidisciplinary team meetings. The perceived lack of therapeutic engagement or opportunity to do so had an impact on the role identity of the mental health nurses who felt discontented and at times disempowered. Participants mentioned exhaustion and burnout as a result of the increased work demands and spoke about increased paperwork at the nurses' station, away from consumers, which contributed to an overall feeling of dissatisfaction. This is unsurprising since it is

known that nurses who spend more time with direct consumer care, especially when developing therapeutic relationships are more satisfied (Hummelvoll & Severinsson 2001; Fourie et al. 2005; Seed, Torkelson & Alnatour 2010).

Reduced opportunities to formally engage therapeutically with consumers sent a message to the nurse that Consumer Plan creation and therapy provided by the nurse were less relevant and not as valued as medical management. The Consumer Plan, which was viewed as the nurses' responsibility and for which there was little regard, was closely linked to the role and status of the mental health nurse. This added to mental health nurses' perception that the profession of the mental health nurse was not as significant as other health professionals which impacted on self- worth. There is a correlation between self-worth and job satisfaction and responsibility and accountability (Sorenson et al. 2009) where a moderately empowering work setting which encourages autonomy will make the enactment of accountability easier (Spence, Laschinger & Wong 1999).

Knowledge, personal motivation and skills have been found in previous studies to facilitate the development of the mental health nurse role (Cusack, Killour & Nugent 2017) but if this is not complemented and supported by the use of the recovery model then these attributes will not be used to their full potential. As outlined above, the organisation plays a vital role in facilitating opportunities for mental health nurses to use their therapeutic skills. This can be challenging as illustrated by Thomson & Hamilton's study (2012), where the medical staff believed that therapeutic time hindered effective clinical work and could represent a barrier to medical assessment of the consumer. If those staff in the work environment do not follow the principles of the recovery model then this will negatively impact on consumer involvement in care plan creation as well as the morale of the mental health nurse. The Enactment of Accountability Study identified that nurses' experience of disempowerment could result in a reduced

sense of responsibility for Consumer Plan discussions and their subsequent contribution to conversations in multidisciplinary team meetings.

7.4. DEMONSTRATING ACCOUNTABILITY

7.4.1. ACCOUNTABILITY ENACTMENT IN THE REAL WORLD

Enacting accountability includes being held to account which results in an appropriate response when tasks have not been completed. Accountable clinicians own up to errors or omissions by entering them in the reporting system to allow review and improvement in processes and systems. The decision whether to report a missing or substandard plan caused by a lack of consumer involvement was influenced by opinions of colleagues and also by what nurses thought was best practice and custom in their unit environment. Therefore the culture in the inpatient unit played an important role in the decision making about what should be entered into the reporting system and this determined reporting practices. Previous research found that local accountabilities can influence clinicians' incident reporting practices and vice versa and that the meanings ascribed to incidents were highly negotiable (Hor 2010). In other words, the incident reporting system and related policy are interwoven with other accountabilities in the local context (Hor 2010). The Enactment of Accountability Study demonstrated there were unwritten rules about what to report in the system and a low quality care plan or a lack of meaningful consumer involvement were not included as warranting reporting.

What is also important is clinician-initiated interprofessional communication or peer-to-peer accountability. This is interpreted in research by Jansen Lockett et al. (2015) as holding self and others responsible for acceptable standards of caregiving as well as receiving feedback and exchanging information from peer-to-peer when observing questionable practice. For peer-to peer accountability to

succeed and be effective a culture is required where it is acceptable to challenge and hold to account other health professionals. Research by Janssen Lockett et al. (2015) found that this can occur in a safe environment where a challenge is not regarded as threatening by the receiver and where there is a perception that the receiver is approachable. A sense of a safety culture is vital, safe for consumers as well as health professionals. This process of peer-to-peer accountability is equally as relevant as incident reporting as a way to demonstrate accountability and can influence the expectations in an inpatient unit and therefore positively or negatively impact on the quality of care.

Nurses and other health professionals did not, however, regard lack of consumer involvement in creating a plan or a substandard plan as an omission that required incident reporting or the use of peer-to-peer accountability and therein lies the issue. Care quality surveys have historically monitored the extent to which care plans are signed by consumers rather than the degree to which genuine involvement is evident (Bee et al. 2015b). This sends a message to health professionals. It is possible that consumer involvement in care planning has over time been diluted to a series of practical activities to comply with auditor standards rather than enhancing the quality of the experience that these standards were originally designed to deliver. Measurement is frequently utilised in health services to ensure and facilitate accountability enactment. Previous studies have found that measurement increased the compliance with certain processes but that the impact on consumer outcomes was undetermined (Carlo et al. 2015; Nolan et al. 2015). The study by Clancy and Happell (2015) highlighted audit consciousness as that which placed nurses increasingly under pressure to complete paper-based risk assessment tools and management documentation. Conflict can occur if the focus on measurable activity detracts from principles of mental health nursing (McCrea et al. 2014).

There is some evidence that across community and inpatient settings a combination of individual, time and organisational constraints may be acting to replace a philosophy of consumer involvement in care planning with task oriented practice (Bee at al. 2015b). Health organisations can formally adhere to care philosophies, but it is the reality of the work environment culture and every day practice which determines whether health professionals will adhere to these ideologies and practice accordingly.

7.4.2. ACCOUNTABILITY PRACTICE: SAFE CARE

In this study, decision making by nurses moved towards risk assessment and the provision of safe care as the focus of their practice and the foundation of accountability enactment. The focus on mitigating risks and the existence of the recovery model with the care plan as the roadmap can be conflicting. Decisions on how to enact accountability were made while the possibility of risk was at the forefront of the mind of nurses. Mental health nurses, as all other health professionals, are required to practice within the recovery model (Australian Government, National Standards for Mental Health Services 2010). This may contradict expectations to manage what the organisation considers risks which can encourage restrictive practices that can preclude meaningful involvement of consumers. In describing what accountability meant all mental health nurses in this study referred to risks and how they needed to take control of these risks, which they considered as safe care. This is similar to findings in the study by Clancy & Happell (2015) where participants reported that the aim of the care provided was to reduce risks which may not always reflect the best interest of the consumer.

What became apparent in the Enactment of Accountability Study was that care was executed from the health professionals' view on safe care and what that entails. In discussing risks and safety, mental health nurses did not refer to

adverse outcomes related to side effects of medications or negative outcomes related to stigma, discrimination or restrictive care. Participants attempted to prevent mistakes in the eyes of the organisation or the wider community by using restrictive practice. Some nurses gave examples of reactive and restrictive care to facilitate what the organisation considered as safety. This had consequences for the consumer who was not involved in the development of these aspects of care. Accountability was enacted to keep the organisation and its health professionals safe while the consumer was at times exposed to risks which were overlooked or not regarded as such. Safe care and consumer safety were viewed from the perspective of the nurse and through the lens of the health service rather than from the point of view of the consumer who should be at the centre of care development and discussions.

Discourses such as risk and risk assessment can create the unrealistic expectation that these are reliable predictors of any adverse event or that they can facilitate a safe environment. These unrealistic expectations can be internalised and when nurses later judge themselves against such standards they will inevitably realise they may not live up to them especially when an adverse incident occurs (Robertson et al. 2010). Nurses concerns were related to what they considered about the safety of the consumer, but these considerations were equally linked to a fear of blame if anything untoward were to happen and the possible consequences this would have for the nurse.

Cultures of self-protection and organisational defensiveness have been identified as potential issues in inquiries after adverse events (Manuel & Crowe 2014). In the study by Manuel and Crowe (2014) participants aimed to balance the consumers' needs in an organisational climate in which they felt they would be blamed if an adverse event occurred. They indicated that in the process they used to shift the responsibility to others who they perceived as less vulnerable to

potential outcomes such as psychiatrists and consumers (Manuel & Crowe 2014). To work within the recovery oriented framework, services need to be able to balance the tension between working with priorities and goals of consumers and addressing the anxieties and expectations of the service and the community (McHugh & Byrne 2012; Wijnveld & Crowe 2011; Bee et al. 2015a). This is not so straightforward. Professional bodies, legislation and guidelines consistently support consumer autonomy, yet we frequently do not hold consumers responsible for their own actions such as suicide (Robertson et al. 2010).

The recovery model for Australian mental health services and consumer care plans was developed when this was incorporated for the first time in the National Mental Health Plan 2003-2008 (Australian Government, 2003). The recovery model and consumer participation are however difficult to put into practice in the reality of the work environment. Findings of this study suggest it is the culture of the work environment and mental health nurses' assessment of consequences which determine their practice and not ideas and definitions of consumer recovery outlined in policies. Previous studies found that health professionals may weigh up the unit's accountability level and calculate risks and benefits as well as internal and external factors before enacting accountability (Freeman et al. 2009; Leonenko & Drach-Zahavy 2016). Risks to the health professionals of enacting accountability included isolation from other staff and resistance and bullying while benefits included a sense of professionalism, empowerment and pride (Leonenko & Drach-Zahavy 2016). External factors included responding to practice standards, legal obligations and client centred practice. Identified internal factors were the clinician's expectations of themselves plus the desire to be remunerated for their services (Freeman et al. 2009).

In demonstrating accountability mental health nurses assessed consequences and in doing so the aspect of safety and risk was paramount. They followed the

policies and procedures in the inpatient unit and made sure they fulfilled expectations which were regarded as important such as completing risk assessments. The involvement of consumers in the creation of their plan was not regarded as a priority and nurses openly discussed this as they thought the lack of a quality Consumer plan did not have any consequences. There was a lack of awareness that absent consumer involvement resulted in a lack of consumer empowerment and could take away the consumer's decision making ability. Such a lack of awareness could stand in the way of nurses acting as consumer advocates. As a result, the accountability obligation of developing a meaningful multidisciplinary care plan through consumer input in the Consumer plan was partially unfulfilled. Nurses engaged with consumers during daily care delivery, but they did not view this as formal therapy or therapeutic engagement. Information obtained during these interactions could be included in care plan creation and discussed during the larger meetings. For some nurses it was reduced confidence and not feeling safe themselves in the unit culture which held them back in involving consumers and speaking up.

7.5. CONCLUSION

Mental health nurses were not always aware that in their daily contact with patients they were involving consumers more or less in care discussions. Hence, the potential for consumer involvement was not realised in a context of high acuity with a work focus on reducing length of stay and risk aversion. While nurses took care of documentation of the Consumer Plan in the electronic system albeit utilising 'cut and paste' in some cases, the problem was that the Consumer Plan was hidden as were the opportunistic discussions the mental health nurse had with the consumer in daily care. These were not visible in the formal meetings where care discussions took place and the treatment plan was compiled.

The mental health nurse utilised their skills in a covert way, sometimes without realising it, as they felt they were not able to provide formal therapy. Some participants believed that their knowledge and qualifications were not valued and they had limited opportunity to use their skills. They believed they had insufficient control over the process of Consumer Plan creation while being responsible for this task. The fact that the Consumer Plan was not part of multidisciplinary team discussions led them to believe the plan was devalued as it remained underutilised. This resulted in care plan discussions being rated as a low priority.

The study highlighted that it was challenging to identify the role of the nurse as they engaged in a wide variety of nursing tasks that were aligned with the medical staff in a highly acute environment. While the lack of a clear identity of the mental health was a problem, this provided potential for the nurses to demonstrate their flexibility and this so could have been an opportunity for development of further roles. The mental health nurse is in an optimal position to advocate for consumers and negotiate their care with other health professionals.

Rather than see the opportunity, the mental health nurses felt disempowered because they were not able to provide formal therapy and because they did not feel supported by the other health professionals. This impacted on these nurses was that they did not feel confident to speak up in team meetings. This sent a message to them that the role the nurse played was less relevant than other health professionals and not as valued. Some of the nurses in this study did not feel supported in developing high quality plans with consumer involvement even though it was the nurses' task to do so.

Regarding accountability for care planning, this study demonstrated there were unwritten rules about what to enter in the reporting system. Nurses and other health professionals did not regard a lack of consumer involvement in care

planning as an omission that required incident reporting or discussion through peer-to-peer accountability. Reporting was more to document the presence of a care plan, rather than the process of its development or the quality of its content, and so the enactment of accountability through an audit was more like a set of "tick box" activities to comply with auditor standards rather than promoting processes to involve consumers in the development of a high quality plan.

In decision making to be accountable, risk management and safe care were high priority to the mental health nurses. Safe care was seen from an organisational perspective that led to reactive or restrictive care, without consumer involvement in the development of this. Nurses' concerns related to what they regarded as safety of the consumer and they were fearful of blame if anything untoward would occur. In this context care provision was complex as mental health nurses are encouraged to promote consumer autonomy while knowing that they (the nurse) could be called to account for the consumers' actions, such as a suicide. In the quest to provide safe care, mental health nurses focused on completing risk assessments rather than see a high quality Consumer Plan as a priority. In this work culture there was a lack of awareness that a substandard plan and a lack of consumer involvement resulted in reduced consumer empowerment and a failed opportunity for the nurse to act as a consumer advocate.

Enacting accountability through creating a high quality Consumer Plan with consumer involvement was unfulfilled. Nurses documented the care provided in the electronic record and engaged with consumers during daily care delivery but did not regard this as therapeutic engagement. Important information obtained during care provision could have been included in care plans and highlighted in discussions with other health professionals, but nurses did not feel safe to express their opinions and speak up as a consumer advocate during multidisciplinary meetings.

CHAPTER EIGHT: CONCLUSION

8.1. INTRODUCTION

As I reflect on what motivated me to write a thesis on accountability enactment, I consider that many aspects of my life have changed as I am employed now in a different service in another state. Yet, the challenges in the current work setting are similar to the circumstances and observations which first troubled me and inspired me to study the issue of accountability enactment. In my current work environment where a majority of consumers are of Aboriginal descent and even more marginalised, a care plan and care discussions between the mental health nurse and the consumer are paramount. It is vital for us mental health professionals to understand the importance of a good care plan to ascertain the wishes of the consumer and to tailor practice and care accordingly.

The Enactment of Accountability Study demonstrated that the work environment impacted on nurses' practice and that acute medical treatment and a focus on risk management to reduce the length of stay caused nurses to feel diminished in their decision making. Nurses directed their accountability enactment towards risk management and acute, medical treatment. As a consequence nurses forewent commitments regarding Consumer Plan development and therefore the provision of any high quality therapeutic engagement. The culture of the inpatient unit played a major role in accountability enactment as nurses weighed up consequences. The research demonstrated that a recovery focused approach and the Consumer Plan are linked and that the presence of the recovery model is a pre-requisite for the successful implementation of the Consumer Plan.
This chapter reviews the aims and research questions that were the focus of the Enactment of Accountability Study and it considers whether the study has answered the research question.

8.1.1. *REVIEW OF AIMS, RESEARCH QUESTIONS AND STUDY CONCLUSIONS*

The study aimed to explore the enactment of accountability by mental health nurses in one inpatient unit and how the environment impacted (or not) on nurses' practice, and to specifically analyse the decision making process to involve consumers in the development of their care plan. The study sought to uncover how nurses execute their accountability obligations in an inpatient environment in regard to care planning.

The specific research questions were to ask the following:

What was the impact of accountability on mental health nurses' development of care plans with consumer involvement?

What was the relationship between a unit culture of accountability and the development of care plans?

The impact of accountability which was prioritised towards organisational needs, led to the decision by the mental health nurses to forego the development of a Consumer Plan and consumer involvement through spending time with them and writing a plan in collaboration. Mental health nurses were aware of the meaning of accountability in that they needed to justify their decisions and actions, but in a risk averse environment this led to reactive and sometimes restrictive practice that resulted in giving less priority to the Consumer Plan. Although the participants in the study knew of policies and standards regarding consumer involvement in care plan development, the day to day unit culture overshadowed the policies and procedures informed by the recovery model. It was a culture with a fear of adverse incidents and time constraints which determined decision making in accountability enactment. This resulted in the Consumer Plan ending up at the bottom of the list of daily activities to be completed.

Mental health nurses understood the concept of accountability as keeping consumers safe and preventing risk. The notions of risk, safety and safeguards were regarded, however, from the organisation's point of view. Participants regarded risk as originating from the consumer and other elements of risk such as restrictive and reactive care or side effects of the medications were not considered in this context. The role of accountability in care plan creation was that mental health nurses carefully weighed up consequences as they were aware they needed to justify their decisions. These considerations focused on increasing discharge numbers and preventing adverse incidents which prioritised acute and medicalised treatment. In an inpatient unit where some nurses believed they were lower in rank than other health professionals they followed the medical staff in accountability enactment and supported medical staff's treatment plans which excluded Consumer Plans and meaningful consumer contributions.

The main conclusion of the Enactment of Accountability Study is that while mental health services comply with accreditation and auditing procedures, with the intention of ensuring accountability, unless individual nurses include consumers in the development of their care plan, quality recovery oriented care will be absent. Therapeutic engagement with the consumer in the processes of care development and subsequent advocacy is the basis of accountability enactment and can facilitate recovery.

8.2. STUDY LIMITATIONS

As with most qualitative research, there are limitations to the conclusions and wider applicability of the study. To begin, this study was set in a specific inpatient unit and the location means that the data relates to specific nurses and health professionals which may or may not be applicable to other inpatient units or mental health teams. However, similar problems that were found in this study may occur in other settings. For instance, in Cleary et al.'s (2004) study

organisational pressures prevented nurses from fulfilling their own expectations for professional mental health nurse practice and it was challenging for the nurses to prioritise nursing work given the role of crisis stabilisation of the inpatient unit. Results in a study by Bee et al. (2015a) highlighted that the greatest barrier reported by health professionals was increasing time and workload pressures. What was unique in the Enactment of Accountability Study was the perceived lack of interest of the medical staff for the content of the care plan and the impact this had on nursing practice.

Some early participants selected for this study were already known to me and therefore formed a convenience sample. I continued to recruit participants using purposive sampling when I asked nurses who I thought could contribute to the information that was required in the study. I recruited participants until I reached the minimum proposed number of ten and then continued until data saturation had been reached. The majority of nurses had more than 20 years of experience which is congruent with the average age and experience of mental health nurses nationally (Australian Government, Australian Institute of Health and Welfare 2016). Although most mental health nurses had been in the profession for more than 20 years they represented a range of experience levels from different work settings. It must be acknowledged, however, that all the participants were willing to reflect on their roles in the inpatient unit and to subject themselves to analysis of their accountability enactment. Some participants saw their involvement as an opportunity to reflect and to improve their practice in the long term.

As with other research, any relationship between researcher and participants may potentially lead to bias in the responses. Bias in qualitative research is accepted, acknowledged and, as in the Enactment of Accountability Study, taken into account. Bias can present itself in the form of the world view that I brought to the setting including my personality, values, belief systems and knowledge. Less

obvious is the bias of the participants towards me. Bias can happen in situations where the interviewees give a reply they anticipated would be favoured by the interviewer and consequently avoid responses that may reflect unfavourably on them (Roper and Shapira 2000). However, my relationship with and personal acquaintance with most of the participants, allowed me to confirm or clarify responses. For example, when John stated he believed a care plan should not be developed with someone who is unwell, I went back to him and explored this. It became apparent then that he had made a considered decision and felt that this practice would be unfair and could jeopardise the relationship between the nurse and the consumer. The way that I managed bias was to assure participants that I wanted their frank and honest responses with no fear of judgement, while assuring confidentiality and that I did not anticipate particular responses. I was openly seeking subjective experiences. I followed up with any clarifications required after transcribing the interviews (Chase 2017).

Another limitation of the study is the absence of consumer and carer views on accountability enactment or on the care planning activities by mental health nurses in the inpatient unit. As a result of the pressure to discharge and the absence of a sufficient number of voluntary consumers to provide informed consent, it was not possible to view consumers' care plans or to observe care plan creation between the consumer and the mental health nurses. The initial research proposal included the observation of care plan creation between the consumer and the nurse, but this had to be abandoned as a result of the high number of involuntary consumers. In addition, the focus is on accountability enactment by mental health nurses only and does not include how other health professionals viewed accountability or how they executed this in the complex inpatient unit environment.

Finally the data were interpreted by me as a nurse. Interpreting data is how meaning is made. Being a mental health nurse I would have brought preconceptions that would have influenced my interpretation of the data. On the other hand this provided me with insider knowledge that enhanced and deepened my understanding of the data. Overall I carried out assiduous approaches to strengthen the study limitations as I have described earlier in the methods chapter.

8.3. WHAT HAS BEEN ADDED TO THE BODY OF ACCOUNTABILITY KNOWLEDGE?

This study identified why the barriers and challenges to consumer involvement in an acute mental health inpatient unit led to a decision by nurses to forego formal consumer involvement in care plan development. Hence this study has advanced the knowledge by focusing on the decision making, which takes the findings beyond previous studies that have described these precursor barriers and challenges. The culture of the unit was the main determinant of the failure of the implementation of the Consumer Plan. The care plan is one of the tools of the recovery model and the two are therefore closely linked. For the care plan to succeed and become an integral part of mental health practice, recovery needs to be embedded in the care delivery system. The work environment was however found to be medicalised with attention to acute treatments and risk management that was driven by a focus on reducing the length of stay rather than recovery.

In their decision making mental health nurses considered consequences as they faced dilemmas. On the one hand nurses felt uncomfortable with reporting systems and the potential for blame as a result of an incident or adverse event and therefore favoured restrictive care. On the other hand nurses understood the importance of the therapeutic relationship and how they needed to adhere to

nursing standards and policies which includes care plan development. Nurses felt that their role was diminished as a result of the medicalisation of treatment. Consequently they deemed the Consumer Plan as low priority and consumer involvement was jeopardised as a result.

Other studies have also focused on individual accountability in general, or in regards to risk assessment and management in the inpatient or community setting, but this study specifically paid attention to accountability enactment in relation to the care plan. It can be argued here that the lack of meaningful care plan discussions between the consumer and mental health nurses occurs through a failure of accountability. Nurses felt their role was devalued and focused their decision making and accountability enactment on the management of risk and medications. In the process nurses deemed the creation of a Consumer Plan with the consumer as a lower priority and paid less attention to opportunities for formal care plan creation in therapeutic engagement.

8.3.1. Significance of this Enactment of Accountability Study

The enactment of accountability is critical to the development of a meaningful care plan with consumer involvement. It is individual accountability which can have an impact and enable the provision of high quality care which includes a care plan. Consumers have a right to be consulted and informed about their care and the absence of consultation brings a risk of abuse of power with less compliance to treatments in which the consumer has no investment (Farrelly et al. 2015). This can have an impact on consumers' mental and physical health (Li & Ford 2006; DeHert et al. 2011; Lawrence et al. 2013; Ewart et al. 2016). Instead of health issues being diagnosed and followed up, there are experiences of disempowerment and a sense of isolation and sometimes (re) traumatisation

from the health care system (Holt-Lunstad, Dith & Laydon 2010; Linz & Sturm 2012; Lawrence et al. 2013).

Accountability enactment takes place while engaging with consumers during everyday conversations in therapeutic engagement. This communication is vital and has the potential to make positive and qualitative difference in the consumer's life as demonstrated in previous research (Howard et al. 2003; Schröder, Ahlström & Larsson 2006; Tee et al. 2007; Daremo & Hagland 2008; Walsh & Boyle 2008). This study illustrated a large focus on documentation, and although documentation is an important part of health professionals' practice, it cannot entirely reflect the intrinsic nature of the relationship with the consumer. It is our practice as a mental health nurse and the use of our skills in everyday encounters that play a major role in the recovery of the consumer.

This study provides insight into how mental health nurses make decisions in their daily practice within the culture of the inpatient unit. The decision making of individual nurses is relevant as accountability is ensured both by organisational processes such as accreditation and auditing procedures as well as by individual nurses providing quality care and making a difference on a daily basis. The care provided by individual nurses is the result of continuous decision making by each nurse throughout every shift. Although mental health nurses are expected to follow a plan formulated by medical staff (Lakeman & Molloy 2017), they are accountable for their own practice and as such can and should express their opinion on the planned treatment and care provision. Knowledge on mental health nurse accountability enactment linked to the care plan can contribute to increased quality of care and ultimately improve health outcomes. Hence, this study adds to the body of knowledge relating to accountability in mental health services. Further such understanding can contribute to mental health nurses'

insight about how accountability can be enacted leading to their potential to improve service delivery.

8.4. WHERE TO FROM HERE? IMPLICATIONS AND FUTURE RESEARCH

In analysing the findings of this study, a number of key areas for change at individual and organisational level were identified. All the participants in the study were willing to reflect on their practices and wished to improve the quality of services provided, but they thought it was difficult in the current environment and culture. Improvements in their personal practice will only be possible if this is accompanied by changes in the immediate work environment.

8.4.1. CONTINUITY AND STATUS OF THE CONSUMER PLAN

The study found that the attention to flow and the number of discharges had an impact on how decisions were made in accountability enactment. Nurses focused on the pressure for discharge through medicalised and reactive care and viewed the care plan as low priority. The Consumer Plan can however be utilised as a tool to assist in the improvement of flow in mental health units as the plan can provide vital information on the consumer, their circumstances and concerns regarding mental and physical health. If the Consumer Plan is regarded as part of the flow and discharge process this will impact on accountability enactment. The Consumer Plan will be seen as high priority as a consequence.

To this end the status of the Consumer Plan needs to be raised and this plan should be central to all care discussions rather than an invisible document in the electronic system. It needs to be a requirement for mental health professionals to develop care with the Consumer Plan at the forefront of care discussions during multidisciplinary team meetings. This will raise the status and profile of the Consumer Plan and will send a message to all health professionals that this plan is important. A suggestion for further research is to explore how the Consumer

Plan can be incorporated in the care development by multidisciplinary teams to ensure that this occurs across all services. In this context research with medical professionals and their ideas and thoughts on the care plan would be helpful as the care plan and attempts of the nursing staff to involve consumers (or not) cannot be seen in isolation. An increased knowledge on medical professionals' motivations to exclude the plan in care discussions can provide an opportunity to overcome this barrier.

8.4.2. MOVING THE RECOVERY MODEL BEYOND RHETORIC

As outlined in the Chapter one of this thesis, mental health care frequently appears to fail its consumers. This study has demonstrated the importance of the implementation of the recovery model in all aspects of mental health care to facilitate the important work that mental health nurses do beyond the administration of medications. Psychiatrists are often considered the leaders of the multidisciplinary team and as a result the treatment decisions made by medical staff are followed through by all other health professionals.

The study found that the focus of care was on symptom management and stabilisation to facilitate discharge through maximising the clinical effectiveness of medications. The focus of care could also include the evaluation of the effect on consumers' functional outcomes through the recovery model, and so include cognitive, behavioural, social, occupational and practical interventions (Kinderman, Sellwood & Tai 2008). For mental health nurses to enact their accountability and provide therapeutically informed care while discussing the care plan, mental health practice must move to services provision based on the recovery model.

Postgraduate education for mental health nurses may positively contribute to nursing practice and consumer outcomes through the broadening of awareness

of factors that contribute to consumer presentations (Carlyle, Crowe & Deering 2012). This practice and newly acquired skills can, however, only be put in place and practiced when facilitated by the dominant philosophical beliefs of care provision. The introduction of a structured psychotherapeutic nursing model would support nurse's everyday practice and strengthen the nurse identity (Carlyle, Crowe & Deering 2012), but cannot be realised unless it is supported by the overarching model of care in the inpatient environment. Barber (2012) suggests that becoming recovery focused does not mean abandoning our medical knowledge. Problems occur however when medical knowledge and acute treatment is the overarching determinant in treatment planning and therapeutic engagement or therapies are not part of the treatment package (Kinderman, Sellwood & Tai 2008; Beecher 2009).

Management as well as medical staff can facilitate consumer involvement by creating and honouring time for mental health nurses to have therapeutic communications with the consumer. In addition, the medical staff can incorporate the Consumer Plan in their treatment planning and ask for it during the multidisciplinary meetings. For this to occur, however, organisational and cultural change may be needed. Leadership is one of the most influential factors impacting organisational culture and change (Erskine et al. 2013). Good leadership that does not foster a culture of blame is paramount in a health environment where other members of the team can speak up comfortably and share errors so that everyone can learn (Azizi, Siddiqui & Iqbal 2017).

A culture needs to be established where irrespective of their designation, all members of the team are treated with an equal amount of respect and consideration (Azizi, Siddiqui & Iqbal 2017). This will empower health professionals to raise concerns and share any errors. In their study Erskine et al. (2013) conclude that without senior leader commitment to continuous

improvement over a long time scale and without serious efforts to distribute leadership tasks to all levels, healthcare organisations are less likely to achieve positive changes to sustainable improvement to organisational culture. This suggests that for cultural and organisational change to occur, strong leadership on meaningful care plan development needs to be initiated at a higher level than middle management in an inpatient unit. The literature suggests that changing behaviour can be a challenging task and is more likely to occur when it is accompanied by a culture change (Azizi, Siddiqui & Iqbal 2017; Curry et al. 2018). More research on the impact of culture on the performance of mental health nurses and other health professionals and how culture can be utilised to initiate change can provide insight on how the work environment can facilitate high quality care.

As highlighted above, a changed working culture may also impact on how feedback is viewed. Feedback can be considered to promote changing behaviour and to increase consumer involvement in care planning and therefore facilitate the use of the recovery model. Feedback is required for linking an outcome to a particular behaviour. It informs team members regarding the progress towards the goal and whether an action plan is effective (Keith & Frese 2011). Contrary to this, however, Rashkovits & Drach-Zahavy (2016) found that only when performance feedback was low did the nursing team's accountability contribute to team learning. When performance pressure increases, team learning may decrease, since the elevated motivation to perform well interferes with experimentation and learning and is translated instead into greater efforts for doing more of the same rather than investing in improving the processes (Gardner 2012). Feedback may then lead to repeat routine work strategies rather than exploration of improved ones (Rashkovitz & Drach-Zahavy 2016). This could be observed in the Enactment of Accountability Study when nurses focused on

the feedback via audits which required the presence of a plan in the electronic system. Therefore limited attention was paid to the improvement of the process of care planning with consumer involvement. The study by Rashkovitz & Drach-Zahavry (2016) indicated that there is a need to provide nurses with adequate time and autonomy rather than feedback only. This suggests that the right kind of feedback needs to be provided to increases a desire to perform well and with consumer outcomes in mind. Further research can be undertaken to explore how feedback impacts on nurses' decision to improve the care provided.

8.4.3. INCREASING NURSES' UNDERSTANDING OF THE COMPLEXITIES OF ACCOUNTABILITY

The measurement of performance and the demonstration of accountability and quality in clinical care has a long history and is part of modern health service management (Carlos et al. 2015; Nolan et al. 2015; Curtis et al. 2018). What is not so well known, however, is what exactly individual accountability looks like and how it could be enacted in an optimal way. The research revealed that accountability was enacted with a strong focus on risk management and acute treatment rather than enacting accountability also through relationships with the consumer. The focus was on clinical care that could be measured and verified through documentation. This could be observed in the development of care plans which were often updated in the electronic system via cut and paste without any consumer consultation.

Accountability enactment for the care plan needs to involve treatment planning and incorporating the consumer's view on the future and where they see themselves. Mental health nurses also need to reflect on what they consider risks in the consumer's treatment and if the care being provided is creating risks. In the enactment of accountability the wellbeing of the consumer needs to be central to

care decisions rather than privileging the risk aversion of the health professionals.

Measurement in mental health services often takes place by evaluating documentation in the electronic system (Kilbourne et al. 2018). The quality of documentation however covers only a part of the accountability requirement. Accountability also consists of the quality of the care provided during face-to-face engagement and the relationships that are developed with the consumer. These relationships and moments of interaction between the mental health nurse and the consumer are most valued by consumers (Snell, Crowe & Jordan 2009; Thomson & Hamilton 2012; Pazargardi et al. 2015).

Moreover, it is important for nurses to realise that there is a dichotomy between working ideally as an accountable practitioner and influences in the real world such as a busy acute inpatient unit which creates its own expectations. Health professionals need to be aware they are being socialised into the team and may not wish to upset any colleagues. Factors such as not wanting to disagree with medical staff or being viewed as a recalcitrant or incompetent clinician may have an impact on how accountability is enacted. I suggest that this is a domain for future research. Further research could also shed light on how other health professionals enact accountability in the inpatient environment.

8.4.4. TRAINING ON HOW TO CREATE A CARE PLAN THROUGH MEANINGFUL ENGAGEMENT

Some nurses in the study made it clear they had the skills and qualifications to provide therapy or to engage in therapeutic communication with the consumer. It was not apparent to all however that these skills can also be used in the development of a meaningful Consumer Plan. Mental health nurses did not always see a relationship between therapeutic skills and therapeutic engagement

on the one hand and consumer care planning on the other hand, which suggests there may be a gap in knowledge. This is not new and in a qualitative study of professional perspectives on consumer and carer involved care planning, staff acknowledged the lack of training in pre and post registration courses with regard to the care plan and reported that professional development training was 'ad hoc' and not always evaluated (Bee et al. 2015a).

Training on its own may however not facilitate a change in practice and improve consumer outcomes. Grundy et al. (2017) evaluated a two-day training intervention on consumer and carer involved care planning amongst community mental health professionals and found that staff believed that the training improved understanding, developed skills and increased confidence. Some professionals however thought that the specific organisational context in which care planning occurred should have been factored into the course. Staff specifically mentioned computer systems and assessment and care plan templates (Grundy et al. 2017). What also stood out was that no psychiatrists or senior management attended the training (Grundy et al. 2017). A lack of training amongst leaders in the organisation may complicate the implementation of consumer involvement in care planning. Interestingly, Lovell et al. (2018) who evaluated the effectiveness of the same training program found no statistically significant difference in primary outcome between the intervention and usual care at 6 months. Results of the study showed no corresponding effects on consumer perceptions of autonomy support or other outcomes (Lovell et al. 2018). These findings highlight that in the process of improving care delivery health professionals must not lose sight of improvement in consumer outcomes that the care aims to achieve.

Brooks et al. (2018) found in an evaluation of this same program that there was a failure of training to become embedded in service provision. The evaluation

demonstrated a lack of readiness by the organisation to accept change and a lack of investment in the amount and range of relational work that was needed to successfully enact the training intervention. Relational work was described as the work that individuals need to develop and invest in negotiating relationships with others which includes intra-professional relational work and the relational work between professionals and consumers (Brooks et al. 2018). While support was available for the training itself, which facilitated attendance, further higher level support was not readily available to encourage the embedding of skills developed during the training which may have compounded the contextual barriers identified by the participants (Brooks et al. 2018). Contextual barriers were lack of resources, increased workloads and staff sickness and attrition (Brooks et al. 2018). This supports the discussion on the importance of the work environment and culture and the potential impact on the practice of health professionals. Training can be rolled out in health care organisation but the environmental culture, processes and structure must support the implementation of the knowledge that has been obtained during the training.

Despite the above outlined limitations of the impact of staff training interventions on practice, it may be helpful to explore and evaluate care planning activities between the nurse and the consumer in the inpatient unit and investigate any potential issues in this process of engagement. Increased understanding of specific challenges in consumer involvement may lead to targeted training with a focus on particular problems rather than general training in consumer involvement. As demonstrated however by previous research, training of health professionals must be accompanied by organisational and cultural change to support the changed practice behaviours.

8.5. CONCLUSION

The care plan and the involvement of consumers and their families in this plan is central to international and national policy initiatives, but consumers often state they feel excluded from the process (Walsh and Boyle 2009; McHugh & Byrne 2012; Bee et al. 2015a). The literature highlighted that mental health nurses and consumers understand the importance of the therapeutic relationship which is the basis for care plan development, but this relationship is often not utilised in care planning. In an increasingly complex mental health care environment with many treatment options, it is important that consumers and their family are consulted and have a say in their ongoing care. It is the enactment of accountability that can ensure that the mental health nurse spends time with the consumer in therapeutic engagement and skilfully guides the conversation. Yet, this study found that a partial failure of accountability was a major contributor to the lack of meaningful Consumer Plans.

As long as mental health services view medical staff as the leaders of the multidisciplinary team and health professionals prefer a medicalised view of possible treatment options, then the capacity for meaningful care plan development remains limited. Undoubtedly most, if not all, health professionals have good intentions and would like to provide high quality care in the interest of the consumer, but the outcomes of that treatment are not always regarded positively by the consumers who would like to be at the centre of its planning (McHugh & Byrne 2012; Bee et al. 2015a; Brooks et al. 2017). Moreover, mental health consumers continue to re-present to our services with low levels of wellbeing and a reduced life expectancy often as a result of mental and physical health challenges (DeHert 2011). The question can be asked, how can mental health nurses provide appropriate care with the complete involvement of consumers and their significant others? The mental health service needs to

embrace the Consumer Plan. This will provide an opportunity for nurses to demonstrate their therapeutic skills, thus raising the profile of mental health nurses as key members of the multidisciplinary team.

This thesis has explored the enactment of accountability by mental health nurses. A focused ethnography involving mental health nurses and other health professionals was undertaken in one inpatient unit. Data from 12 in-depth semi-structured interviews and 6 months of non-participant observation of multidisciplinary meetings and clinical handovers were analysed using the theory of accountability, care planning and the role of the nurse in the inpatient setting. The need to forego non-participant observations of consumer-nurse engagement in care planning and the observations of Consumer Plans was indicative of the highly acute nature of the inpatient unit where a majority of consumers were admitted on an involuntary basis.

The study provides a deeper understanding of the enactment of accountability by mental health nurses and how a ward culture of accountability impacts on Consumer Plan creation. The findings highlighted the medicalisation of the work environment with attention to acute treatment and risk management, driven by a focus on reducing the length of stay and therefore increasing the discharge rate. In this environment nurses felt their role was diminished and decision making in accountability enactment focused on managing risks and medications. As a result, nurses let go of meaningful Consumer Plan development activities and in the process the provision of high quality engagement.

NINE: APPENDICES

9.1. OPERATIONAL DEFINITIONS

Clinical Practice Consultant

A senior nurse who is responsible for the clinical leadership in a community mental health team or the inpatient unit.

Community Treatment Order

A Community Treatment Order is a legal way of proving treatment to a person with a mental illness in the community setting when they are unable to agree to treatment and may not be safe. A Community Treatment Order can only be made when there are no less restrictive ways of ensuring that a person gets appropriate treatment.

Consumer Plan

The Consumer Plan is one key component of the NCare Plan (multidisciplinary care plan) and focuses on the signs of un-wellness and actions to be taken as well as the wishes of the consumer and the recovery goals the consumer would like to achieve. This plan outlines the consumer perspective on recovery.

Cut and paste

A process by which text or other data is cut and moved from one part of a document and inserted elsewhere.

Electroconvulsive Therapy or ECT

A procedure used to treat certain psychiatric conditions. It involves passing a carefully controlled electric current through the brain which affects the brain's activity and aims to relieve depressive and psychotic symptoms.

Guardianship Board

Now known as the South Australian Civil and Administrative Tribunal (SACAT) deals with applications with regard to prescribed medical treatment and the making of orders to grant special powers authorising the use of force to ensure proper treatment and care, restriction of movement and detention.

Inpatient Treatment Order

An Inpatient Treatment Order is a legal way of providing treatment to a person with a mental illness when they are unable to agree to treatment and may not be safe. An Inpatient Treatment Order can only be made when there are no less restrictive ways of ensuring that a person gets appropriate treatment

Inpatient Unit

Inpatient units provide short to medium term 24 hour inpatient assessment and treatment services for people experiencing serious episodes of mental illness who cannot be adequately supported in the community environment.

Mental Health Nurse

Mental health nursing is a specialised branch of nursing with a focus on the care of people with mental illness or distress. Mental health nurses work with their clients to promote psychological well-being, emotional health and physical wellbeing. Generally mental health nurses are registered nurses who have completed a post graduate qualification in mental health nursing.

NCare Plan

New Care plan or multidisciplinary care plan used in the state where the research was undertaken. The plan consists of a Consumer Plan, a Family/Carer's Plan and children's safety plan and a Service Plan.

Registered Nurse

Registered Nurses in Australia include persons with at least a three-year training certificate, diploma or degree. From 2010 a national registration scheme came into effect, the Australian Health Practitioner Registration Authority (AHPRA).

SLS system

The Safety Learning System is an application that enables health services to record, manage and investigate and analyse consumer and worker incidents as well as consumer feedback. It facilitates clinical governance by providing a single system across the state and helps to embed a culture of safety and quality into the daily routines of health professionals in the state (Government of South Australia 2016).

Team Leader

A senior mental health professional who is responsible for the overall leadership of a community mental health team or inpatient unit. In the inpatient unit the team leader is a nurse, in community mental health teams the team leader can be a nurse, psychologist, occupational therapist or social worker.

Service Plan

The Service Plan is the component of the NCare Plan which describes how the service will support the consumer while taking into consideration the wishes of the consumer.

9.2. LITERATURE SEARCH STRATEGIES

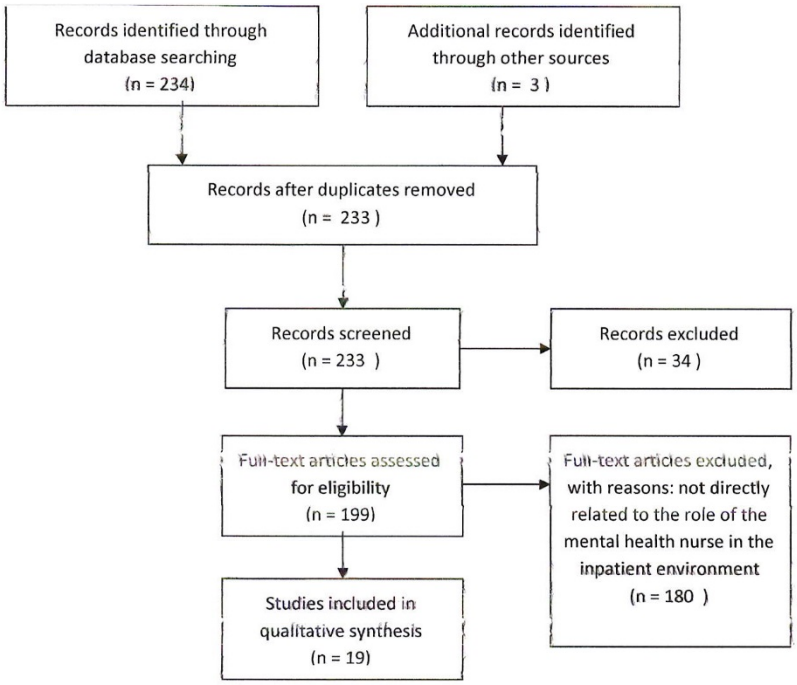
The first component of the search concentrated on the role of the mental health nurse in the multidisciplinary team. The terms in this search were: **(MH "Mental Health"), (MH "Mental Health Services"), (MH "Hospitals, Psychiatric"), (MH "Community Mental Health nursing") OR (MH "Community Mental Health Services").** These words were combined with the search terms (**MH "Multidisciplinary Care Team"), Multidisciplinary, interprofessional, multidisiplinary, inter-professional, interdisciplinary, inter-disciplinary, "integrated care"**. This was combined with (**MH "accountability"), (MH "Nursing Role").** Words or combination of terms were subsequently combined with the Boolean operator 'OR' and across all concepts with 'AND'.

Another search was conducted on the topic of care plans and care planning. The inclusion criteria incorporated all literature on care plans by mental health nurses in an inpatient setting. The terms used here were **MH "Patient Care Plans", "care plan*", "Consumer Participation", (patient, consumer*, client*, user), (driven, involve* participation, centred).** These terms were combined with the words **(MH "Mental Health", Mental Health Services"), (MH "Hospitals, Psychiatric"), (MH Community Mental Health Nursing"), (MH "Community Mental Health Services").** Again search terms or combination of terms were subsequently combined with 'OR' and across all concepts with 'AND'.

The third search concentrated on enactment of accountability in health services. The search terms used were: **accountab* AB accountab*, MH** "**accountability", (health, healthcare, emergency, medical), (worker* practitioner* professional*technician*), audiolog*, clinician*, dentist*, doctor*, midw*, nurs*, "occupational therapist*",paramedic*, pathologist*, physician*, psychologist*, "social worker*", "speech pathologist*", "speech**

therapist*". These search terms were combined with the words (**MH "Mental Health Services", "Hospitals, Psychiatric"), ("MH Community Mental Health Nursing"), (MH "Community Mental Health Services"), (MH "Mental Health Personnel"), (MH "Mental Health"), (MH "Mental Health Organisations")**. Search terms or combination of terms were subsequently combined with the Boolean operator 'OR' and across all concepts with 'AND'.

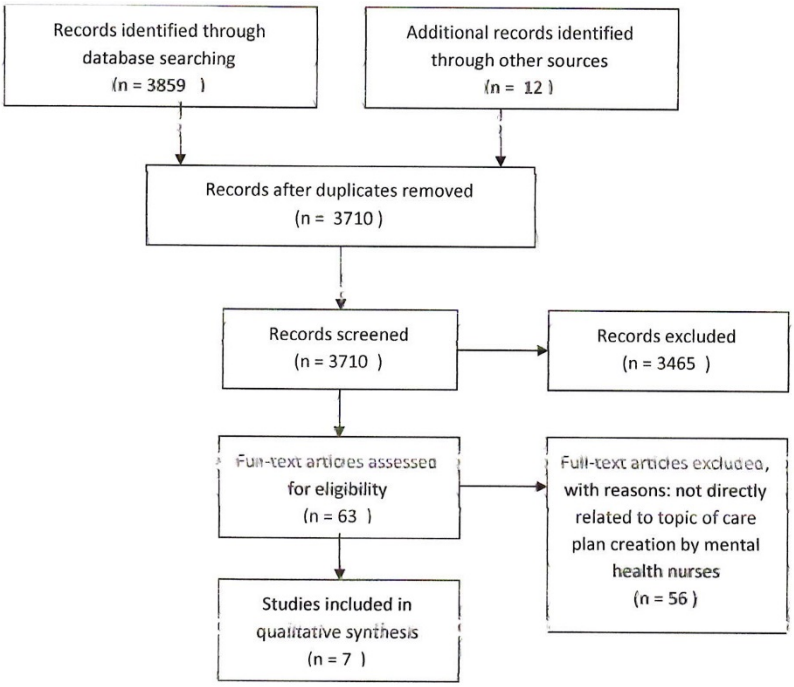
PRISMA 2009 Flow Diagram
Search One



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement.* PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

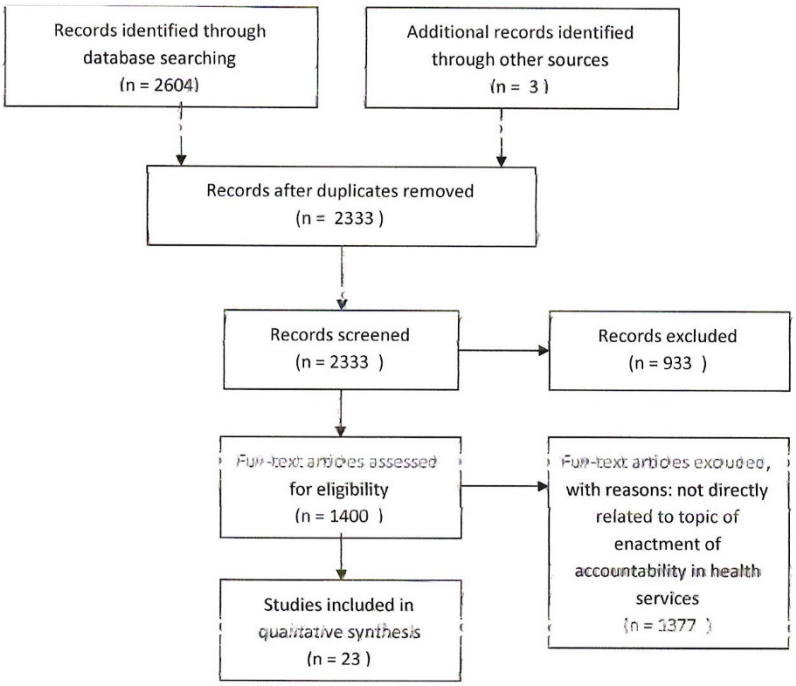
PRISMA 2009 Flow Diagram
Search Two



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement.* PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

PRISMA 2009 Flow Diagram
Search Three



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement.* PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

9.3. DATA ANALYSIS

First Level Significant segments, Words, Phrases (Sample only)	Second level categories	Third level – Sub themes	Fourth level – Theme example
The low self-esteem of mental health nurses You feel undermined and dismissed Nurses waiting around for doctors Nurses are drones Nursing as profession not valued It is not acceptable to use skills Nursing staff were exhausted, and completely traumatised Crisis mode in the ward I struggle with the consumer's sort of perspective of it because we do it with clients who are really unwell and its gobbledygook Unfair to develop a care plan for someone who is unwell A care plan should not be done until patient becomes voluntary Frustrations of nurses about ward environment I have been frustrated for the last 15 years as the acuity has gone up Some have said that they have felt put down or they're just not confident Nursing staff busy or frustrated Task mentality in nursing The holisticness gets lost in the routine Doctors need to walk the talk I don't believe the medical staff actually read nursing notes Nursing has gone towards more paperwork I have got to type it (care plan) up Lack of consistency in systems There were many things I could see and felt I didn't have a voice Care planning not done with client Doctors being the focal point People just put odd one or things in there, that's all they do They just copy it Two systems paper and computer Cut and paste Exhaustion in their voice. You could tell it was 21.00 at night and they were exhausted You haven't got the opportunity Because there's always somebody there wanting something. To do that you've got to neglect someone else, that's frustrating for them and for me There are a lot of things a nurse has to do every shift The key priority is the medications	Undervalued as nurse Low self esteem Viewing nurses role as inferior Lack of use of skills Following medical staff Feeling overwhelmed Crisis mode Time constraints Feeling pressured Frustration	Impact on nursing practice Lack of therapeutic engagement Task oriented care planning Expectation of reactive care Defensive care Nursing practice as extension of medical staff	The current state of mental health nursing: mental health nurse practice

Nurse 1 Denise

Nurse 2 Marion

Nurse 3 John

Nurse 4 Suzanne

Nurse 5 Karen

Nurse 6 Andrew

Nurse 7 Wendy

Nurse 8 Sam

Nurse 9 Mark

Nurse 10 Gloria

Nurse 11 John

Nurse 12 Joseph

9.4. ETHICS APPROVAL

Government of South Australia
SA Health

SA Health Human Research Ethics Committee
Level 10, Citi-Centre Building
11 Hindmarsh Square
ADELAIDE SA 5000
Telephone: (08) 8226 6367
Facsimile: (08) 8226 7088

Josephien Rio
Flinders University of South Australia
[redacted]

Dear Mrs Rio

HREC reference number: HREC/15/SAH/42

Project title: The enactment of accountability by mental health nurses in a mental health inpatient unit

RE: HREC Application – Approval

Thank you for responding to the issues raised by the SA Health HREC in relation to the above project. Your response was reviewed by a sub group of the HREC out-of-session.

I am pleased to advise that your application has been granted full ethics approval and appears to meet the requirements of the *National Statement on Ethical Conduct in Human Research*.

Please note the following conditions of approval:

- The research must be conducted in accordance with the 'National Statement on Ethical Conduct in Human Research.'
- A progress report, at least annually, must be provided to the HREC.
- When the project is completed, a final report must be provided to the HREC.
- The HREC must be notified of any complaints by participants or of adverse events involving participants.
- The HREC must be notified immediately of any unforeseen events that might affect ethical acceptability of the project.
- Any proposed changes to the original proposal must be submitted to and approved by the HREC before they are implemented.
- If the project is discontinued before its completion, the HREC must be advised immediately and provided with reasons for discontinuing the project.

HREC approval is valid for 3 years from the date of this letter.

Should you have any queries about the HREC's consideration of your project please contact Pamela Cooper, Executive Officer of the HREC, on (08) 8226 6431 or hrec@health.sa.gov.au

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a SA Health site until separate authorisation from the Chief Executive or delegate of that site has been obtained via the completion of a Site Specific Assessment form. Please contact David van der Hoek via email at ResearchGovernance@health.sa.gov.au to discuss this process further.

If University personnel are involved in this project, the Principal Investigator should notify the University before commencing their research to ensure compliance with University requirements including any insurance and indemnification requirements.

The HREC wishes you every success in your research.

Yours sincerely

[redacted]

Andrew Alston
A/CHAIRPERSON
HUMAN RESEARCH ETHICS COMMITTEE

2/6/2015

HREC/15/SAH/42 – The enactment of accountability by mental health nurses in a mental health inpatient unit

9.5. SITE SPECIFIC APPROVAL

Government of South Australia
SA Health

Ms Josephien Rio
[redacted]

Dear Ms Rio

RE: SITE SPECIFIC ASSESSMENT – AUTHORISATION

Project Title: The enactment of accountability by mental health nurses in a mental health inpatient unit.

SSA Reference: SSA/15/SAH/78

Site Name: [redacted]

Thank you for submitting the site specific assessment (SSA) form for the above named project.

Following a review of the SSA form and attachments for the above project, and noting the protocol was ethically approved in full by the Human Research Ethics Committee (TQEH) (HREC/15/SAH/42), I am pleased to advise that your project is now authorised at the above site and may commence.

Please note the following conditions of authorisation:

- Authorisation is limited to the site identified in this letter only.
- Project authorisation is granted for the term of your project outlined in Section 9 of the SSA, or until the project is complete (whichever date is earlier). Should you require an extension to this timeframe, please submit an amendment to the SSA with a brief justification.
- The Coordinating Principal Investigator is responsible for notifying the institution via the Research Governance Officer of any changes to the status of the project within a timely manner, including discontinuation or withdrawal of the study at the named site, or changes to the scope of the project including the participants, research staff, site resources or other governance matters affecting the site.
- If University personnel are involved in this project, the Principal Investigator should notify the University before commencing their research to ensure compliance with University requirements including any insurance and indemnification requirements.
- The study must be conducted in accordance with the conditions of ethical approval provided by the lead HREC, and in conjunction with the standards outlined in the *National Statement on Ethical Conduct in Human Research (2007)*.

- The Coordinating Principal Investigator must ensure regular (at least annual) progress notes are submitted. These progress reports should be submitted directly to the Research Governance Officer.
- A copy of this letter should be maintained on file by the Coordinating Principal Investigator as evidence of project authorisation.

Should you have any queries regarding your project authorisation, or any other matters pertaining to research governance, please contact [redacted]@health.sa.gov.au Ph: (08) 8553 4208; or researchgovernance@health.sa.gov.au Ph: (08) 8463 6145.

Yours sincerely

[redacted]

[redacted]
RESEARCH GOVERNANCE OFFICER
[redacted]ocal Health Network Inc

23 June 2015

9.6. LETTERS OF SUPPORT

Government of South Australia
SA Health

File: 2015-03456/1
Doc: eA882384

[redacted]ocal Health
Network Inc.
Adelaide Office
Level 1 & 2
[redacted]
Adelaide SA 5000
PO Box 287, Rundle Mall
Adelaide SA 5000
DX 243
Tel 08 8226 6120
Fax 08 8226 7170
ABN 96 157 660 816
www.countryhealthsa.sa.gov.au

The Executive Officer
SA Health Human Research Ethics Committee
PO Box 287
Rundle Mall SA 5000

Dear members of the SA Health Human Research Ethics Committee,

RE: Research ethics application - The enactment of accountability by mental health nurses in a mental health inpatient unit.

I am pleased to provide this letter of support for Ms Josephien Rio in her research project:

'The enactment of accountability by mental health nurses in a mental health inpatient unit.'

The proposed research can support SA Country Mental Health Services to better understand the barriers to creating and implementing high quality care plans and the role of accountability in the process. It is anticipated that this will positively impact on care plan compliance and ultimately improve the care for patients with ongoing mental health problems.

Yours sincerely

[redacted]

Clinical Director, [redacted] Local Health Network
Mental Health Services

Government of South Australia
SA Health

File: 2015-03456/1
Doc: eA882393

[redacted]ocal Health Network Inc.
Adelaide Office
Level 1 & 2
[redacted]
Adelaide SA 5000
PO Box 287, Rundle Mall
Adelaide SA 5000
DX 243
Tel 08 8226 6120
Fax 08 8226 7170
ABN 96 157 660 816
www.countryhealthsa.sa.gov.au

The Executive Officer
SA Health Human Research Ethics Committee
PO Box 287
Rundle Mall SA 5000

Dear members of the SA Health Human Research Ethics Committee,

RE: Research ethics application - The enactment of accountability by mental health nurses in a mental health inpatient unit.

I am pleased to provide this letter of support for Ms. Josephien Rio in her research project:

'The enactment of accountability by mental health nurses in a mental health inpatient unit.'

The proposed research can support SA Country Mental Health Services to better understand the barriers to creating and implementing high quality care plans and the role of accountability in the process. It is anticipated the research can assist in improving the care plan compliance rates and ultimately the delivery of services for people with serious ongoing mental health problems.

Yours sincerely

[redacted]

[redacted]
Acting Executive Director, [redacted] Local Health Network Mental Health Services

9.7. PARTICIPANT INFORMATION SHEET - STAFF

Flinders UNIVERSITY

Participant Information Sheet/Consent Form
Health/Social Science Research - *Staff*

Title: 'The enactment of accountability by mental health nurses in a mental health inpatient unit'

Short Title	*The enactment of accountability*
Protocol Number	*HREC/15/SAH/42*
Project Sponsor	*N/A*
Principal Investigator	*Josephien Rio*
Location	*X Inpatient unit at X Hospital*

What does my participation involve?

You have been invited to participate in the research project exploring the enactment of accountabiliy by mental health nurses in an inpatient unit. This may include one or more of the following:in depth interviews, focus groups and field observation. You will be asked to consent for each element of participation.

Introduction
This Participant Information Sheet tells you about the research project. Please ask about anything that you don't understand or want to know more about.

If you decide you want to take part, you will be asked to sign the consent section. By signing it you are telling us that you:
• Understand what you have read
• Consent to take part in the research project as described in this sheet.

The purpose of this research

The aim of the study is to understand:

'What impact, if any, accountability has on the development and use of care plans by mental health nurses?

The purpose is to investigate barriers to creating and implementing high quality care plans and the role of accountability in the process.

The study is being initiated and will be used by the researcher Josephien Rio to obtain a PhD degree through Flinders University of South Australia. This research has not been funded by a third party.

Other relevant information about the research project
The aim is to recruit around 50 participants in total. The Rural and Remote inpatient unit at Glenside Hospital is the setting in which the study will be conducted.

What does participation in this research involve?

There are several elements to the research: interviews, observation and focus groups.

Interviews ☐ **Yes** ☐ **No**
Semi structured interviews which will take approximately 1 hour. While some questions will be asked to guide the interview, the discussion will allow for new ideas to be brought in and discussed. The interview will be audio taped. If you decide to participate there are two options. We can meet after hours and negotiate a time and place off campus to undertake the interview. Alternatively the interview can take place during work time in which case the time will be

10.

negotiated with the ward manager to minimize any interruptions in the ward. The last option might result in the ward manager being aware of your participation in the research. Interviews will take place in a private room at the far end of the Rural and Remote Ward.

Observation ☐ **Yes** ☐ **No**
The researcher will observe how you develop the care plan with your patient. The patient will be asked for consent as well. This might take half an hour, depending on how long the development of the care plan takes. This will take place in a separate room in the rural and remote ward to maintain confidentiality.

Do I have to take part in this research project?
Participation in the research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you find that some of the questions asked during the research cause you some discomfort or stress, or that you simply do not wish to answer, then you are free to not answer and move to the next question, or you may stop.

If you do decide to take part, you will be asked to sign a Consent Form and you will be given a copy to keep. Your decision whether to take part or not, or to withdraw at a later stage, will not affect your relationship with professional staff or your relationship with Josephien Rio or the organisation of Country Mental Health.

What are the possible benefits of taking part?
We cannot guarantee or promise that you will receive any benefits from this research. Possible benefits may include the opportunity to reflect on own practice and to be part of service development.

What are the possible risks and disadvantages of taking part?
It might be difficult to ensure complete anonymity of participants with research conducted in a small community of one psychiatric inpatient unit at Glenside Hospital. However, the names and identifying details of participants will be kept confidential. To maintain confidentiality pseudonyms will be used. If preferred then interviews will be held off campus.

Participants in focus groups will be asked not to reveal discussions that took place within the focus group.

Should there be a possibility of identification of you through the reporting of particular data then this will be discussed with you prior to the use of this data.

To monitor and manage potential risks a Site Advisory Committee will be established consisting of a mental health peer support worker, a staff member, the Aboriginal Liaison person and the team leader/manager to discuss any issues that might arise. Members of the committee will be asked to give advice and will be invited to provide suggestions with regard to the research process. Regular meetings will be held to discuss the progress of the research which includes any issues/problems that have arisen. This might include the presence of 'gossip' or speculation on the ward as to who participates in the research.

What if I withdraw from this research project?
If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify Josephien Rio. If you do withdraw, you will be asked to sign a 'Withdrawal of Consent' form that will be provided to you.

Data collected up to the time you withdraw will form part of the research. If you do not want your data to be included, you must tell the researcher when you withdraw from the research project.

11.

What happens when the research project ends?
After the interviews have been completed and transcribed, transcripts will be given to participants to check whether anything needs to be amended to ensure an accurate representation of discussions. If there are changes, these will be incorporated in the data collection and analysis.

After completion of the research Josephien Rio will return to the Rural and Remote inpatient unit and undertake a presentation to the ward staff on the findings of the research. The Rural and Remote ward will also be informed of any subsequent publications.

How is the research project being conducted?

What will happen to information about me?
Any information obtained in connection with this research project that can identify you will remain confidential. Signed consent forms, any hardcopies with data and audio tapes will be stored in a secure place at the School of Nursing and Midwifery at Flinders University. Electronic information will be stored on the secure Flinders server. The data will be kept for a minimum of 5 years in accordance with the standards in the 'National Statement on Ethical Conduct in Human Research' (2007). Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums, but in such a way that you cannot be identified, except with your express permission.

In accordance with relevant Australian and/or South Australian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the researcher named at the end of this document if you would like to access your information.

Complaints and compensation
If you do experience discomfort or concern as a result of your participation in the research project, then you can raise this with the researcher or the ethics contact officer whose details are provided at the end of this sheet.
If appropriate and with your permission you will be assisted with arranging appropriate support. Counselling is available through the Employee Assistance Program.

Who has reviewed the research project?
The ethical aspects of this research project have been approved by the Human Research Ethics Committee of SA Health and Flinders University. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*.

Further information and who to contact
The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the following people:

Research contact person

Name	*Josephien Rio*
Position	*PhD student*
Telephone	[redacted]
Email	*Josephien.rio@health.sa.gov.au or zwar0010@flinders.edu.au*

12.

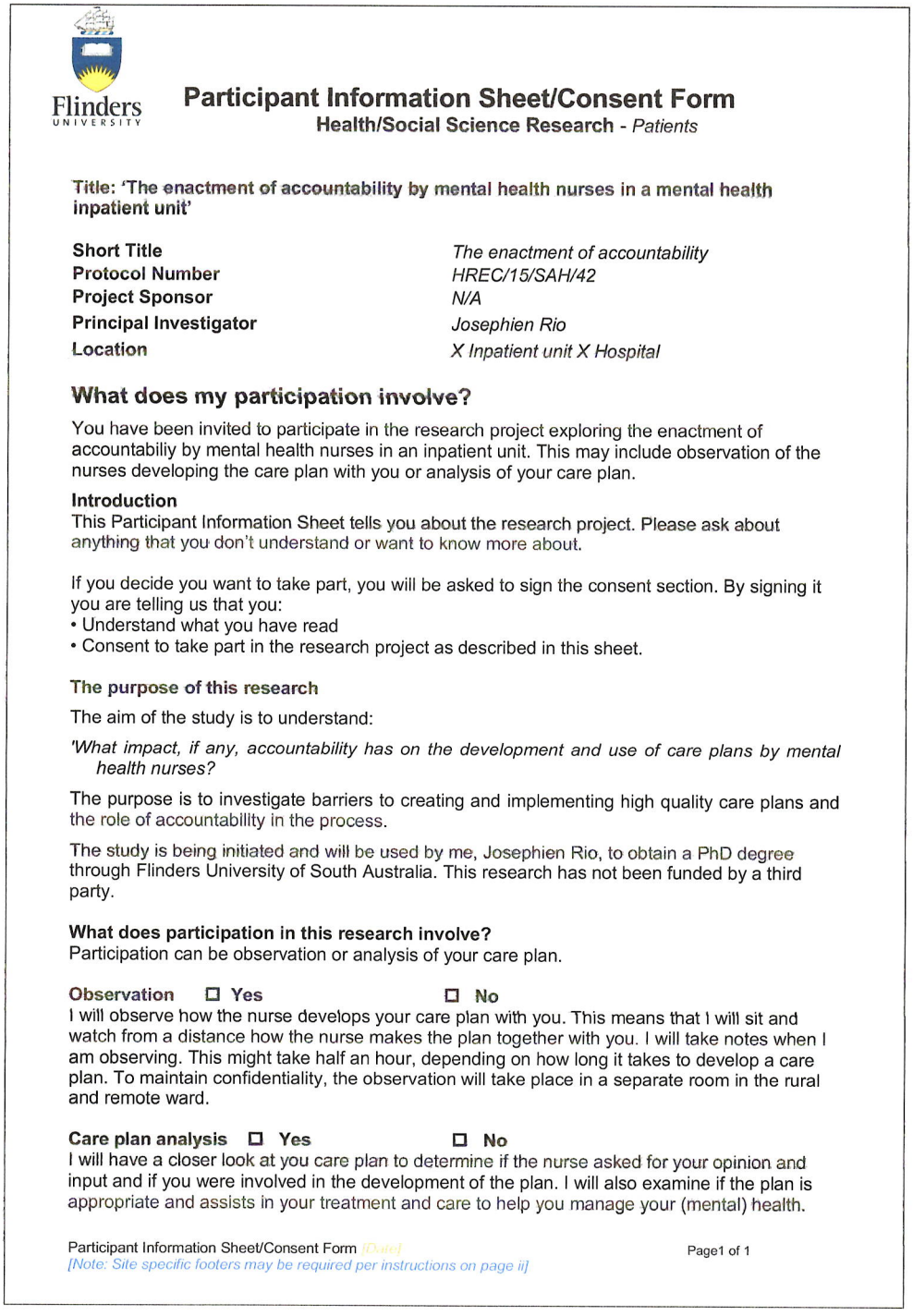
For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Complaints contact person

Name	*Pamela Cooper……..*
Position	*Chief Executive Officer at HREC at SA Health*
Telephone	*(08) 8226 7088*
Email	*hrec@health.sa.gov.au*

13.

9.8. PARTICIPANT INFORMATION SHEET- PATIENTS



Flinders UNIVERSITY

Participant Information Sheet/Consent Form
Health/Social Science Research - *Patients*

Title: 'The enactment of accountability by mental health nurses in a mental health inpatient unit'

Short Title	*The enactment of accountability*
Protocol Number	*HREC/15/SAH/42*
Project Sponsor	*N/A*
Principal Investigator	*Josephien Rio*
Location	*X Inpatient unit X Hospital*

What does my participation involve?

You have been invited to participate in the research project exploring the enactment of accountabiliy by mental health nurses in an inpatient unit. This may include observation of the nurses developing the care plan with you or analysis of your care plan.

Introduction
This Participant Information Sheet tells you about the research project. Please ask about anything that you don't understand or want to know more about.

If you decide you want to take part, you will be asked to sign the consent section. By signing it you are telling us that you:
• Understand what you have read
• Consent to take part in the research project as described in this sheet.

The purpose of this research

The aim of the study is to understand:

'What impact, if any, accountability has on the development and use of care plans by mental health nurses?

The purpose is to investigate barriers to creating and implementing high quality care plans and the role of accountability in the process.

The study is being initiated and will be used by me, Josephien Rio, to obtain a PhD degree through Flinders University of South Australia. This research has not been funded by a third party.

What does participation in this research involve?
Participation can be observation or analysis of your care plan.

Observation ☐ **Yes** ☐ **No**
I will observe how the nurse develops your care plan with you. This means that I will sit and watch from a distance how the nurse makes the plan together with you. I will take notes when I am observing. This might take half an hour, depending on how long it takes to develop a care plan. To maintain confidentiality, the observation will take place in a separate room in the rural and remote ward.

Care plan analysis ☐ **Yes** ☐ **No**
I will have a closer look at you care plan to determine if the nurse asked for your opinion and input and if you were involved in the development of the plan. I will also examine if the plan is appropriate and assists in your treatment and care to help you manage your (mental) health.

Participant Information Sheet/Consent Form *[Date]* Page1 of 1
[Note: Site specific footers may be required per instructions on page ii]

9.

The care plan will be given to me in de-identified form which means that I do not know who the patient is the plan belongs to.

Do I have to take part in this research project?
Participation in the research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part, you will be asked to sign a Consent Form and you will be given a copy to keep. Your decision whether to take part or not, or to withdraw at a later stage, will not affect your relationship with professional staff or your relationship with Josephien Rio or the organisation of Country Mental Health.

What are the possible benefits of taking part?
We cannot guarantee or promise that you will receive any benefits from this research. Possible benefits may include that in the long term better, more appropriate care plans are developed together with you.

What are the possible risks and disadvantages of taking part?
It might be difficult to ensure complete anonymity of participants with research conducted in a small community of one psychiatric inpatient unit at Glenside Hospital. However, the names and identifying details of participants will be kept confidential. To maintain confidentiality pseudonyms will be used.

Should there be a possibility of identification of you through the reporting of particular data then this will be discussed with you prior to the use of this data.

To monitor and manage potential risks a Site Advisory Committee will be established consisting of a mental health peer support worker, a staff member, the Aboriginal Liaison person and the team leader/manager to discuss any issues that might arise. Members of the committee will be asked to give advice and will be invited to provide suggestions with regard to the research process. Regular meetings will be held to discuss the progress of the research which includes any issues/problems that have arisen.

What if I withdraw from this research project?
If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify Josephien Rio. If you do withdraw, you will be asked to sign a 'Withdrawal of Consent' form that will be provided to you.

Data collected up to the time you withdraw will form part of the research. If you do not want your data to be included, you must tell Josephien Rio when you withdraw from the research project.

What happens when the research project ends?

After completion of the research I will return to the Rural and Remote inpatient unit and give a presentation to the ward staff and patients on the findings of the research. I will also conduct a presentation to the Consumer Advisory Group at Glenside for which you can receive an invitation if you wish to attend. The Rural and Remote ward will also be informed of any publications.

How is the research project being conducted?

What will happen to information about me?

10.

Any information obtained in connection with this research project that can identify you will remain confidential. Signed consent forms, any hardcopies with data and audio tapes will be stored in a secure place at the School of Nursing and Midwifery at Flinders University. Electronic information will be stored on the secure Flinders server. The data will be kept for a minimum of 5 years in line with the standards in the 'National Statement on Ethical Conduct in Human Research' (2007). Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.

I expect that the results of this research project will be published and/or presented in a variety of forums, but in such a way that you cannot be identified, except with your permission.

In line with relevant Australian and/or South Australian privacy laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform Josephien Rio if you would like to access your information.

Complaints and compensation
If you do experience discomfort or concern as a result of your participation in the research project, then you can raise this with Josephien Rio or the ethics contact officer whose details are provided at the end of this sheet. If appropriate and with your permission you will be assisted with arranging appropriate support.

Who has reviewed the research project?
The ethical aspects of this research project have been approved by the Human Research Ethics Committee of SA Health and Flinders University. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007).*

Further information and who to contact
The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the following people:

Research contact person

Name	*Josephien Rio*
Position	*PhD student*
Telephone	[redacted]
Email	*Josephien.rio@health.sa.gov.au or zwar0010@flinders.edu.au*

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Complaints contact person

Name	*Pamela Cooper……..*
Position	*Chief Executive Officer at HREC at SA Health*
Telephone	*(08) 8226 7088*
Email	*hrec@health.sa.gov.au*

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Reviewing HREC name	*[Name of HREC]*
HREC Executive Officer	*[Name]*
Telephone	*[HREC Executive Officer Phone number]*
Email	*[HREC Executive Officer Email address]*

Reviewing HREC approving this research and HREC Executive Officer details

11.

9.9. CONSENT AND WITHDRAWAL FORM STAFF

Consent Form - *Staff*

Title: 'The enactment of accountability by mental health nurses in a mental health inpatient unit'

Short Title	*The enactment of accountability*
Protocol Number	*HREC/15/SAH/42*
Project Sponsor	*N/A*
Coordinating Principal Investigator/ Principal Investigator	*Josephien Rio*
Associate Investigator(s)	*N/A*
Location	*X Inpatient unit, At X Campus*

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) _____

Signature _____ Date _____

Declaration by Researcher†

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher† (please print) _____

Signature _____ Date _____

† An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.

Form for Withdrawal of Participation - *Staff*

Title: The enactment of accountability by mental health in a mental health inpatient unit

Short Title	*The enactment of accountability*
Protocol Number	*HREC/15/SAH/42*
Project Sponsor	*N/A*
Coordinating Principal Investigator/ Principal Investigator	*Josephien Rio*
Associate Investigator(s)	*N/A*
Location	*X Inpatient unit, at X Campus*

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my relationships with the researchers or colleagues at X Mental Health Services.

Name of Participant (please print) _____

Signature _____ Date _____

In the event that the participant's decision to withdraw is communicated verbally, the Senior Researcher must provide a description of the circumstances below.

Declaration by Researcher†

I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

Name of Researcher (please print) _____

Signature _____ Date _____

† An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own signature.

9.10 CONSENT AND WITHDRAWAL FORM PATIENTS

Consent Form - *Patients*

Title: 'The enactment of accountability by mental health nurses in a mental health inpatient unit'

Short Title	*The enactment of accountability*
Protocol Number	*HREC/15/SA/42*
Project Sponsor	*N/A*
Coordinating Principal Investigator/ Principal Investigator	*Josephien Rio*
Associate Investigator(s)	*N/A*
Location	*X Inpatient unit, X Campus*

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) _____

Signature _____ Date _____

Declaration by Researcher†

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher† (please print) _____

Signature _____ Date _____

† An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.

9.

Form for Withdrawal of Participation - *Patient*

Title: The enactment of accountability by mental health in a mental health inpatient unit

Short Title	*The enactment of accountability*
Protocol Number	*HREC/15/SA/42*
Project Sponsor	*N/A*
Coordinating Principal Investigator/ Principal Investigator	*Josephien Rio*
Associate Investigator(s)	*N/A*
Location	*X Inpatient Unit, at X Glenside*

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my relationships with the researchers or colleagues at X Health Services.

Name of Participant (please print) _____

Signature _____ Date _____

In the event that the participant's decision to withdraw is communicated verbally, the Senior Researcher must provide a description of the circumstances below.

Declaration by Researcher†

I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

Name of Researcher (please print) _____

Signature _____ Date _____

† An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own signature.

10.

9.11 INTERVIEW GUIDE

INTERVIEW GUIDE

OPENING QUESTIONS

1. What is a mental health care plan and why is it developed?
2. When and how do you develop a mental health care plan?
3. How do you use the mental health care plan in the daily care for the patient?

OTHER QUESTIONS

1. Who is accountable for the development of a mental health care plan?
2. What does accountability mean to you?
3. How does accountability impact on care planning?
4. If a ward culture of accountability could be seen as the values, procedures and practices on the ward, how do you think these affect the care planning that (a) you undertake with your patients and (b) that other staff undertake

9.12 AWARD – BEST POSTER - OCTOBER 2016

Conference Australian College of Mental Health Nurses, October 2016, Adelaide

Accountability Matters: Mental Health Care Plans

Ms Josephien Rio, Supervisors: Professor Jeffrey Fuller, Professor Eimear Muir-Cochrane, Associate Professor Kerry Taylor

Flinders UNIVERSITY
inspiring achievement

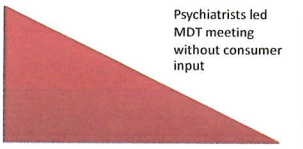
Study Aims
To understand barriers & facilitators in creating & implementing high quality care plans & role of accountability in the process.

Objectives
To uncover how the work environment influences understanding & practice of accountability.
What other factors may be implicated in the enactment of accountability by nurses in a mental health inpatient unit.

Significance
- Accountability is intended to ensure quality of patient care by holding practitioners to certain standards of practice[1].
- Care plans developed in collaboration with the consumer are considered best practice and can have positive effects on service and individual outcomes[2].
- Evidence suggests that care plans are not always prioritised, developed or implemented, calling into question how practitioners regard accountability.
- There is limited knowledge on how accountability is linked to the creation of a care plan in the mental health setting.

Care plans operationalise accountability – but what happens in practice? A focused ethnographic study of a mental health unit.

Findings
- Mental health nurses viewed accountability through care plans of a lesser priority than other aspects of care.
- Parallel processes of care planning were undertaken – one during MDT meetings without the consumer and another with the consumer outside this meeting.
- Content and quality of the care plans compromised as participants in the MDT meeting were unaware of the details of the consumer (wellness) plan.
- Some care plan development involved cutting and pasting of information to fulfil accountability obligations rather than direct engagement with consumers. This demonstrated that accountability can be executed in different ways some of which are not necessarily related to best practice.



Significance/policy and practice change
Increased understanding of how accountability affects nursing practice particularly with regards to the creation of the care plan can lead to:
1. A change in practice and improved care plan compliance.
2. Increased and meaningful inclusion of consumers in the planning of care and improved delivery of services for people who experience mental illness.

Email: [illegible]

[illegible]

CRICOS Provider No. 00114A

9.13 PRESENTATIONS

Conference of Australian College of Mental Health Nurses, October 24-26, 2018 in Cairns.

Title	Accountability facilitating recovery: An exploration of the enactment of accountability by mental health nurses
Paper Number	56
Paper Status	Accepted - Concurrent
Presentation Type	Oral Presentation - Research Award
Session Details	4B - Contemporary Practice Issues Oct 26, 2018 11:00 AM - 12:30 PM
Abstract Submission	Introduction Mental health consumers continue to re-present with low levels mental and physical health and reduced life expectancy. It is a consumer's human right to lead a fulfilling life, which can be facilitated through care planning as consumers are empowered to actively manage their own recovery. Yet, evidence suggest that the care plan is not routinely created, discussed or updated. We argue that the lack of meaningful care plan discussions between consumers and mental health professionals occurs through a failure of accountability. Aims/Objectives The aim of this research is to explore the relationship between a unit culture of accountability and the development of care plans by nurses. Methodology and methods A focused ethnography involving mental health nurses and other health professionals in one acute inpatient unit. Data from 12 in-depth semi-structured interviews with nurses and 6 months non-participant observation of multidisciplinary meetings and clinical handovers were analysed using the theory of accountability, care planning and the role of the mental health nurse. Results The work environment was found to be medicalised with attention to acute treatments and risk management that was driven by a focus on reducing the length of stay rather than recovery. Nurses felt their role was diminished with their decision making and accountability enactment directed to medical management. As a result nurses forewent commitments regarding consumer care plan development and therefore the provision of high quality therapeutic engagement. Outcomes/significance/implications for the profession Despite mental health service accreditation and auditing to ensure accountability, unless individual nurses include consumers in their care development then quality recovery oriented care will be absent. Therapeutic engagement with the consumer in the processes of care development and subsequent advocacy is the basis of accountability enactment and can facilitate recovery. Translation to policy and/or practice change - Education is required for all health professionals on the enactment of accountability - The role of inpatient mental health nurses should require consumer care plan development through therapeutic engagement Learning objectives - To gain an understanding of

	the workings and significance of accountability - To promote the therapeutic role of mental health nurses in the recovery model
Presenting Author	Ms Josephien Rio Affiliations: Flinders University
Co-Author	Professor Jeffrey Fuller Affiliations: Flinders University
Co-Author	Professor Eimear Muir-Cochrane Affiliations: Flinders University
Co-Author	Associate Professor Kerry Taylor Affiliations: Flinders University

The enactment of accountability by mental health nurses

Professor Eimear Muir-Cochrane, Professor Jeffrey Fuller, Josephien Rio[1], Associate Professor Kerry Taylor

[1]*SA Health*

S042: Aspects of workforce, Sutherland Theatrette, August 27, 2015, 10:30 AM - 12:30 PM

The aim of the presentation is to explore accountability and quality in mental health nursing practice. Accountability is an important aspect of nursing practice as it can improve quality of patient care by ensuring the standards of practice are upheld. An example of 'best practice' and quality care is the development of a mental health care plan in collaboration with the patient. There is evidence that mental health care plans are not developed, timely updated and/or implemented in SA country mental health teams. A literature review on accountability and quality of care indicated there is little knowledge on the relationship between clinician's perception of accountability and care planning practices. However, available research shows the work environment can influence how accountability is understood and practiced (Manual and Crowe 2014) and so there is a need for workplace clarity on what accountability is and how it can work in daily mental health nursing practice, such as through care planning. The enactment of accountability is affected by internal and external factors and there are tensions between these elements which affect the decision making in the process (Freeman et al. 2009). To facilitate quality mental health care there is a need to understand these 'accountability dilemmas' and how it is played out in everyday nursing. **Learning Objectives:** Accountability by health services and staff is vital so that quality is understood and communicated. A review of the literature will be discussed as it informs an ethnographic study on accountability by mental health nurses. Participants will learn about the relationship between accountability and quality and how these play out in current mental health services. Accountability is important in the ongoing reform of mental health services towards quality in a recovery model while the government is still in the process of developing Key Performance Indicators for Australian Public Mental Health Services (2011). **References:** Freeman, A., McWilliam, C, MacKinnon, J, DeLuca, S and Rappolt, S (2009). "Health professionals enactment of their accountability obligations: doing the best they can'." Social Science and Medicine 69(7): 1063-1071. Manual, J., Crowe, M (2014). "Clinical responsibility, accountability and risk aversion in mental health nursing: a descriptive qualitative study." International Journal of Mental Health Nursing 23: 336-343.

BIBLIOGRAPHY

Acker, G. (2011). Burnout among mental health care providers. *Journal of Social Work, 12*(5), 475-490.

Agar, M. (2006). An ethnography by any other name. *Forum: Qualitative Social Research, 7*(4), Art. 36. Retrieved from http://www.qualitative-research.net/fqs-texte/4-06/06-4-36-e.htm.

Allen, H. (2006). Using participants observation to immerse oneself in the field. *Journal of research in nursing, 11*, 397.

Allen, D. (2004). Ethnomethodological insights into insider-outsider relationships in nursing ethnographies of healthcare settings. *Nursing Inquiry, 11*(1), 14-24.

Anthony, P., & Crawford P. (2000). Service user involvement in care planning: the mental health nurse's perspective. *Journal of Psychiatric and Mental Health Nursing, 7*, 425-434.

Atkinson, P., Hammersley, M. (1998). Ethnography and participant observation. In N. Denzin, Y. Lincoln, (Eds.), *Strategies of qualitative research*. London: Sage Publications.

Australian Bureau of statistics (2015). 4329.0.00.004 – *National Health Survey: Mental Health and co-existing physical health conditions.* Australia 20014-2015. Retrieved from http:www.abs.gov.au/ausstats/abs@nsf/EB5F81AAC6462C72CA2581B40012A37d?opendocument.

Australian College of Mental Health Nurses (2010). *Standards of Practice for Australian mental health nurses*. Canberra. Retrieved from www.acmhn.org/publications/standards-of-practice.

Australian Commission on Safety and Quality in Health Care (2017). *National Safety and Quality Health Services Standards*. Sydney. Retrieved from https://www.safetyandquality.gov.au/.

Australian Government, Department of Health (2010). *The National Standards for Mental Health Services.* Canberra. Retrieved from: www.health.gov.au > Home > Education and Prevention > Mental Health > Publications.

Australian Government, Department of Health (2013). *Indicator 1a: Participation rates by people with mental illness of working age in employment: general population.* Retrieved from: http://www.health.gov.au/internet/publishing.nsfContent/mental-pubs-n.

Australian Government, Department of Health (2013). National Practice Standards for the Mental Health Workforce. Melbourne, Victoria. Retrieved from: https://www.health.gov.au/internet/main/publishing.nsf/content/...wkstd13.pdf.

Australian Government, Department of Health (2016). Administrative Record Keeping Guidelines for health practitioners. Retrieved from: www.health.gov.au/internet/main/publishing.nsf/.../admin-record-keeping-book.

Australian Government, Australian Institute of Health and Welfare (2018). *Mental health services in Australia: Key Performance Indicators for Australian Public Mental Health Services.* Retrieved from: https://www.aihw.gov.au/.../mental-health-services/mental-health-services-in-australia/.

Australian Government, Australian Institute of Health and Welfare (2018). *Restrictive practices,* Canberra. Retrieved from: https://www.aihw.gov.au/reports/mental-health.../mental-health.../restrictive-practices.

Australian Government, Australian Institute of Health and Welfare (2016). *Mental health Workforce,* Canberra. Retrieved from: https://www.aihe.gov.au/getmedia/...be60...Mental-health-workforce-2014.pdf.aspx.

Australian Government, Australian Health Ministers (2003). *National Mental Health Plan 2003-2008*, Canberra. Retrieved from www.health.gov.au > …>Education and Prevention>Mental health>Publications.

Azizi, S., Siddiqui, F., & Iqbal, I. (2017). Changing health culture: a prerequisite to improving patient safety. *Therapeutics and Clinical Risk Management, 13,* 623-624

Barber, M. (2012). Recovery as the new medical model for psychiatry. *Psychiatric Services, 63* (3), 277-279.

Bee, P., Brooks, H., Fraser, C., & Lovell, K. (2015a). Professional perspectives on service user and carer involvement in mental health planning: a qualitative study. *International Journal of Nursing Studies, 52 (12),* 1834-1845.

Bee, P., Price, O., Baker, J., & Lovell, K. (2015b). Systematic synthesis and facilitators to service user led care planning. *The British Journal of Psychiatry, 207*, 104-114.

Bee, P., Richards, D, & Loftus, S. (2006). Mapping nursing activity in acute inpatient mental healthcare settings. *Journal of Mental Health*, *207*, 217-226.

Beecher, B. (2009). The medical model, mental health practitioners, and individuals with schizophrenia and their families. *Journal of Social Work Practice, 23*(1), 9-20.

Beglinger, R., Roberts, N., & Zinkle, J. (2014). Creating a culture if accountability through obligations of membership. *Nurse Leader*, *12*(2), 44-47.

Bergsteiner, H. (2011). *Accountability theory meets accountability practice*. Bingley, UK: Emerald Group Publishing.

Berman, W. (2006). When will they ever learn? Learning and teaching from mistakes in the clinical context. *Clinical Law Review, 13*(1), 115.

Boster, D., & Manias, E. (2009). Person-centred interactions between nurses and patients during medications activities in an acute hospital setting: qualitative observation and interview study. *International Journal of Nursing studies, 47*(2), 154-165.

Bower, P., Roberts, C., O'Leary, N., Callaghan, P., Bee, P., Fraser, C., Gibbons, C., Olleveant, N., Rogers, A., Davis, L., Drake, R., Sanders, C., Meade, O., Grundy, A., Walker, L., Cree, L., Berzins, K., Brooks, H., Beatty, S., Cahoon, P., Rolfe, A., & Lovell, K. (2015). Evaluation of a training program for mental health professionals to enhance user involvement in care planning in service users with severe mental health issues (EQUIP): study protocol for a randomized controlled trial. *Trials Journal, 16*(1), 348.

Bradley, E., Curry, L, Devers, K. (2007). Qualitative data analysis for health services research. *Health services research, 42*(4), 1758-1772.

Brady, M. (2013). How to improve patient care by learning from mistakes. *Art & Science, 20*(9), 32-35.

Brady, N., Spittal, M., Brophy, L., & Harvey, C. (2017). Patients' experiences of restrictive interventions in Australia: Findings from the 2010 Australian survey of psychosis. *Psychiatric Services, 68*(9), 966-969.

Brinkerhoff, D. (2003) *Accountability and Health Systems: Overview, Framework and Strategies*, PHRplus, Maryland, United states. Retrieved from: https://www.who.int/.../accountability/AccountabilityHealthSystemsOverview.pdf.

Brooks, H., Lovell, K., Bee, P., Sanders, C., & Rogers, A. (2017). Is it time to

abandon Care Planning in mental health services? A qualitative study exploring the views of health professionals, service users and carers. *Health Expectations Journal, 21*(3), 597-605.

Brooks, H., Lovell, K., Bee, P., Fraser, C., Molloy, C., & Rogers, A. (2018). Implementing an intervention designed to enhance service user involvement in mental health care planning: a qualitative process evaluation. *Social Psychiatry and Psychiatric Epidemiology, 54*(2), 221-233.

Buchanan-Barker, P., & Barker, P. (2008). The Tidal commitments: extending the value base of mental health recovery. *Journal of Psychiatric and Mental Health Nursing*, *15*, 93-100.

Burns, N., & Grove, S. (2005). *The practice of nursing research: Conduct, critique and utilization*. St Louis, MO: Elsevier/Saunders.

Butcon, J., & Chan, E. (2017). Certainty in uncertainty: our position on culture, focused ethnography and researching older people. *International Journal of qualitative methods, 16*, 1-9.

Byrne, L., Happelll, B., & Reid-Searl, K. (2016). Lived experience practitioners and the medical model: world's colliding? *Journal of Mental Health 25*(3), 217-223.

Campbell, P. (2001). The role of psychiatric services in service development-influence not power. *British Journal of Psychiatry Bulletin, 23*(3), 84-86.

Carlat, D. (2010). *Unhinged: the trouble with psychiatry: a doctor's revelations about a profession in crisis*. New York: Free Press

Carlos, W., Patel, D., Vannostrand, K., Gupta, S., Cucci, A., & Bosslet, G. (2015). Intensive care unit rounding checklist implementation. *Annals of American Thorac Society, 12*(4), 533-538.

Carlyle, D., Crowe, M., & Deering, D. (2012). Models of care delivery in mental health nursing practice: a mixed method study. *Journal of Psychiatric Mental Health Nursing, 19,* 221-230.

Caronna, C. (2010). Why use qualitative methods to study health care organizations. In I. Bougeault, R Dingwall, R de Vries, R (Eds.), *The Sage Handbook of qualitative methods in health research*. London: Sage Publications.

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum, 41*(5), 545-547.

Casey, D., & Murphy, K. (2009). Issues in using methodological triangulation in research. *Nurse Research 16*(4), 40-55.

Castel, E., Ginsburg, L, Zaheer, S, Tamim, H. (2015). Understanding nurses and physician's fear of repercussions for reporting errors: clinician characteristics, organization demographics or leadership factors? *BMC Health Services research, 15*(326), 1-10.

Caulfield, H. (2005). *Accountability*. Oxford: Blackwell publishing.

Cerbiglia-Lowensen, J. (2015). Learning from mistakes and near mistakes: using root cause analysis as a risk management tool. *Journal of Radiology Nursing, 34*(1), 4-7.

Chambers, M., Gillard, S., Turner, K., & Borschmann, R. (2013). Evaluation of an educational practice development programme for staff working in mental health inpatient environments. *Journal of Psychiatric and Mental Health Nursing, 20*(4), 362-373.

Chase, E. (2017). Enhanced Member Checks: Reflections and insights from Participant-Researcher collaboration. *The Qualitative Report*, *22*(10), 2689-2703.

Chavez, E., Yoder, L. (2014). Staff nurse clinical leadership: a concept analysis. *Nursing Forum, 50*(2), 90-100.

Chernomas, W., Clarje, D., &Marchinko, S. (2008). Relationship-based support for women living with serious mental illness. *Issues in Mental Health Nursing, 29*, 437-453.

Chin, G., Warren, N., Kornman, L., & Cameron, P. (2012). Transferring responsibility and accountability in maternity care: clinicians defining their boundaries of practice in relation to clinical handover. *British Medical Journal Open, 2*(5), 1-9.

Choiniere, J. (2011). Accounting for care. *Advances in Nursing Science, 34*(4), 330-344.

Clancy, L., & Happelll, B. (2017). Being accountable or filling in forms: Managers and Clinicians' views about communicating risk. *Perspectives in psychiatric care, 53*, 38-46.

Clarke, J. (1991). Moral dilemmas in nursing research. *Nursing Practice, 4*(4), 22-25.

Cleary, M. (2003). The challenges of mental health care reform for contemporary mental health nursing practice. *International Journal of Mental Health Nursing, 12*, 139-147.

Cleary, M. (2004). The realities of mental health nursing in acute inpatient environments. *International Journal for Mental health Nursing, 13*, 53-60.

Coates, D., & Howe, D. (2015). Combatting staff burnout in mental health: Key managerial and leadership tasks that are fundamental to staff wellbeing and retention. *Asia Pacific Journal of Health Management 10*(2), 24-32.

Coffey, M., Hannigan, B., Meudell, A, Hunt, F., & Fitzsimmons, D, (2016). Study protocol: A mixed methods study to assess mental health recovery, shared decision-making and quality of life (Plan4Recovery). *Birtish Medical Journal Health Services Research*, *16*(1), 392.

Collin, J. (2010). Qualitative contributions to the study of health professions and their work. In I. Bougeault, R Dingwall, R de Vries, R (Eds.), *The Sage Handbook of qualitative methods in health research*. London: Sage Publications.

Commonwealth of Australia, Department of Health, (2013). A national framework for recovery-oriented mental health services: Policy and theory.

Cook, A., Hoas, H, Guttmannova, K, & Joyner, J. (2004). An error by any other name. *American Journal of Nursing, 104*(6), 32-43.

Council of Australian Governments (2011). *National Health Reform Agreement.* Canberra. Retrieved from www.federalfinancialrelations.gov.au/content/npa/health/_.../national-agreement.pdf.

Crawford, M., Rutter, D., Manley, C., Weaver, T., Bhui, K., Fulop, N., & Tyrer, P. (2002). Systematic review of involving patients in the planning and development of health care. *British Medical Journal, 325*(7375), 1263-1265.

Crotty, M. (2013). *Exploring responsibility and accountability in clinical handover.* (Psychology PhD), University of South Australia, Adelaide.

Crowe M., O'Malley, J., & Gordon, S. (2001). Meeting the needs of consumers in the community: a working partnership in mental health in New Zealand. *Journal of Advanced Nursing, 35*, 88-96.

Cruz, E., & Higginbottom, G. (2013). The use of focused ethnography in nursing research. *Nurse Researcher, 20*(4), 36-43.

Curry, L., Brault, M., Linnander, E, McNatt, Z., Brewster, A., Cherlin, E., Flieger, S., Ting, H., & Bradley, E. (2018). Influencing organizational culture to improve hospital performance in care of patients with acute myocardial infarction: a mixed-methods intervention study. *British Medical Journal Quality & Safety, 27*(3), 207-217.

Curtis, J., Sathitratananacheewin, S., Starks, H., Lee, R., Kross, E., Dwoney, L., Sibley, J., Lober, W., Loggers, E., Fausto, J., Lindvall, C., Engelberg, R. (2018). Using electronic health records for quality measurement and accountability in care of the seriously ill: opportunities and challenges. *Journal of Palliative Medicine, 21*(Suppl 2), S52-S60.

Cusack, E., Killoury, F., & Nugent, L. (2017). The professional psychiatric/mental health nurse: skills, competencies an supports required to adopt recovery-oriented policy in practice. *Journal of Psychiatric and Mental Health Nursing, 24*, 93-104.

Cutcliffe, J., & Stevenson, C. (2008). Feeling our way in the dark: the psychiatric nursing care of suicidal people, a literature review. *International Journal of Nursing studies, 45*(6), 942-953.

Daly, J., Jackson, D., Mannix, J., Davidson, P., & Hutchison, M. (2014). The importance of clinical leadership in the hospital setting. *Journal of healthcare leadership, 6*, 75-83.

Daremo, A., & Haglund, L. (2014). Activity and participation in psychiatric institutional care. *Scandinavian Journal of Caring Sciences, 15*(3), 131-142.

Davidson, L., O'Connell, M., Tondora, J., Lawless, M., & Evans, A. (2005). Recovery in serious mental illness: a new wine or just a new bottle? . *Professional Psychology: Research and Practice, 36*, 480-487.

Deacon, M., & Fairhurst, E. (2008). The real-life practice of acute inpatient mental health nurses: an analysis of eight interrelated bundles of activity. *Nursing Inquiry, 15*(4), 330-340.

Deacon, B. (2013). The biomedical model of mental disorder: a critical analysis of its validity, utility, and effects on psychotherapy. *Clinical Psychology Review, 33*(7), 846-861.

DeHert, M., Correll, C., Bobes, J., Cetkovich-Bakmas, Cohen, D., Asai, I., Detraux, J., Gautman, S., Moller, H., Ndetei, D., Newcomer, J., Uwakwe, R., & Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry, 10*(1), 52-77.

Denzin, N., & Lincoln, Y. (2000). Introduction: the discipline and practice of qualitative research. In N. Denzin, Y. Lincoln, (Eds.), *Handbook of qualitative research*. London: Sage Publications.

De Santis, M., Myrick, H., Lamis, D., Pelic, C., Rhue, C., & York, J. (2015). Suicide-specific safety in the inpatient psychiatric unit. *Issues in Mental*

Health Nursing, 36(3), 190-199.

Dey, I. (1993). *Qualitative data analysis. A user friendly guide for social scientists*. London and New York: Routledge.

Dignam, P. (2009). Accountability and responsibility? The challenge of policies in clinical psychiatry. *Australasian Psychiatry, 17*(2), 79-81.

Donaldson, L. (2001). Professional accountability in a changing world. *Postgraduate medical Journal, 77*, 65-67.

Doody, O., Butler, M., Lyons, R., & Newman, D. (2017). Families' experiences of involvement in care planning in mental health services: an integrative literature review. *Journal of Psychiatric and Mental Health Nursing, 24*, 412-430.

Drach-Zahavy, A., Leonenko, M., & Sculovici, E. (2018). Towards a measure of accountability in nursing: A three stage validation study. *Journal of Advanced Nursing, 74*(10), 2450-2464.

Draper, J. (2015). Ethnography: principles, practice and potential. *Nursing Standard, 29*(36), 36-41.

Dwight-Johnson, M., Unutzer, J., Sherbourne, C., Tang, L., & Wells, K. (2001). Can quality improvement programs for depression in primary care address patient preferences for treatment. *Medical Care, 39*, 934-944.

Erskine, J., Hunter, D., Small, A., Hicks., C., McGovern, T, Lugsden, E, Whitty, P, Steen, N., & Eccles M. (2013). Leadership and transformational change in healthcare organizations: A qualitative analysis of the North East Transformation System. *Primary Research*, *26*(1), 29-37.

Ewart, S., Bocking, J., Happelll, B., Platania-Phung, C., & Stanton, R. (2016). Mental health consumer experiences and strategies when seeking physical health care. *Global Qualitative Nursing Research, 3*, 77-101.

Ezziane, Z. (2012). The importance of clinical leadership in twenty-first century health care. *International Journal of Health Promotion and Education, 50*(5), 261-269.

Farmakas, A., Papastavrou, E., Siskou, O., Karayiannas, G., & Theodorou, M. (2014). Challenges in mental health nursing: working in institutional or community setting? *Journal of Psychiatric and Mental Health Nursing, 21*, 39-45.

Farrelly, S., Lester, H., Rose, D., Birchwood, M., Marshall, M., Waheed, W., Henderson, C., Szukler, G., & Thornicroft, G. (2015). Barriers to shared decision making in mental health care: qualitative study of Joint Crisis plan for psychosis. *Health expectations, 19*, 448-458.

Fay, D., Borrill, C., Amir, Z., Haunit, R., &West, M. (2006). Getting the most out of multidisciplinary teams: a multi-sample study of team innovation in health care. *Journal of occupational and organizational psychology, 79*, 553-567.

Fiddler, M., Borglin, G., Galloway, A., Jackson, C., Gowan, L., & Lovell, K. (2010). Once-a-week psychiatric unit round or daily inpatient team meeting? A multidisciplinary mental health team's experience of new ways of working. *International Journal for Mental health Nursing, 19*, 119-127.

Field, B., & Reed K. (2016). The rise and fall of the Mental Health Recovery Model. *The International Journal of psychosocial rehabilitation, 20*(2), 86-95.

Finkelman, A. (2013). The Clinical Nurse Specialist. *Clinical Nurse Specialist Journal*, 31-35.

Fisher, J. (2005). Mental health nurse practitioners in Australia: improving access to quality mental health care. *International Journal for Mental health Nursing, 14*, 222-229.

Fisher, J. (2014). The use of psychological therapies by mental health nurses in Australia. *Journal of Psychiatric and Mental Health Nursing, 21*, 264-270.

Force, M., Deering, L., Hubbe, J., Andersen, M., Hagemann, B., Cooper-Hahn, M., & Peters, W. (2006). Effective strategies to increase reporting of medication errors in hospitals. *Journal of nursing administration, 36*(1), 34-41.

Fouka, G., & Mantzorou, M. (2011). What are the major ethical issues in conducting research? Is there a conflict between the research ethics and the nature of nursing? *Health Science Journal, 5*(1), 3-14.

Fourie, W., McDonald, S., Conner, J., & Bartlett, S. (2005). The role of the registered nurse in an acute mental health inpatient setting in New Zealand: perceptions versus reality. *International Journal of Mental Health Nursing, 14*, 134-141.

Freeman, A., McWilliams, C., MacKinnon, J., DeLuca, S., & Rappolt, S. (2009). Health professionals enactment of their accountability obligations: doing the best they can. *Social Science and Medicine, 33*, 659-665.

Frink, D., & Klimoski, R. (1998). Towards a theory of accountability in resource management. *American psychological Association, 14*, 1-17.

Frink, D., Hall, A, Perryman, A., Ranft, A., Hochwarter, W., Ferris, G., & Royle, M. (Eds.). (2008). *A meso-level theory of accountability in organizations.*

Research in personnel and human resources management. UK: Emerald Publishing.

Frow, J., & Morris, M. (2000). Cultural Studies. In N. Denzin, Y. Lincoln, Y. (Eds.), *Handbook of qualitative research*. London: Sage Publications.

Ganju, V. (2006). Mental health and accountability: the role of evidence based practices and performance management. *Administrative policy in mental health and mental health services research, 33*, 659-665.

Gardner, H. (2012). Performance pressure as a double-edged sword enhancing team motivation but undermining the use of team knowledge. *Administrative Science Quarterly 57*(1), 1-46.

Giacomini, M. (2010). Theory matters in qualitative research. In I. Bougealt, R. Dingwall, R, de Vries, (Eds.),*The Sage handbook of qualitative methods in health research*. London: Sage Publications.

Giovannucci, E. (2007). Metabolic Syndrome, hyper-insulinemia, and colon cancer: a review. *The American Journal of Clinical Nutrition, 86*, s836-842.

Gonzalez-Roma, V., & Gamero, N. (2012). Does positive team mood mediate the relationship between team climate and team performance? *Psicothema, 24* (1), 94-99.

Goodson, L., & Vassar, M. (2011). An overview of ethnography in healthcare and medical education research. *Journal of educational evaluation for health professions, 8*(4).

Gordon, S., & Ellis, P. (2013). Recovery of evidence-based practice. *International Journal of Mental Health Nursing, 22*(1), 3-14.

Government of South Australia (2018). *SA Health Safety Learning System.* Adelaide retrieved from: www.sahealth.sa.gov.au/SafetyLearningSystem.

Government of South Australia (2017). *Country Mental Health Services SA Health,* Adelaide. Retrieved from www.sahealth.sa.gov.au/.../sa+health.../health+services/mental+health+services/country.

Government of South Australia, SA Health (2015). *Clinical Handover Guidelines.* Adelaide. Retrieved from www.sahealth.sa.gov.au/wps/wcm/...guideline_clinical/handover_Handover_oct2010_final.pdf?

Government of South Australia, SA Health (2015). *Clinical Handover Policy*

Directive. Adelaide. Retrieved from www.sahealth.sa.gov.au/wps/wcm/.../sa.../policies/clinical+handover+policy+directive.

Government of South Australia (2017). *South Australian Mental Health Strategic Plan 2017-2022,* Adelaide. Retrieved from: https://samentalhealthcommission.com.au/.../SA-Mental-Health-Strategic-Plan-2017-2.

Government of South Australia (2010). *South Australia's Mental Health and Wellbeing Policy 2010-2015,* Adelaide. Retrieved from www.sahealth.sa.gov.au.au/...health../policies/south+australias=mental+health+and+wellb.

Goulter, N., Kavanagh, D., & Gardner, G. (2015). What keeps nurses busy in the mental health setting? *Journal of Psychiatric and Mental Health Nursing, 22*, 449-456.

Green, C., Wisdom, J., Wolfe, L., & Firemark, A, . (2012). Engaging youth with serious mental illness in treatment: STARS Study Consumer Recommendations. *Psychiatric Rehabilitation Journal, 35*(5), 360-368.

Grundy, S. (2006). Metabolic syndrome: connecting and reconciling cardiovascular and diabetes worlds. *Journal of the American College of Cardiology, 47*, 1093-1100.

Grundy, A., Bee, P., Meade, O., Callaghan, P., Beatty, S., Olleveant, N., & Lovell, K. (2016). Bringing meaning to user involvement in mental health care planning: a qualitative exploration of service user perspectives. *Journal of Psychiatric and Mental Health Nursing, 23*, 12-21.

Grundy, A., Walker, L., Meade, O., Fraser, C., Cree, L., Bee, P., Lovell, K., & Callaghan, P. (2017). Evaluation of a co-delivered training package for community mental health professionals on service user- and carer-involved care planning. *Journal of Psychiatric and Mental Health Nursing*, *24*, 358-366.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interview are enough? An experiment with data saturation and variability. *Field Method, 18*, 59-82.

Hall, A., & Ferris, G. (2011). Accountability and extra-role behaviour. *Employees responsibilities and Rights Journal, 23*, 131-144.

Hall, J., & Callaghan, P. (2008). Developments in managing mental health care: a review of the literature. *Issues in Mental Health Nursing, 2, 1245-1272.*

Hammersley, M., & Atkinson, P. (2007). *What is ethnography? Ethnography, Principles in practice*. New York: Routledge.

Happell, B. (2009). Appreciating history: the Australian experience of direct-entry mental health nursing education in universities. *International Journal for Mental health Nursing, 18*, 35-41.

Harnett, P., Bowels, N., & Coughlan, A. (2009). Refocusing acute psychiatry, performance management, standards and accountability, a new context for mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 16*, 434-439.

Harper, M., & Helmreich, R. (2005). Identifying barriers to the success of a reporting system. In K. Hendriksen, Battles, J, Marks E, et al. (Ed.), Advances in patient safety: from research to implementation (Volume 3: *Implementation Issues).* Rockville (MD): Agency for Healthcare Research and Quality US.

Havig, A., Skogstad, A., Veenstra, M., & Romoren, T. (2011). The effects of leadership and unit factors on job satisfaction in nursing homes: a multilevel approach. *Journal of clinical Nursing, 20*, 3532-3542.

Henderson, H., Flood, C., Leese, M., Thornicroft, G., Sutherby, K., & Szmuckler, G. (2004). Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomized controlled trial, *British Medical Journal 329*(7458), 136.

Henderson, H., Flood, C., Leese, M., Thornicroft, G., Sutherby, K., & Szmuckler, G. (2009). Views of service users and providers on joint crisis plans. *Social Psychiatry and Psychiatric Epidemiology 44*(5), 369-376.

Henry, L. (2005). Disclosure of medical errors: ethical considerations for the development of a facility policy and organizational culture change. *Policy, Politics and Nursing Practice, 6*(2), 127-134.

Hercelinskyj, G., Cruickshank, M., Brown, P., & Phillips, B. (2014). Perceptions from the front line: professional identity in mental health nursing. *International Journal of Mental Health Nursing, 23*, 24-32.

Higgs, J., & Trede, F (Eds.). (2009). Framing research questions and writing philosophically. In J. Higgs, D. Horsfall & S. Grace (Eds.), *Writing qualitative research on practice* (pp. 13-26). Rotterdam: Sense Publishers.

Higginbottom, G. (2004). Sampling issues in qualitative research. *Nurse Researcher, 12*, 7-19.

Higginbottom, G., Pillay, J., & Boadu, N. (2013). Guidance on performing focused ethnographies with an emphasis on healthcare research. *The qualitative report, 18*, 1-16.

Hill, K., Aldrich, R., Lawson, D., & Easton, T. (2007). Enhancing clinical communication: characterizing the role of communication in clinical incidents and complaints. *International Society for Quality in Health Care Conference*.

Hodgins, S., & Klein, S. (2017). New clinically relevant findings about violence by people with schizophrenia. *Canadian Journal of Psychiatry, 62*(2), 86-93.

Hoeck, B., & Delmar, C. (2017). Theoretical development in the context of nursing. The hidden epistemology of nursing theory. *Nursing philosophy, 19*(1).

Hoff, T., & Witt, L. (2000). Exploring the use of qualitative methods in published health services and management research. *Medical care research and review, 57*(2), 139-160.

Holt-Lunstad, J., Sith, T., & Layton, J. (2010). Social relationships and mortality risk: A meta-analytic review. *Public Library of Science Medicine,* PLoS Medicine *7*(7): e1000316.

Hor, S., Williams, K., White, L., Kennedy, P., & Day, A. (2008). Multiple Accountabilities in incident reporting and management. *Qualitative Health Research, 20*(8), 1091-1100.

Horsfall, J., Cleary, M., & Hunt, G. (2010). Stigma in mental health: clients and professionals. . *Issues in Mental Health Nursing, 31*, 450-455.

Howard, P., El-Mallakh, P., Kay Rayens, M., & Clark J. (2003). Consumer perspectives on quality in inpatient mental health services. *Archives of Psychiatric Nursing 17*(5), 205-2017.

Hummellvoll, J., & Severinsson, E. (2001). Imperative ideals and the strenuous reality: focusing on acute psychiatry. *Journal of Psychiatric and Mental Health Nursing, 8*, 17-24.

Hurley, J. (2009). Mental health nurse identity: building upon Crawford et al. *International Journal of Nursing studies, 46*, 291-293.

Hurley, J., Mears, A., & Ramsay, M. (2009). Doomed to fail: the persistent search for a modernist mental health nurse identity. *Nursing Philosophy*, *10*(1), 53-59.

Independent Hospital Pricing Authority (2017). *Annual Report 2016-2017*. NSW

Iqbal, N. (2014). Decision making, responsibility and accountability in community mental health teams. *Mental Health practice, 17*(7), 26-28.

James, W. (1983). *The Principles of Psychology*: Harvard University Press.

Jansen Lockett, J., Barkley, L., Stichler, J., Palomo, J., Kik, B., Walker, C., Donelly, J., Willon, J., Sanborn, J., & O'Byrne, N. (2015). Defining peer-to-

peer accountability form the nurse's perspective. *The journal of nursing administration, 45*(11), 557-562.

Jeffs, L., Lingard, L., Berta, W., & Baker, R. (2012). Catching and correcting near misses: the collective vigilance and individual accountability trade off. *Journal of Inter-professional Care, 26*, 121-126.

Johansson, C., Aström, S., Kauffeldt, A., Helldin, L., & Carlström, E. (2014). Culture as a predictor to resistance to change: a study of competing values in a psychiatric nursing context. *Health Policy and Planning, 114*(2-3), 156-162.

Johnson, J., Barach, P., Cravero, J., Bilke, G., Godfrey, M., Batalden, P., & Nelson, E (Eds.). (2007). *Improving patient safety*. San Francisco: John Wiley & Sons, Inc.

Kaiser, K. (2009). Protecting respondent confidentiality in qualitative research. *Qualitative Health Research, 19*(11), 1632-1641.

Kanerva, A., Lammintakanen, J., & Kivinen, T. (2016). Nursing staff's perceptions of patient safety in psychiatric inpatient care. *Perspectives in psychiatric care, 52*(1), 25-31.

Keith, N., & Frese, M. (2011). Enhancing firm performance and innovativeness through error management culture. In Ashkanasy, N. Wilderom, C. & Peterson, M. (Eds.). *Handbook of Organizational culture and climate 9*, 137-157. London: Sage Publications.

Kilbourne, A., Beck, K., Spaeth-Rublee, B, Ramanuj, P., O'Brien, R., Tomoyasu, N., & Pincus, H. (2018). Measuring and improving the quality of mental health care: a global perspective. *World Psychiatry, 17*(1), 30-38.

Kinderman, P., Sellwood, W., Tai, S. (2008). Policy implications of a psychological model of mental disorder. *Journal of mental disorder, 17*(1), 93-103.

Knoblauch, H. (2005). Focused ethnography. *Forum: Qualitative Social Research,* 6(3), Art. 44.

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120-124.

KPMG (2015). *South Australia Health. Review of consumer flow across the mental health stepped system of care, Final report.* Retrieved from www.sahealth.sa.gov.au/...health.../review+of+consumer+flow+across+the+mental+health.

Kraus, D., Castonguay, L., & Boswell, J., Nordberg, S., & Hayes, J. (2011).

Therapist effectiveness: Implications for accountability and patient care. *Psychotherapy Research, 21*(3), 267-276.

Krautscheid, L. (2014). Defining professional nursing accountability: a Literature review. *Journal of Professional nursing, 30*(1), 43-47.

Krawitz, R., & Batcheler, M. (2006). Borderline personality disorder: a pilot survey about clinician views on defensive practice. *Australasian psychiatry, 14*(3), 320-322.

Kurjenluoma, K., & Rantanen, A., McCormack, B., Slater, P., Hahtela, N., & Suominen, T. (2017). Workplace culture in psychiatric nursing described by nurses. *Scandinavian Journal of Caring Sciences, 31*, 1048-1058.

Kuzub, M., & Skidmore, R. (2001). Least to most restrictive interventions: a continuum for mental health facilities. *Journal of psychosocial nursing, 39*(3), 32-38.

Laitila, M., Nummelin, J., Kortteisto, T. & Pitkänen, A. (2018). Service users' views regarding user involvement in mental health services: A qualitative study. *Archives of Psychiatric Nursing 32*, 695-701.

Lakeman, R., & Molloy, L. (2017). Rise of the zombie institution, the failure of mental health nursing leadership, and mental health nursing as a zombie category. *International Journal of Mental Health Nursing*, *27*(3), 1009-1014.

Lamb, B., Brown, K., & Nagpal, K. (2011). Quality of care management decisions by multidisciplinary cancer teams: a systematic review. *Annals of Surgical Oncology, 18*, 2116-2125.

Large, M., Sharma, S., Cannon, E., Ryan, C., & Neilssen, O. (2011). Risk factors for suicide within a year of discharge from psychiatric hospital: a systematic meta-analysis. *Australian & New Zealand Journal of Psychiatry, 45*(8), 619-628.

Latalova, K. (2014). Violence and duration of untreated psychosis in first-episode patients. *The International Journal of Clinical Practice, 68*(3), 330-335.

Laschinger, H., & Fida, R. (2014). New nurses' burnout and workplace wellbeing: the influence of authentic leadership and psychological capital. *Burnout Research, 1*, 19-28.

Laugharne, R., Priebe, S., McCabe, R., Garland, N., & Clifford, D. (2011). Trust, choice and power in mental health care: Experiences of patients with psychosis. *International Journal of Social Psychiatry, 58*(5), 496-504.

Lawrence, D., Hancock, K, & Kiseley, S. (2013). The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia:

Retrospective analysis of population based registers. *British Medical Journal, 346,* Article 2539, 1-14.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry, 199*, 445-452.

Leonenko, M., & Drach-Zahavy, A. (2016). 'You are either out on the court, or sitting on the bench': understanding accountability from the perspectives of nurses and nurse managers. *Journal of advanced nursing, 72*(11), 2718-2727.

Lerner, J., & Tedlock, P. (1999). Accounting for the effects of accountability. *Psychological Bulletin, 125*(2), 255-275.

Li, C., & Ford, E. (2006). Definition of metabolic syndrome: what's new and what predicts risk". *Metabolic Syndrome related disorders, 4*, 237-251.

Linz, S., & Sturm, A. (2012). The Phenomenon of social isolation in the severely mentally ill. *Perspectives in psychiatric care, 49*, 243-254.

Longo, J. (2007). *Bullying in the workplace: reversing a culture*. Silver Springs, Maryland: Centre fir American Nurses.

Lovell, K., Bee, P., Brooks, H., Cahoon, P., Callaghan, P., Carter, L, Cree, L., Davies, L., Drake., Fraser, C., Gibbons, C., Grundy, A., Hinsliff-Smith, K., Meade, O., Roberts, C., Rogers, A., Rushton, K., Sanders, C., Shields, G., Walker, L., Bower, P. (2018). Embedding shared decision-making in the care of patients with severe and enduring mental health problems: The EQUIP pragmatic cluster randomized trial, PLoS ONE *13*(8): e0201533.

MacKay, I., Paterson, B., & Cassels, M. (2005). Constant or special observation of inpatients presenting a risk of aggression or violence: Nurses' perceptions of the rules of engagement. *Journal of Psychiatric and Mental Health Nursing, 12*, 464-471.

Manley, K. (2008). The way things are done here. Developing a culture of effectiveness: prerequisite to individual and team effectiveness in critical care. *Journal of Australian Critical Care, 21*(2), 83-85.

Manley, K., Sanders, K., Cardiff, S., & Webster, J. (2011). Effective workplace culture: the attributes, enabling factors and consequences of a new concept. *International Practice Development Journal, 1*(2), Article 1, 1-29.

Manuel, J., & Crowe, M. (2014). Clinical responsibility, accountability and risk aversion in mental health nursing: a descriptive study. *International Journal of Mental Health Nursing, 23*, 336-343.

Mauthner, N., & Doucet, A. (2003). Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology, 37*(3), 413-431.

Mayan, M. (2009). *Essentials of qualitative inquiry*. Walnut Creek, CA, Left Coast Press.

McAllister, M., & McCrae, N. (2017). The therapeutic role of mental health nurses in psychiatric intensive care: A mixed-methods investigation in an inner-city mental health service. *Journal of Psychiatric and Mental Health Nursing, 24*, 491-502.

McCormack, B., Kitson, A., Harvey, G., Rycroft-Malone, J., Tichen, A., & Seers, K. (2002). Getting evidence into practice: the meaning of 'context'. *Journal of Advanced Nursing, 38*(1), 94-104.

McCrae, N., Askey-Jones, S., & Laker, C. (2014). Merely a stepping stone? Professional identity and career prospects following postgraduate mental health nurse training. *Journal of Psychiatric and Mental Health Nursing, 21*, 767-773.

McElroy, S. (2009). Obesity in patients with severe mental illness: overview and management. *Journal of Clinical Psychiatry, 70*, 12-21.

McHugh P., & Byrne, P. (2011). The Team working challenges of care planning. *Irish Journal of psychological medicine, 29*(3), 185-189.

McMain, S., Links, P., Gnam, W., Guimond, T., Cardish, T., Cardish, R., Korman, L., Streiner, D. (2009). A randomised trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry, 166*(12), 1365-1274.

Melia, K. (2010). Recognising quality in qualitative research. In I. Bougeault, Dingwall, R, de Vries, R (Ed.), *The Sage Handbook of qualitative methods in health research*. London: Sage Publications.

Miles, M., & Huberman, M. (1994). *Qualitative data analysis: an expanded sourcebook*. London: Sage Publications.

Milton, C. (2008). Accountability in Nursing. Reflecting on Ethical Codes and Professional Standards of Nursing practice form a global perspective. *Nursing Science Quarterly, 21*(4), 300-303.

Mitchell, G. (2001). A qualitative study exploring how qualified mental health nurses deal with incidents that conflict with their accountability. *Journal of Psychiatric and Mental Health Nursing, 8*, 241-248.

Moon, K., Brewer, T., Januchowski-Hartley, S., Adams, V., & Blackman, D. (2016). A guideline to improve qualitative social science publishing in ecology and conservation journals. *Ecology and Society, 21*(3), 17.

Morgan, J. (2007). *Giving up the culture of blame. Risk assessment and management in psychiatric care*. London UK: .

Morse, J. (2007). Does health research warrant the modification of qualitative methods? *Qualitative Health Research, 17*(7), 863-865.

Muecke, M. (1994). On the evaluation of ethnographies. In J. Morse (Ed.), *Critical issues in qualitative research methods*. Thousand Oaks, CA: Sage Publications.

Mullen, A. (2009). Mental health nurses establishing psychosocial interventions within acute inpatient settings. *International Journal of Mental Health Nursing, 18*(2), 83-90.

Munn, Z., Peters, M., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology*, *18*(143), 1-7.

Mullen, R., Admiraal, A., & Trevena, J. (2008). Defensive practice in mental health. *New Zealand Medical Journal*, *121*(1286), 85-91.

Nardi, D., & Gyurko, C. (2013). The global nursing faculty shortage: status and solutions for change. *Journal of Nursing Scholarship, 45*(3), 317-326.

Nazaruk, M. (2011). Reflexivity in anthropological discourse analysis. *Anthropological Notebooks, 17*(1), 73-83.

Nolan, S., Burkard, J., Clark, M., , Davidson, J, & Agan, D. (2010). Effect of morbidity and mortality peer review on nurse accountability and ventilator-associated pneumonia rates. *The journal of nursing administration, 40*(9), 374-383.

Nursing and Midwifery Board of Australia (2013). *Code of Professional Conduct for nurses in Australia*. Melbourne, Victoria.

Nursing and Midwifery Board of Australia (2013). *National Competency Standards for the Registered Nurse.* Melbourne, Victoria.

Nusbaum, L., Douglas, B., Damus, K., Paasche-Orlow, M., and Estrella-Luna, N. (2017). Communicating risks and benefits in informed consent for research: A qualitative study. *Global qualitative nursing research*, *4,* 1-13.

O'Donovan, A. (2007). Patient-centred care in acute psychiatric admission units: reality or rhetoric? *Journal of Psychiatric and Mental Health Nursing, 14*, 542-548.

O'Hagan, J., & Persaud, D. (2009). Creating accountability in health care. *The healthcare manager, 28*(2), 124-133.

Patton, D. (2013). Strategic direction or operational confusion: level of service user involvement in Irish acute admission unit care. *Journal of Psychiatric and Mental Health Nursing, 20*, 387-395.

Pazargadi, M., Moghadam, M., Khoshknab, M., Renani, H., & Molazem, Z. (2015). The therapeutic relationship in the shadow: Nurses' experiences of barriers to the Nurse-Patient relationship in the Psychiatric Unit. *Issues in Mental Health Nursing, 36*, 551-557.

Pelto-Piri, V., Engstrom, K., & Engstrom, I. (2013). Paternalism, autonomy and reciprocity: ethical perspectives in encounters with patients in psychiatric in-patient care. *BMC Medical Ethics, 14*(49), 1-8.

Penninx, B. & Lange, S. (2018). Metabolic syndrome in psychiatric patients: overview, mechanisms, and implications. *Dialogues of clinical neuroscience*, 20(1), 63-73.

Perese, E., & Wolf, M. (2005). Combating loneliness among persons with severe mental illness: Social network interventions' characteristics, effectiveness and applicability *Issues in Mental Health Nursing, 26*, 591-609.

Philipson, N. (2011). The criminalisation of mistakes in nursing. *Journal for Nurse Practitioners, 7*(9), 719-726.

Pitard, J. (2017). A journey to the centre of self: positioning the researcher in Auto-ethnography. *Forum: Qualitative Social Research, 18*(3), Article 10.

Plakhotnik, M., Rocco, T., & Roberts, N. (2011). Development review integrated literature review: Increasing retention and success of first-time managers: A model of three integral processes for the transition to management. *Human Resource Development Review, 10*(1), 74-100.

Pope, C. (2005). Conducting ethnography in medical settings. *Medical Education, 39*, 1180-1187.

Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in healthcare. Analyzing qualitative data. *British Medical Journal, 320*, 114-116.

Prentice, R. (2010). Ethnographic approaches to health and development research: the contributions of anthropology. In I. Bougeault, R. Dingwall, R. de Vries, (Eds.), *The Sage Handbook of qualitative research in health research*. London: Sage Publications.

Priebe, S., Fioritti, A., Badesconyi, A., & Wiersma, D. (2005). Reinstitutionalization in mental health care: comparison data on service provision from six European countries. *British Medical Journal*, *330*(7483), 123-126.

Raine, R., Wallace, I., Bhaird, C., Xanthoulou, P., Lanceley, A., Clarke, A., Prentice, A., Ardron, D., Harris, M., Gibs, S., Ferlie, E., King, M., Blazeby, J., Michie, S., Livinston, G., & Barber, J. (2014). Improving the effectiveness of multidisciplinary team meetings for patients with chronic diseases: a prospective observational study. *Health services and delivery research, 2*(37), 1-172.

Rappolt, S., Mitra, A., & Murphy, E. (2002). Professional accountability in restructured contexts of occupational therapy practice. *Canadian Journal of Occupational Therapy, 69*(5), 293.

Rashkovits, S., & Drach-Zahavy, A. (2016). The moderating role of team resources in translating nursing team's accountability into learning and performance: a cross sectional study. *Journal of advanced nursing, 73*(5), 1124-1136.

Reeves, S., Kuper, A, & Hodges, B. (2008). Qualitative research methodologies: ethnographies. *British Medical Journal, 337*.

Rhodes, L. (1991). *Emptying Beds: The work of an Emergency Psychiatric Unit.* Berkeley, University of California Press.

Rice, P., & Ezzy, D. (1999). *Qualitative research methods*. Oxford: Oxford University Press.

Rickwood, D. (2004). Recovery from mental illness: a service user perspective on facilitators and barriers. *Community Mental Health Journal, 5*, 11-13.

Rickwood, D. (2017). Recovery and Mental Health Care in Australia – A time of change. *Journal of recovery in mental health, 1*(1), 10-19.

Roberts, K., & Taylor, B. (1999). *Nursing Research processes: an Australian perspective*. Melbourne: Nelson Thomas Learning.

Robertson, M., Paterson, B., Lauder, B., Fenton, R., & Gavin, J. (2010). Accounting for accountability: a discourse analysis of psychiatric nurses' experience of a patient suicide. *The Open Nursing Journal, 4*, 1-8.

Roper, J., & Shapira, J. (2000). *Ethnography in nursing research*. Thousand Oaks, CA: Sage Publications.

Rosenberg, J., Hickie, I., McGorry, P., Salvador-Carulla, L., Burns, J., Christensen, H., Mendoza, Rosen, A., Russell, L., & Sinclair, S. (2015). Using accountability for mental health to drive reform. *The Medical Journal of Australia, 203*(8), 328-330.

Rydon, S. (2005). The attitudes, knowledge and skills needed in mental health nurses: The perspective of users of mental health services. *International Journal of Mental Health Nursing, 14*, 78-87.

Saldana, J. (2009). *The Coding Manual for qualitative researchers*. London: Sage Publications.

Savage, J. (2000). Participative observation: standing in the shoes of the other. *Qualitative Health Research, 10*(3), 432-439.

Savage, J., & Moore, L. (2004). Interpreting accountability. An ethnographic study of practice nurses, accountability and multidisciplinary team decision making in the context of clinical governance. *RCN Institute, Research Reports.*

Savage, J. (2006). Ethnographic evidence: the value of applied ethnography in healthcare. *Journal of research in nursing, 11*(5), 383-393.

Schröder, A., Ahlström, G., & Larsson, B. (2006). Patients' perceptions of the concept of the quality of care in the psychiatric setting: A phenomenographic study. *Journal of clinical Nursing, 20*, 93-102.

Schwandt, T., Lincoln, Y., & Guba, E. (2007). Judging interpretations: but is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New directions for evaluation, 114*, 11-25.

Scott-Findlay, S., & Estabrooks, C. (2006). Mapping the organizational culture research in nursing: a literature review. *Journal of advanced nursing, 56*(5), 498-513.

Scrivener, R., Hand, T., & Hooper, R. (2011). Accountability and responsibility: principle of nursing practice. *Nursing Standard, 25*(29), 35-36.

Seed, M., Torkelson, D., & Alnatour, R. (2010). The role of the inpatient psychiatric nurse and its effect on job satisfaction. *Issues in Mental Health Nursing, 31*, 160-170.

Sercu, C., Ayala, R., & Bracke, P. (2015). How does stigma influence mental health nursing identities? An ethnographic study of the meaning of stigma for nursing role identities in two Belgian Psychiatric hospitals. *International Journal of Nursing studies, 52*, 307-316.

Simpson, A., Hannigan, B., Coffey, M., Barlow, S., Cohen, R., Jones, A., Vseteckova, J., Faulkner, A., Thornton, A., & Cartwright, M. (2016). Recovery-focused care planning and coordination in England and Wales: a cross-national mixed methods comparative case study. *BMC Psychiatry, 16*(147), 1-18.

Slemon, A., Jenkins, E., & Bungay, V. (2017). Safety in psychiatric inpatient care: the impact of risk management culture on mental health nursing practice. *Nursing Inquiry, 24*(4), 1-10.

Smith, R., & Bartholomew, T. (2006). 'Will hospitals recover?: the implications of a recovery-orientation'. *American Journal of Psychiatric Rehabilitation, 9*, 85-100.

Snell, L., Crowe, M., & Jordan, J. (2009). Maintaining a therapeutic connection: nursing in an inpatient eating disorder unit. *Journal of clinical Nursing, 19*, 351-358.

Sorensen, R., Iedema, R., & Severinsson, E. (2008). Beyond profession: nursing leadership in contemporary healthcare. *Journal of Nursing Management, 16*, 535-544.

Sorensen, R., & Iedema, R. (2008). Redefining accountability in health care: managing the plurality of medical interests. *Health: an Interdisciplinary Journal for the social study of health illness and medicine, 12*(1), 87-106.

Sorensen, E., Seebeck, E., Scherb, C., Specht, J., & Loes, J. (2009). The relationship between RN job satisfaction and accountability. *Western Journal of Nursing research, 31*(7), 872-888.

Spence Laschinger, H., & Havens, D. (1997). The effect of workplace empowerment on staff nurses' occupational mental health and work effectiveness. *Journal of nursing administration, 27*(6), 42-50.

Spradley, J. (1980). *Participant observation*. New York: NY: Holt, Rinehart & Winston.

Stalker, C., & Harvey, C. (2002). Partnerships for children and families project. Professional burnout: A review of theory, research and prevention.

Stevenson, K., Jack, S., O'Mara, L., & LeGris, J. (2015). Registered nurses' experiences of patient violence on acute care psychiatric inpatient units: an interpretive study. *Biomed central Nursing, 14*(35), 1-13.

Strasser, D., Smits, S., Falconer, J., Herrin, J. (2002). The influence of hospital culture on rehabilitation team functioning in VA hospitals. *Journal of Rehabilitation Research and Development, 39*(1), 115-126.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research techniques and procedures for developing grounded theory*. London: Sage Publications.

Stroup, T., Gerhard, T., Crystal, S., Huang, C., & Oflson, M. (2016). Comparative Effectiveness of Clozapine and standard antipsychotic Treatment in Adults with schizophrenia. *American Journal of Psychiatry*, *173*(2), 166-173.

Stump, L. (2000). Re-engineering the medication error-reporting process: removing the blame and improving the system. *American Journal of Health-System pharmacy, 15*(57), Supplement 4: S10-17.

Stuhmiller, C. (2005). Rethinking mental health nursing education in Australia: a case for direct entry. *International Journal for Mental health Nursing, 14*, 156-160.

Szmukler, G., & Rose, N. (2013). Risk assessment in mental health care: values and costs. *Behavioural sciences and the Law, 31*, 125-140.

Tedlock, B. (2000). Ethnography and ethnographic representation. In N. Denzin, Y. Lincoln, (Eds.), *Handbook of qualitative research*. London: Sage Publications.

Tee, S., Lathlean, J., Herbert, L., Coldham, T., East, B., & Johnson, T. (2007). User participation in mental health nurse decision making: a cooperative enquiry. *Journal of advanced nursing, 60*(2), 135-145.

Theodoridou, A., Schlatter, F., Ajdacic, V., Rossler, W., & Jager, M. (2012). The therapeutic relationship in the context of perceived coercion in a psychiatric population. *Psychiatry Research, 200*, 939-944.

Thomson, L., & Hamilton, R. (2012). Attitudes of mental health staff to protected therapeutic time in adult psychiatric units. *Journal of Psychiatric and Mental Health Nursing, 19*, 911-915.

Thornicroft, G., & Tansella, M. (2005). Growing recognition of the importance of service user involvement in mental health service planning and evaluation. *Epidemiology and Psychiatric Sciences 14*(1), 1-3.

Tillot, S. (2013). Critical reflection on practice development. The importance if staff engagement to the development of positive workplace cultures. *International Practice Development Journal, 3*(1) Article 9.

Townsend, M. (2011). *Nursing Diagnoses in psychiatric nursing. Care plans and psychotropic medications*. Philadelphia: FA Davis Company.

Tunmore. (2000). Nursing care plans in acute mental health nursing. *Royal College of Nursing, 4*(3), 32-37.

Twigg, D., & McCullough, K. (2014). Nurse retention: a review of strategies to create and enhance positive practice environments in clinical settings. *International Journal of Nursing Studies, 51*(1), 85-92.

Usher, K. (2006). Nursing education. *Journal of advanced nursing, 3*, 219-220.

Valenti, E., Giacco, D., Katasakou, C., & Priebe, S. (2014). Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients. *Journal of Medical ethics, 40*, 832-836.

Van der Geest, S., & Finkler, K. (2004). Hospital ethnography: introduction. *Social Science and Medicine, 59*(10), 1995-2001.

Wall, S. (2015). Focused ethnography: A methodological adaptation for social research in emerging contexts. *Forum: Qualitative Social Research, 16*(1), Article 1.

Walsh, M. (2000). *Accountability and the boundaries of care*: Butterworth-Hennemann Oxford.

Walsh, J., & Boyle, J. (2009). Improving acute psychiatric hospital services according to inpatient experiences. A user-led Piece of research as a means to empowerment. *Issues in Mental Health Nursing, 30*, 31-38.

Wand, T. (2017). Considering the culture of blame in mental health care and service delivery. *International Journal of Mental Health Nursing, 26*, 3-4.

Wang, C., Zhang, L., Zhai, Y., Weng, Y., Zhao, & Zhou, H. (2004). The differential effects of steady-state fluvoxamine on the pharmacokinetics of olanzapine and clozapine in health volunteers. *Journal of clinical pharmacology, 44*(7), 785-792.

Weaver, S., Lumbomski, L., Wilson, R., Pfoh, E., Martinez, K., & Dy, S. (2013). Promoting a culture of safety as a patient strategy. *Annals of Internal Medicine, 158*(5), 369-375.

Weiss Roberts, L., Louie, A., Guerrero, A., Balon, R., Beresin, E., Brenner, A., & Coverdale, J. (2017). Premature mortality among people with mental illness. *Academic Psychiatry, 41*, 441-446.

Welch, S., Klassen, C., Borisova, O., & Clothier, H. (2013). The DSM-5 controversies: how should psychologists respond? *Canadian Psychologists, 54*(3), 166-175.

Werner, O., & Schoepfle, M. (1987). *Systematic fieldwork: foundations of ethnographic interviewing*. Michigan: Sage Publications.

Wijnveld. A., & Crowe, M. (2010). Walking a fine line: managing the tensions asosicated with medication non adherence in an acute inpatient psychiatric setting. *Journal of Clinical Nursing 19,* 1378-1386.

Wolf, Z., & Hughes, R. (2008). Chapter 35. Error reporting and disclosure. In R. Hughes (Ed.), *Patient safety and quality: An evidence-based handbook for nurses. Rockville (MD): Agency for healthcare and quality* US.

World Health Organisation (2013). *Information sheet: Premature death among people with mental disorders.* Geneva

Wright, N., Rowley, E., Chopra, A., Gregoriou, K., & Waring, J. (2015). From admission to discharge in mental health services: a qualitative analysis of service user involvement. *Health Expectations, 19*, 367-376.