A Medical–Surgical Nurse's Perceptions of Caring for a Person With Severe Mental Illness

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Abstract

BACKGROUND: When hospitalized for medical conditions, many people with severe mental illness (SMI) have poor outcomes, yet little is known about contributing factors. Studies exploring the care experience from nurses' perspectives described care processes as "difficult." None of these studies were conducted in the United States, and sociocultural contexts significantly affect perceptions of SMI. **OBJECTIVE:** The purpose of this inquiry was to explore a medical–surgical nurse's perceptions of caring for a hospitalized person with SMI in the United States. **DESIGN:** A qualitative, descriptive case study was used. **RESULTS:** The nurse's experience was characterized by categories of tension, discomfort, lack of professional satisfaction, and difficult. **CONCLUSIONS:** This case study revealed a negative care experience, similar to conclusions of investigations conducted in other countries. Understanding of nurses' care experiences can inform efforts to improve practice environments, provide resources, or develop models of care that support nurses who care for patients with SMI and improve health outcomes for people with SMI.

Keywords

psychiatric comorbidity, medical comorbidity, nonpsychiatric hospitalization, mental illness, nurse perceptions

One in four persons will experience a mental disorder in a given year (National Institute of Mental Health, 2008). When symptoms create marked impairment in social or occupational functioning, the illness is considered severe or serious (American Psychiatric Association, 2000). Severe mental illness (SMI) afflicts 1 in 17 Americans, or 6% of the population (Kessler et al., 2005) and includes schizophrenia, bipolar disorder, and depression.

People with SMI experience a number of other chronic medical illnesses (e.g., diabetes, pulmonary disease, and heart disease) at a rate of two to three times the general population (Dickey, Normund, Weiss, Drake, & Azena, 2002; Leucht, Burkard, Henderson, Maj, & Sartorius, 2007). Despite this vulnerability, persons with SMI are less likely to receive adequate primary health care in ambulatory settings (Cashin, Adams, & Handon, 2008; Li, Glance, Cai, & Mukamel, 2008). Experiences of not being taken seriously, positive encounters with emergency services that reinforce their use, and lack of enabling factors (i.e., access, knowledge, and advocacy) contribute to delays in help-seeking behavior in the absence of a crisis (Decoux, 2005). In addition, reduced pain perception experienced by people with schizophrenia may result in delays in seeking care for acute conditions such as appendicitis, myocardial infarction, or compartment syndrome (Singh, Giles, & Nasrallah, 2006). Poor physical health, inadequate primary care, and delays in treatment may predispose persons with SMI to hospitalization for medical conditions. When hospitalized, persons with SMI experience poorer health outcomes than patients without mental illness—increased complications (e.g., infections and postoperative deep venous thrombosis) and adverse events (e.g., pressure ulcers), longer lengths of stay, and greater costs of care (Bressi, Marcus, & Solomon, 2006; Bourgeois, Kremen, Servis, Wegelin, & Hales, 2005; Daumit et al., 2006; Sayers et al., 2007).

Nurses make important contributions to patient outcomes in medical–surgical settings; specific nurse-sensitive patient outcome indicators include falls, pressure ulcers, and nosocomial infections among others (Montalvo, 2007).

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Through patient surveillance, nurses also play a protective role in detecting and responding to evolving complications (such as pneumonia, deep venous thrombosis, shock, and others), effectively "rescuing" patients from death (Manojlovich & Talsma, 2007). It is significant then that medical–surgical nurses tend to label patients with psychiatric comorbidity as "difficult" (Manos & Braun, 2006; Morrison, Ramsey, & Synder, 2000), and such characterizations can negatively influence quality of care (Carveth, 1985). Thus, there is a need to better understand the experience of nurses who provide care for individuals with SMI in medical–surgical settings so that effective interventions to support the care process can be designed and care and outcomes for people with SMI can be improved. The purpose of this study is to explore the perceptions of a medical–surgical nurse providing care for a person with SMI in an inpatient general hospital setting.

Background

Nurses' perceptions of patients with mental illness in the general hospital setting have been investigated in several studies. Nonpsychiatric nurses tend to view patients with psychiatric comorbidity negatively: difficult and problematic (Priami, Planti, & Mantas, 1998), disruptive (Atkin, Holmes, & Martin, 2005), more complex (de Jonge et al., 2001), and unpredictable (Lethoba, Netswera, & Rankhumise, 2006). These perceptions are consistent with negative stereotypes of persons with mental illness and have been shown to affect nurses' responsiveness to medical symptoms (McDonald et al., 2003). Generally, nurses feel that they lack the knowledge, skills, and support needed to effectively care for persons with mental illness in general hospital settings (Atkin et al., 2005, Bailey, 1998; Clark, Parker, & Gould, 2005; Lethoba, et al. 2006; Mavundla, 2000; Sharrock, 2006). Nurses lack confidence and experience fear (Brinn, 2000; Reed & Fitzgerald, 2005).

Nurses are not immune from the negative stereotyping surrounding persons with mental illness. In a study involving medical–surgical nurses, psychiatric nurses, and lay people, Rogers and Kashima (1998) confirmed that a "reasonably consistent and negative stereotype of the mentally ill exist" (p. 202). However, they suggested that education and exposure to persons with mental illness can assist individuals to inhibit this negative stereotype and respond more positively. Bailey (1998) found similar negative stigmatizing in an investigation of nurse and physician attitudes toward patients with a psychiatric illness who had attempted suicide and were hospitalized in an intensive care unit. She concluded that "assumptions and prejudices . . . are related to a deficit in knowledge and prevailing social stigma" (p. 8).

Psychiatric comorbidity influences nurse perceptions of care needs. Patients on general internal medicine wards with high scores on a depression and anxiety screen were perceived by general nurses as having more complex needs than patients with lower scores, even though there were no actual differences in limited functional status and nursing interventions (de Jonge et al., 2001). That is, nurses perceived and experienced an increased complexity of care for patients with mental illness, even though such care could not be objectively substantiated from documented interventions in the medical record. The authors concluded that nurses may need additional help in caring for patients with mental illness.

McDonald et al. (2003) used an experimental design to test how the presence of a psychiatric diagnosis would affect care for medical problems. They noted that nurses were significantly, $F(2, 56) = 3.21$, $p < .05$, less likely to identify that a patient was experiencing a myocardial infarction and, thus, less likely to respond to physical symptoms when provided with information indicating the patient was also psychotic (medication regimen including Haldol, an antipsychotic). The researchers suggested that nurses may stereotype patients with psychiatric diagnoses and plan to respond differently toward these patients.

In a qualitative study examining nurse attitudes, half of general hospital nurses interviewed expressed dislike for caring for persons with mental illness (Reed & Fitzgerald, 2005). The authors suggested that such attitudes directly influence a nurse's ability to provide care. Interestingly, all four of the general nurses interviewed by Sharrock (2006) had positive attitudes toward people with mental illness; yet, they lacked confidence in their competence in providing quality care.

Studies examining the experience of nurses caring for patients with psychiatric comorbidity have been conducted in Australia, Greece, the Netherlands, South Africa, and the United Kingdom. However, such research has not been conducted in the United States, and studies specifically considering the SMI patient population are lacking. Because conceptualizations of mental illness and perceptions of persons with mental illness are significantly influenced by sociocultural contexts (Küey, 2008), the importance of understanding the experience of nurses in the United States becomes pronounced. Mental illness may be perceived differently across cultures and countries, and differences in nursing education, nursing practice, and health systems may affect these perceptions. Therefore, there is a need to study the experience for nurses in the United States. The purpose of this case study was to explore a medical–surgical nurse's perceptions of caring for a hospitalized adult person with SMI in the United States.

Design

This study applied a qualitative–descriptive design, as described by Sandelowski (2000, 2010) and aimed to explore individual perceptions of a particular experience and to accurately represent that perspective by constructing meaning of that experience. Meaning comes from the individual; reality or knowledge is derived from the meaning persons ascribe to their interaction with the world (e.g., experience of events). The design uses techniques, for example, a semistructured interview, that facilitated the participant's sharing of personal experience and perceptions.

Method

Case study is "a research methodology grounded in an interpretive, constructivist paradigm which guides an empirical inquiry of contemporary phenomenon within inseparable real-life contexts" (Anthony & Jack, 2009, p. 1172). This case study was reviewed and approved by a university institutional review board. An interview guide was developed to provide initial direction to the interview. The nurse was asked to recall a particular patient with SMI she had taken care of in the past year and to describe what it was like for her to provide care for this individual. Other questions were prepared to stimulate discussion about particular aspects of the experience, for example, how she felt about the care she provided, how she might respond if the patient was readmitted. The interview was audio-recorded and transcribed verbatim so that the participant's expressions were accurately captured to enable accurate descriptive summary. Verbal informed consent was obtained via telephone prior to the interview and again before the actual interview commenced. The interview was conducted in the hospital's outpatient infusion center, where the nurse was currently employed, during an interval when the nurse was not caring for patients. The interview was approximately 60 minutes in duration. During and following the interview, field notes were recorded, which were later used during analysis to identify nonverbal behaviors and impressions that could have been overlooked during transcription and to remind the investigator of significant responses.

Sample

A convenient, purposive sample was identified as a registered nurse employed in an inpatient medical–surgical setting in the United States who had been assigned to care for an adult person with an SMI comorbidity for at least one shift within the past year. The participant was a 26-year-old Caucasian baccalaureate-prepared (4 years of undergraduate education) registered nurse with 4 years experience working on a medical–surgical unit.

Data Analysis

In qualitative descriptive data analysis, the investigator attempts to accurately present the facts of the case rather than reframe the data within a theoretical context. In keeping with the research design, qualitative content analysis was selected as the most appropriate technique (Sandelowski, 2000). Within qualitative content analysis, several methods have been described: inductive or conventional, deductive or directive, and summative (Elo & Kyngäs, 2007; Hsieh & Shannon, 2005; Weber, 1990). Inductive content analysis was determined to be the appropriate method for this study. Using this approach, the investigator identified data bits, or phrases, and arranged them in categories labeled as codes. Codes were not predefined but rather derived from the data using an inductive process (Sandelowski, 2000).

Coding

Word sense, coding the different contextual meaning of words with multiple meanings and coding "phrases that constitute a semantic unit, such as idioms" (Weber, 1990, p. 22), was selected as the coding unit for this analysis. Coding occurred as the transcript was reviewed. These codes were placed in a table and grouped into plausible categories. Categories suggesting relatedness or shared meaning were then collapsed together into clusters (Weber, 1990; Table 1). Data were validated through peer debriefing and reviewed by an experienced qualitative researcher.

Results

Data were arranged in four separate categories: *tension, discomfort, lack of personal satisfaction*, and *difficult*.

Tension

The nurse described a need to be constantly cognizant of safety for the patient, the self, and others when caring for an individual with SMI. This conscientiousness was pervasive and influenced all aspects of care. The patient was considered at an increased risk for self-harm and for violence because of treatment and the unpredictable nature of behavior that is best described as a need to constantly "keep watch" and "keep your eye on them" to minimize risks.

> Because of the meds we put them on, they're at a greater risk of falling, so most of the time we have the bed alarm on, afraid that they may get up and fall. The ones we do let walk around, they have to walk with somebody in case . . . you don't know

Table 1. Coding Categories: What Are the Perceptions of Caring for a Hospitalized Adult Person With Severe Mental Illness for Medical–Surgical Nurses?

Cluster: Sense of Tension	
Initial Code	Category

Fear
• He scared a lot of the nurses.
• A creepy sense and feeling when you walked into the room.
• We would have to call security up there.
• He would try to get violent. . . . I don't think he ever punched anybody, but just that you're going to get hurt while taking care of this patient was an issue.
Safety
• Patient
  • They're at a greater risk of falling . . . they might get up and fall.
  • Tend to their safety.
  • Safety is a huge issue with these patients.
  • You've got to worry about the blood pressure . . . state of consciousness . . . safety for them.
  • You have to make sure they're safe by all means.
  • He would get out of bed, he would try to walk down the halls, so you constantly had to keep an eye on him.
• Self and others
  • You're more cautious . . . cautious when you go in and . . . you just work more careful or cautious with the work you are going to do.
  • You have to think of the safety of everybody else as well.
  • Try to keep an eye on this patient, he likes to wander or he punches, he bites or whatever.
  • It's difficult when they're not in the vicinity where a lot of people are, where they can't be watched, like at the end of the hall and only your set of eyes are on them and not five others.
  • If it gets out of hand, it is almost certain everybody is in there trying to help you do something.
	Vigilance

Cluster: Discomfort	
Initial Code	Category
Being unprepared • Having (someone) maybe every day try to help guide us . . . tell us what to do better as far as the care of this patient (would have been helpful). • When I got here I didn't feel like I had enough to know . . . • I don't think I was prepared . . . school will not prepare you for something like this. • I was never taught to do that. • They're always looking in books trying to find out things. • As a new nurse coming on, I would have freaked out. Not understanding the person or illness • It's more difficult because you don't know the person. • You learn from other shifts . . . (what) makes them feel better or more calm. • Patients come in with mental illness . . . off the street or something and you have no clue . . . you don't know this person, you don't know anything. • You have to find their niche, what they like, what they don't like. Everybody's different. • You tend to go in a little more cooperative with them, more calm, to their style, and if they're agitated . . . you just step out for awhile and then you come back. • With each patient that comes up here, you learn something new every time they come up. • You walk into their world and base it in their world. • You don't understand their world when they're coming up here.	Being unfamiliar
Cluster: Lack of Professional Satisfaction	
Initial Code	Category
Cyclic pattern • He's just going to be back in here in the next couple of days—same thing all over again. • It's that vicious cycle everybody tends to know about.	Futility

(continued)

Table 1. (continued)

Cluster: Lack of Professional Satisfaction	
Initial Code	Category
• Just seems to be a vicious cycle . . . • You always have in the back of your mind, as soon as they leave, what's it going to be like . . . will they be back in the same condition they showed up in? Hopelessness • You plan out the day . . . you try to go over that with them and it means nothing to them, it doesn't make any difference. • It's just . . . we're doing something that is just never going to make this person better. We're not treating the real issue. • It's a little bit harder because it's not as gratifying. Because you don't see them . . . sometimes you see them get better as their stay goes on but sometimes we don't get to see that part of it. • It's just the same feeling that this is never going to end. This person is never going to get better and it just keeps on going.	
Cluster: Difficult	
Initial Code	Category
Constancy of care • You couldn't do what you needed to do with the others because you constantly had to keep watch on that one. • Constantly tending to their needs. • It took a lot more effort in taking care of that one. • You get frustrated in the fact that you have to spend so much time with him. • You leave them last on the list because they're going to take a lot of time and effort . . . you're going to spend a lot of time in there. • They're a lot to take care of. Burdensome • They are demanding, they want to be in control of everything. • That one in particular, he didn't like anyone telling him what to do, so you would go in and ask him, ok are you ready to take your pills . . . • You kinda give them the control of their own care. • You have to give them a choice in the matter. • Give them options, give them a little bit of control of their care and they tend to work with you a little more. Competing responsibilities • . . . and leaving the rest of your patients dangling. • You want to divvy up your time and your care equally among everybody but sometimes it's just not what it takes. Aversion • This is our work, this is what we do, and we just deal with it. • You're dreading that particular room number on your assignment sheet, because you know it's going to be a hard day. • I don't want that one today . . . this is going to be hell . . . • We're left trying to deal with this person. • All the nurses usually have had enough with them. • They're heavy (high care requirements) patients. You just need a break (from their care) sometimes.	The care experience

whether they're going to leave the hospital or go into someone else's room . . . or try to go down the stairwell and get hurt that way.

Although the participant did not directly express fear, she did identify apprehension regarding personal safety and gave considerable attention to concerns for the personal safety and injury of others who cared for the patient.

He'd walk into the hall and sometimes we would have to call security up there because he wouldn't go back in his room . . . he would try to get violent. . . . I don't think he ever punched anybody but just

that physical well being that you're going to get hurt while taking care of this patient was an issue.

In response to an apprehension about safety, the nurse described a state of vigilance, of being judicious in patient care decisions and a constant posture of caution: "You're more cautious . . . cautious when you go in and . . . you just work more careful or cautious with the work you are going to do." The nurse explained how fear and concern for personal safety and the safety of the patient and others contributed to being vigilant that resulted in tension.

Discomfort

The nurse struggled to understand the person and the illness. She felt unprepared—lacking education and expertise—to effectively provide care for the patient. In addition, the patient with SMI was difficult to get to know and that made the process of care difficult.

Patients come in with mental illness off the street or something, you have no clue. No clue at all. It's just more difficult because you don't know this person. You don't know anything. Nor does the doctor know anything or anybody else know anything because they don't have that family there. That background information.

The nurse felt unprepared for the challenges of caring for a mentally ill patient in a general hospital setting. Although nursing school provided the basics, "I don't think I was prepared . . . school will not prepare you for something like this." Being unprepared was uncomfortable.

The discomfort was severe at times. The nurse describes experiencing moral distress as she participated in coercive treatment.

I remember one incident where this lady, she was bipolar, came out and wanted to leave . . . she was flailing her arms. Her family was there and they were all crying. The doctor came and he said to give her a shot of Haldol. I wondered how I was going to do that because she was thrashing around and yelling. The security guard grabbed her arm and she scratched my arm, but I somehow got the Haldol into her. But I felt really bad doing it. It wasn't right. I wasn't ever taught to do that.

Not only was the nurse unprepared for intervening with escalating patient behavior, she was not prepared to deal with involuntary medication administration or the experience of being assaulted by a patient. The experience of feeling unprepared and of not understanding the person or the illness, leads to a collective sense of unfamiliarity that results in an overall sense of discomfort.

Lack of Professional Satisfaction

Lack of professional satisfaction results from a sense of being ineffective or useless in making a difference. The nurse perceived a cyclic pattern of unresolved patient needs, which made the care process seem a futile endeavor. Although the patient's physical illness was treated during the hospitalization, the mental illness was not adequately addressed such that the patient would maintain physical health gains achieved in the hospital.

You know this person is never going to get better and it just keeps on going. . . . We're doing something that is just never going to make this person better. We're not treating the real issue. . . . We're treating what's physically wrong with them, let's say if they come in with dehydration or pneumonia or something like that, we may be treating that, but we're not treating their background illness. So that just seems to be a vicious cycle.

Hopelessness was also experienced in the patient's lack of participation in their care.

And you go to the chart and you kinda plan out the day . . . in your mind and sometimes, you know, you try to go over that with them, and it means nothing to them. It doesn't make any difference to them, so you try to . . . (pause). You try to get your mind set.

The nurse's expectations that her efforts to plan and involve the patient in his care would make a difference were not validated as meaningful by the patient. Often the nurse was not able to witness the patient's physical recovery, which added to the sense of hopelessness: "It's a little bit harder because it's not as gratifying. Because you don't see them . . . sometimes you see them get better as their stay goes on, but sometimes we don't get to see that part of it."

Difficult

The perceived constancy of care needed by patients with SMI interfered with the nurse's ability to achieve tasks related to her patient care assignment: "You couldn't do what you needed to do with the others because you constantly had to keep watch on that one." The care demands seemed excessive.

You tend to leave them last on the list . . . because you know that they're going to take a lot of time and effort. So you tend to go see everybody else and then go see them because you're going to spend a lot of time in there . . . and, if I have to spend

> an hour and a half in that room trying to do something with this patient, and I'm behind on meds with my four other patients, then I get frustrated. . . . You want to divvy up your time and your care equally among everybody but sometimes that's not what it takes. That's where my frustration is.

Caring for a patient with SMI disrupted the structure and flow of the nurse's work requiring greater time and effort resulting in frustration. And, demands were perceived as disproportionate.

> It's frustrating . . . when you have this mentally ill patient, let's say with pneumonia, but yet he's on his last couple days before discharge so he's getting better, he's fine. He's walking around. The only thing is that it takes more time to take care of him. This other person is doing ten times worse than this one is, but yet you're spending more time with this one than the other one. And the other one needs more attention, and you get frustrated in the fact that you have to spend *so* (emphasis) much time with him and . . . I get frustrated when I fall behind.

Rigid schedules, hospital routines, and a focus on physical needs challenged the ability to accommodate the medical–surgical patient with SMI. The nurse provided opportunities for choices, sometimes relinquishing usual hospital routines, in order to deal with competing responsibilities.

> He didn't like anyone telling him what to do. And you would go in and ask him, are you ready to take your pills today? These are the pills I have for you. Are you ready to take them? He could say yes, he could say no. If he said no, I'd wait an hour and come back . . . even though those meds have a certain time.

Aversion surrounded anticipation of the care experience.

> You walk in in the morning and you're thinking, "OK, what kind of assignment am I going to have today? I hope I don't have that person." You're dreading that particular room number on your assignment sheet because you know it's going to be a hard day . . . you know "this is going to be hell."

The overall care experience was something to be endured: "This is our work, this is what we do, and we just deal with it." The nurse describes a difficult care experience full of tension and discomfort and lacking professional satisfaction.

Limitations

The sample of one participant who was asked to focus on one particular patient is a major limitation. However, a case study allows the perspective and voice of one individual, who is considered an expert informant, to be heard and to assist in directing future investigations. The qualitative perspective is especially beneficial when there is little or no research on a given topic (Creswell, 2009). Additional interviews are required to determine the transferability of the participant's responses and final clusters.

Conclusions

Consistent with other international studies (Brinn, 2000; Mavundla, 2000; Priami et al., 1998; Reed & Fitzgerald, 2005), this American participant tended to perceive the overall experience of caring for a patient with psychiatric comorbidity negatively—she felt unprepared for the situation and viewed an assignment to a person with an SMI comorbidity as frustrating and as one that nurses must deal with or endure. This experience seemed to be generalized among patients with SMI, as evidenced by references to "they," although individual needs may be distinctly different. Such stereotyping can be risky—as reported by McDonald et al. (2003), stereotyping can influence the nurse's interpretation and responsiveness to physical symptoms of serious physical conditions.

Structure within the hospital environment (i.e., availability of time and resources and a focus on task completion) may contribute to the way nurses respond to a patient's psychiatric needs (Macdonald, 2007; Sharrock, 2006). As described by the study participant, a patient with SMI was a misfit on a medical–surgical unit—requiring more time and effort as well as special accommodations. She described a particular situation evoking moral distress—a phenomenon in which an individual identifies the ethically appropriate action to take but is unable to take that action (Epstein & Delgado, 2010). Forceful administration of injectable medication "wasn't right," but the participant felt powerless to act differently. She "felt really bad." When moral distress lingers, it creates "moral residue"—the wound that remains when one has compromised one's values. Moral residue is accumulative and can contribute to a sense of futility and burnout (Epstein & Delgado, 2010). Patients who are associated with morally distressing events may be experienced as difficult. Moral distress consultation services are described as an intervention to address issues of moral distress and reduce moral residue (Epstein & Delgado, 2010).

A patient with SMI was difficult and a perception of difficulty alone negatively affects the care process (Carveth, 1995). This raises the question whether the experience of difficulty contributes to poorer outcomes

experienced by patients with SMI when they are hospitalized in medical–surgical settings.

The process of caring for a person with SMI in a medical–surgical hospital environment is complex, and many variables can influence the nurse–patient relationship. Patients with SMI were described as difficult to get to know, yet knowing the patient is key to establishing effective nurse–patient relationships (Zolnierek, 2011). Furthermore, the traditional medical–surgical hospital environment may not be conducive to nurses' knowing their patients and individualizing care. At least one model has been described (Duffy, Baldwin, & Mastorovich, 2007) in which nurses are explicitly required to plan uninterrupted time with assigned patients for purposeful interaction—time to get to know their patients. Both nurses and patients expressed increased satisfaction following implementation of this model.

Education and increased exposure to persons with mental illness can alter negative stereotypes and positively affect the way nurses respond to patients with psychiatric comorbidities (Brinn, 2000; Clark et al., 2005; Lethoba et al., 2006; McDonald et al., 2003; Munro, Watson, & McFadyen, 2007; Reed & Fitzgerald, 2005). A study of nursing students suggested that "adequate educational preparation has the potential to affect student's beliefs, anxieties, preparedness and likelihood of choosing to work in the mental health field" (Hayman-White & Happell, 2005, p. 191). Rohde (1996) discussed a process of uncovering, involving self-reflection and self-awareness, to assist students in transforming perceptions, understandings, and misunderstandings of persons with SMI.

Studies suggesting content or methodology for nursing education include structuring interventions based on nurses' stress levels (Individual Psychology) to help nurses deal with interpersonal conflict in caring for patients (Santamaria, 2000), using preceptorships to support the development of positive attitudes (Charleston & Happell, 2005), and considering the patient's experience of being understood by health care professionals (Shattell, McAllister, Hogan, & Thomas, 2006). How widely these approaches are used in nursing curricula is unknown. Furthermore, how competencies achieved in mental health nursing education translate to nonpsychiatric settings has not been studied.

Interventions implemented to improve care and support the care process for patients with psychiatric and physical health comorbidities in general hospital units have primarily consisted of consultant-liaison services by psychiatrists and/or nurses. Although such services are perceived positively by nursing staff, they fail to demonstrate an improvement in patient outcomes when controlling for confounders (e.g., severity of symptoms, chronicity, level of functioning, and others; Baldwin, Pratt, Goring, Marriott, & Roberts, 2004; Camus et al., 2003; Cullum, Tucker, Todd, & Brayne, 2007; de Jonge, Latour, & Huyse, 2003; Sharrock, Grigg, Happell, Keeble-Devlin, & Jennings, 2006). The literature does not yet identify effective approaches for improving care outcomes for patients with SMI hospitalized in general hospital settings.

While mental illness can adversely affect outcomes of care for somatic illness, the reverse also appears to hold true. Thompson, Kupfer, Fagiolini, Scott, and Frank (2006) found that medical illness could influence the outcome of SMI (bipolar disorder) and posited that appropriate treatment of the medical disorder could enhance the psychological well-being and course of the SMI. Additionally, mental health is inextricably linked with a number of medical illnesses—such as diabetes, heart disease, cancer, HIV, stroke, multiple sclerosis, and others—and when treatment targets both mental and physical conditions, the person's overall functioning is improved (Waghorn, 2009). Health professionals, particularly nurses, must acknowledge this linkage and develop approaches that address the whole person. Successful strategies to improve general hospital inpatient care for persons with SMI will honor the person as a whole and be based on a better understanding of factors contributing to adverse outcomes in the hospital environment.

Relevance to Clinical Practice

Nurses have a powerful role in preventing adverse events and achieving positive patient outcomes during hospitalization. Therefore, nurses can make significant contributions to improve the care of persons with SMI in general hospital environments. As in other international studies, the nurse in this case study affirmed perceptions of difficulty experienced when providing care for a person with SMI in a general medical–surgical setting. Enhanced understandings of this difficulty may inform nurse leaders about opportunities to improve the practice environment, provide resources, or develop new models of care that would better support nurses in their efforts to provide care to persons with SMI. An understanding of challenges nurses experience may also facilitate implementation of educational approaches, such as clinical rotations that integrate mental and physical health care within various settings (general hospital, psychiatric hospital, ambulatory care), and promote a holistic person-centered approach. Consumers can be especially effective educators (Meehan & Glover, 2007) and could be included in generic as well as continuing nursing education. Finally, research that illuminates how nurse perceptions may influence the provision of care and health outcomes (e.g., adverse events) for patients with SMI hospitalized in medical–surgical settings may inform the development

of approaches that can improve the care process from both nurses' and patients' perspectives.

Author Roles

Ms. Zolnierek conducted the interview, participated in data analysis, and drafted the manuscript. Dr. Clingerman provided expert guidance in research design, facilitated data analysis, and provided input and editorial comments on manuscript drafts.

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