

Clinical Responsibility: The Mental Health Nursing Perspective

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Abstract

This study sought to identify mental health nurses' perceptions of clinical responsibility. Clinical responsibility refers to the tasks and skills that professional bodies, employers and the court of law can legitimately demand from a health professional and accountability refers to the mechanism in which if a practitioner fails to exercise their responsibilities that disciplinary action can occur. Current standards and guidelines only provide limited information to nurses about the topic. Further to this public inquiries have identified issues in regards to health professionals' understanding of their clinical responsibilities. A descriptive qualitative design was used to explore the mental health nursing perspective of clinical responsibility. Participants were sampled from the local mental health nursing population and semi-structured interviews were used as the means of data collection. Transcriptions were thematically analysed which produced three major themes; patient responsibility, medical responsibility, and conflicting nursing responsibility. The consumer discourse, the medical discourse and risk management discourse were all considered as competing factors relevant to mental health nursing responsibility which set up a conflicting position in which the nurses perceived their own responsibility. These findings highlighted the challenge for nurses of balancing competing discourses related to clinical responsibility in practice. It is critical that mental health nurses have an awareness of societal and organisational factors that influence practice and decision making. This knowledge will better inform decisions in practice so that they are less likely to be based on misconceptions of accountability.

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List of Abbreviations

CDHB: Canterbury District Health Board

SMHS: Specialist Mental Health Services

DHB: District health board

MHA: Mental Health Act

DAO: Duly Authorised Officer

NCNZ: The Nursing Council of New Zealand

NZCMN: The New Zealand College of Mental Health Nursing

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Chapter One: Introduction

As a nurse I had been introduced to the concept of clinical responsibility in the early stages of training. A strong emphasis even at this stage was placed on one having an understanding of their clinical responsibilities. This was frequently conveyed in the context that we as nurses were no longer handmaidens to doctors but rather independent professionals in our own right who have their own set of responsibilities. This also came with reference to potential outcomes if we were to fail to exercise these. This unsurprisingly installed a small amount of fear in all of us even though we did not have a clear understanding of what it meant at this stage.

Starting out as a registered nurse in a mental health setting the concept of clinical responsibility remained somewhat ambiguous and only over time my understanding of what this term meant for me developed. I suspect that it has a different meaning for everyone depending on their nursing journey. There are still times that I remain unsure exactly what I am considered responsible for and have difficulty articulating what it means to be clinically responsible. When my colleagues asked about this thesis topic it became obvious that the definition of clinical responsibility is unclear for many.

I am still aware of the small amount of discomfort that is underlying in regards to carrying a high level of responsibility in my daily work. This does not so much relate to the potential of being held accountable if I get something wrong but more to the potential for adverse outcomes that can occur for the people that I work with. Due to the nature of mental health work adverse events such as suicide are inevitably going to occur regardless of how well we do our jobs. This in turn places a high level of responsibility on mental health nurses to perform to the best of their abilities. I have noted that the weight of this responsibility has different effects on varying staff. Some appear quite clearly burdened by it and are reluctant to make independent decisions in fear of getting it wrong whereas others appear to take it in their stride with confidence in their abilities. Amongst most mental health nurses there is an understanding about what we are capable of doing and what is out of our control. However there is also an awareness that this does not mean that the people we work with, their families or the general public have this understanding.

The concept of clinical responsibility is frequently incorporated into clinical discussion. Questions such as “are we responsible for this person?” or “will we be seen to be responsible?” are voiced. Recent to the development of the study the service was subject to a short series of patient suicides. The occurrence of this was not particularly unusual given the nature of mental health work. However, it did cause not only some anxieties for clinicians but also generated discussion amongst staff about the topic of clinical responsibility. What was clear from this discussion was that it was a subject that was complex and multifaceted in nature. It was these events and the subsequent discussion that lead to the interest in the research topic of clinical responsibility. And being a mental health nurse I was first and foremost interested in the mental health nursing perspective.

The Study Context

The study was conducted in the Canterbury District Health Board [CDHB] Specialist Mental Health Service [SMHS] of New Zealand. This SMHS provides mental health and addiction services to the whole of the Canterbury region with some specialist services catering to the wider South Island population. The participants were recruited from within these services including both inpatient and outpatient teams.

It is important to note that during the period of time this study was conducted local policy on the topic of clinical responsibility underwent significant changes. At the time of commencing the study, local SMHS policy indicated that the consultant psychiatrist was deemed “ultimately responsible” for the treatment of people in the service. This policy specified that the consultant psychiatrist had the authority to decide who would be admitted to the services, when a person was discharged from services and responsibility for the overall treatment including the assignment of various clinicians to key roles in a person’s care. However, this protocol was revised and the information pertaining to responsibility had been significantly changed by the end of the study. The position statement that referred to the consultant psychiatrist as having ultimate responsibility had been removed altogether and not replaced with any specific statement about how clinical responsibility is distributed within the mental health care teams. Instead I was referred to the service provision frameworks which are guides that provide an overview of the operation of each individual service. Within these frameworks responsibility was addressed on an individual level based on a person position description. These descriptions

of responsibility referred to the tasks expected of them and no longer make reference to the term clinical responsibility as a whole.

Thesis Structure

CHAPTER ONE

The first chapter provides an introduction to the research study including background information that relates to the study's conception. Information pertaining to the context in which the study took place is also provided as well an overview of the thesis structure.

CHAPTER TWO

This chapter sets out to explore literature that is relevant to the topic of clinical responsibility. Background information is reviewed including current New Zealand policy and protocol for mental health nurses, literature that covers mental health nursing roles and responsibilities and mental health legislation and nursing statutory roles. Literature that addresses responsibility within multidisciplinary teams is then covered and then reference is made to a landmark health and disability inquiry that identified issues with a mental health nurse's understanding of clinical responsibility. Concluding statements about the literature are made.

CHAPTER THREE

Chapter three offers an overview of the research methodology used in this study. It includes an overview of qualitative research and more specifically the qualitative descriptive design along with the rationale for its use. Theoretical underpinnings relevant to the study are described including, interpretivism, naturalistic enquiry and the theoretical positioning of the researcher. Ethical considerations are provided, including information pertaining to ethical and local approval, consent, confidentiality and potential risks to participants. The research questions are then set out. Specific information pertaining to the chosen methods which include purposeful sampling, semi-structured interviewing and thematic analysis are then supplied. Lastly, the topic of rigour is addressed.

CHAPTER FOUR

This chapter reports on the findings of the study. This includes three major themes; ‘Patient Responsibility’, ‘Medical Responsibility’ and the largest theme of ‘Conflicting Nursing Responsibility’. The themes are supported with narrative from the interviews. Each theme has two subthemes with relevant subtitles.

The first theme, ‘Patients’ Responsibility’, includes the subtheme of ‘Self Responsibility’ which refers to patients taking responsibility for themselves and their own safety, the nurses also discussed fostering independence in them and sitting with the discomfort of not controlling risky situations. The nurses also explored the patients’ ability to take responsibility and considered a person’s level of wellness and diagnosis as factors for consideration in regard to this. Finally, narrative that referred to judgements inherent in the concept of patient responsibility were discussed.

The second theme, ‘Medical Responsibility’, includes two subthemes; ‘Ultimate Medical Responsibility’ and ‘The Nurse Doctor Relationship’. ‘Ultimate Medical Responsibility’ refers to the narrative that indicates the nurses’ belief that doctors are ultimately responsible which includes the beliefs that the doctors feel they are responsible, that doctors make final decisions over care and that they are ultimately accountable. The second subtheme refers to the nurse doctor relationship which explores communication between mental health nurses and doctors as well as consideration of who knows the patient better.

The third and final theme ‘Conflicting Nursing Responsibility’ describes two subthemes; ‘Accepting Responsibility for One’s Practice’ and ‘Accountability’. The first subtheme covers narrative that indicates the nurses take responsibility for practice as well as reflecting on their responsibility. The second subtheme describes competing factors to clinical responsibility in the mental health nursing practice environment that relate to accountability.

CHAPTER FIVE

This chapter firstly addresses the study limitations and then discusses the findings. A synthesis of findings is described including a diagram of how the themes interrelate. The findings are then explored in conjunction with relevant literature. This discussion covers

the consumer discourse, medical discourse and the risk management discourse. The implications for nurses are then discussed.

Chapter Two: Literature Review

Introduction

The term responsibility started to emerge in the nursing literature in the 1970's however it was not a new concept at this time. One of the first terms used to describe the topic was 'dedication to duty'. When this phrase was used there was an expectation that nurses would be totally devoted to their duty and always perform at their very best. However the word duty became outdated and dedicated was considered to have religious connotations. The term was therefore replaced with responsibility which suggests a wider social conscience (Peplau, 1999). Peplau (1999) reports that when the term responsibility surfaced in the literature it referred to one being: "reliable, trustworthy and doing what was expected; a kind of moral and personal liability was implied" (Peplau, 1999 p. 20).

In contemporary times the term 'clinical responsibility' refers to tasks or duties that involve professional components of clinical practice, that require the implementation of clinical judgement in regard to patient care (McGraw-Hill, 2002). Oynett (1995) defines responsibility as; "a set of tasks that a professional body, employing authority or court of law can legitimately demand of a practitioner" (Oynett, 1995 p. 281). Responsibility also refers to being called to account for one's actions (Herman, Truer & Warnonk, 2002; Oynett, 1995) and accountability describes the mechanism by which if a practitioner fails to exercise their responsibility disciplinary action may be produced (Vize, 2009a).

There are three main areas of responsibility that are outlined in the literature; employee, professional and legal responsibilities. Employee responsibilities are defined by a contract of employment and should be set out in a job description. The objectives of employment should be discussed at the time of performance appraisal (Vize, 2009b) and the nurse is accountable for these responsibilities to the organisation in which they work (Oynett, 1995; Vize, 2009b). Professional responsibilities refer to responsibilities specific to one discipline (Oynett, 1995; Vize, 2009b), for nursing in New Zealand such responsibilities are outlined through guidelines and competencies of practice set out by the New Zealand Nursing Council (2007) and New Zealand College of Mental Health Nurses (2004). Professional accountability lies with these professional bodies. Although guidelines of acceptable practice are defined by nursing professional bodies, nurses also remain subject to legal responsibilities and are accountable to a court of law (Vize, 2009b).

Given the limited amount of literature available on the topic of clinical responsibility background topics considered relevant will be explored. The following chapter will firstly provide a brief overview of current nursing competencies and standards of practice as a foundation for what is expected of nurses practising in today's health care system in New Zealand. The roles and responsibilities of the mental health nurse will then be reviewed with special consideration of the therapeutic relationship which is considered a core component of mental health nursing. Current practice and decision making is often influenced by risk assessment and management processes which are intertwined with concepts related to responsibility, this will be addressed in the next section, followed by literature related to mental health legislation and statutory roles. Literature that explores the concept of responsibility in relation to multidisciplinary teams will be reviewed before finishing with the with reference to a landmark Health and Disability Commissioner inquiry that was conducted in Southland District Health Board Inpatient Services in New Zealand in 2001 as an example of accountability processes in practice.

Nursing Guidelines and Standards

Current standards help to define the contemporary role of the mental health nurse and provide what is expected as a minimum level of practice, it aids the monitoring of clinical practice and provide an important element in quality assurance. Standards also provide a guide when considering legal and professional accountability of practitioners and are often used in Health and Disability Commissioner inquiries (Neville, Hangan, Eley, Quinn & Weir, 2008; O'Brien, Boddy, Hardy & O'Brien, 2004). Key documents are provided by The Nursing Council of New Zealand [NCNZ] (2007) and The New Zealand College of Mental Health Nurses [NZCMN] (2004).

The NCNZ (2007) sets out four domains of practice that are considered as basic competencies for registered nurses. The domains are professional responsibility, management of nursing care, interpersonal relationships and interprofessional health care and quality improvement. Each domain of practice contains the relevant competencies expected of a nurse including; i) the acceptance and demonstration of competency related to professional and ethical responsibilities and cultural safety. This includes the demonstration of knowledge and judgement and the nurse being accountable for one's decisions and actions; ii) the provision of assessment and management of client care that is supported by nursing knowledge and evidence based practice; iii) the demonstration of

effective interpersonal and therapeutic communication with clients, other nursing staff and interprofessional communication and documentation; and iv) the nurse's ability to evaluate and promote the nursing perspective within a health care team (NCNZ, 2007).

The Nursing Council of New Zealand also provides a code of conduct for nurses; this code supplies a guide for nurses and the public to assess expected standards of nursing (NCNZ, 2009). Under the Health Practitioners Competence Assurance Act (2003) the council has the right to call into question, withdraw or limit the practice of any nurse whose conduct falls short of these standards. The four principles of the code are;

“ I) the nurse complies with legislative requirements; II) acts ethically and maintains standards of practice; III) respects the rights of patients/clients; and IV) justifies public trust and confidence” (NCNZ, 2009, p. 5).

More specific standards to the area of mental health nursing are provided by Te Ao Maramatanga, The New Zealand College of Mental Health Nurses Standards of Practice for Mental Health Nursing in New Zealand (2004). Six standards are provided that state the Mental Health Nurse:

“I) ensures his/her practice is culturally safe; II) establishes partnerships as the basis for therapeutic relationships with consumers; III) provides nursing care that reflects contemporary nursing practice and is consistent with the therapeutic plan; IV) is committed to ongoing education and contributes to the development of the theory and practice of Mental Health Nursing; and VI) is a health professional that demonstrates the qualities of identity, independence, authority and partnership” (NZCMN, 2004, p.4).

Standard six elaborates further on the domain of accountability by stating the nurse is accountable and obligated to oneself, nursing, peers, consumers, families and the community and that collectively mental health nurses are accountable to the public for the quality of their knowledge and practice. This standard also states that mental health nurses need to accept responsibility to be up to date in terms of knowledge and skill, to know when nursing is needed, to take action and to be able to provide justification for judgements and actions that “can endure the scrutiny of peers” (NZCMN, 2004, p. 18).

A quantitative study was conducted in New Zealand that aimed to evaluate mental health nursing practice in accordance with an earlier edition of these standards of practice

(O'Brien et al, 2004). A national field study was conducted utilising 327 sets of consumer notes at 11 District Health Board [DHB] sites. Clinical notes were used and searched for indicators that related to the standards of practice. The results of the study showed wide variation in the occurrence of the indicators from individual DHB's predominantly in the areas of informed consent, information about legal rights, and culturally safe care. The study suggests that there is the need for future improvement for mental health nursing practice to meet the standards at a higher rate (O'Brien et al, 2004).

The Nursing Council of New Zealand and The New Zealand College of Mental Health Nurses provide guidelines and codes of practice that describe mental health nursing responsibilities. These are an essential consideration in regards to clinical responsibility as they provide a measure for mental health nursing practice within the New Zealand setting however one New Zealand study has indicated that these standards may not be achieved in practice. The roles and responsibilities of mental health nurses are further expanded on in other relevant literature.

Mental Health Nursing Roles and Responsibilities

There are various studies that examine the roles of the mental health nurse (Cleary, 2003a; Cowman, Farrelly & Gilheany, 2001; Fourie, McDonald, Connor & Bartlett, 2005; Hurley, 2009) which when combined provide a long list of tasks and responsibilities. By way of overview, the nursing process includes assessment, nursing diagnosis, planning, implementation and evaluation (Bishop & Ford-Bruins, 2003; Kudless & White, 2007). Each aspect of the process involves collaboration with the individual, family, peers, other members of the health care team and wider community services. There are added nursing responsibilities such as staff or student supervision, group facilitation, administrative tasks, area coordination roles (Fourie et al, 2005), along with professional development tasks (Kudless & White, 2007). The mental health nurse can be considered as a generic specialist who enacts a cluster of capabilities. And because of this the nurse needs to be willing to adopt flexible work roles that are responsive to service user's needs (Hurley, 2009).

Documentation is involved in each part of the above nursing process and is considered relevant as it is deemed to provide nurses with protection from blame in the event of an adverse outcome (Cleary, 2003a). Within nurse perspective studies documentation is acknowledged as being important (Cleary, 2003a; Cowman et al, 2001;

Fourie et al., 2005) however it is also described as frustratingly time consuming which reduces client contact (Cleary, 2003a; Fourie et al., 2005). Some studies have indicated that nurses describe documentation taking precedence over client contact because it is the documentation that they are held accountable for (Fourie et al., 2005).

The therapeutic relationship is considered fundamental to the mental health nursing identity (Cleary, 2003b; Dziopa & Ahern, 2009; Fourie et al, 2005; New Zealand College of Mental Health Nurses, 2004; Nursing Council of New Zealand, 2007; Scanlon, 2006; Shattell, Starr, & Thomas, 2007; Welch, 2005) and perhaps because of this it is one of the most important responsibilities of the mental health nurse. It is thought that a positive therapeutic relationship is a good predictor of positive patient outcomes (Welch, 2005) and nurses are considered by some as being in the best position to develop therapeutic relationships based on the amount of time spent with consumers. There is a broad range of nursing attributes that enable the therapeutic relationship (Dziopa & Ahern, 2009) and various studies have reported from the nursing perspective what these attributes are (Hurley, 2009; Scanlon, 2006; Welch, 2005). Some of the attributes reported include interpersonal skills, humour, decisive decision making, knowledge (Scanlon, 2006), congruency, authenticity and self-revelation (Welch, 2005). Further consideration is given to professionalism, therapeutic boundaries, conflicting personalities and one's own assumptions and attitudes within the relationship (Scanlon, 2006). Talk based therapies are also considered by some to be an innate part of the nursing package along with the therapeutic use of self in interactions with clients (Hurley, 2009). There are additional studies that explore the therapeutic relationship from the consumer perspective (Hurley, 2009; Shattell et al, 2007; Jackson & Stevenson, 2000). In these studies patients described the need for a reciprocal relationship with nurses (Shattell et al., 2007; Jackson & Stevenson, 2000) which involves the use of self disclosure (Shattell, et al., 2007) and the nurse demonstrating an everyday attitude (Hurley, 2009). Interventions such as spending time, touch, listening and the ability to provide blunt feedback have also been considered important, along with the demonstration of knowledge, and honesty (Shattell, et al., 2007).

There is a vast range of roles and responsibilities that a mental health nurse may be expected to perform together with various people whom they have responsibilities towards. Documentation is highlighted in the literature as being important in terms of accountability and the therapeutic relationship is considered as a fundamental part of

mental health nursing. In addition to the responsibilities and roles that have been discussed nurses are also required to undertake statutory roles.

Mental Health Legislation and Statutory Roles

The Mental Health (Compulsory Assessment and Treatment) Act [MHA] (1992) provides the legal framework for compulsory mental health care in New Zealand and has broad implications for the mental health nurse (Fishwick, Tait & O'Brien, 2001). Traditionally, mental health nurses have played key roles in the care provided to consumers who are subject to compulsory treatment (O'Brien and Kar, 2006). The implications of such involve treatments and interventions such as detention, seclusion, restraint or administration of medications being carried out by a nurse without an individual's consent.

A recent mental health legislation reform in New Zealand emphasized a shift from medical dominance in decision making related to the act, this allowed for other disciplines such as nurses to perform formal statutory roles (McKenna, O'Brien, Dal Din & Thom; 2006; O'Brien & Kar, 2006). Statutory roles now undertaken by nurses include the role of Second Health Professional, Duly Authorised Officer, and less commonly the Responsible Clinician. The development of nursing undertaking such roles has created some challenges, particularly in consideration of the therapeutic relationship that is considered intrinsic to nursing (O'Brien & Kar, 2006). There has been some ambivalence from nurses about undertaking these roles given concerns about the effect on the therapeutic relationship (McKenna et al., 2006; Farrow et al., 2002; Fishwick et al., 2001; Hurley & Linsley, 2007; O'Brien & Kar, 2006). However, to date there is little research that corroborates such concerns (McKenna et al, 2006), and it is considered by some authors that it is unlikely that if damage occurs that it will be permanent (McKenna et al, 2006; Hurley & Linsley, 2007; O'Brien & Kar, 2006). Hurley and Linsley (2007) consider the therapeutic use of self, advanced communication skills and genuineness as ways of combating the conflict between therapeutic responsibilities and legislative roles. The development of standardised educational frameworks that assist nurses to perform these roles while maintaining the therapeutic relationship have also be considered as a potential area for future development (McKenna et al., 2006; Hurley & Linsley, 2007; O'Brien and Kar, 2006).

The Second Health Professional is a reasonably common role of the nurse; it involves providing an opinion as to whether a consumer should be subject to compulsory treatment in a judicial setting. A New Zealand study, although limited in sample size (n=31) and specific to a single facility, highlighted some potential issues in regard to nurses' level of knowledge and training for this role. Fifty-five percent of the participants did not feel adequately prepared for the role and seventy seven percent had not received any training or preparation. (O'Brien & Kar, 2006). The authors of this study highlight an incident where a consumer was discharged from in-patient care following a section 16 hearing (judicial process of appeal) and subsequently killed his father. The inquiry that followed found that neither health professional had adequate time to prepare for the hearing and that both were unaware that they could request the hearing to be deferred (O'Brien & Kar, 2006). This regrettable outcome gives an illustration of the significant responsibility held by nurses carrying out such roles and further identifies the need for education for nurses fulfilling such roles.

The Duly Authorised Officer (DAO) is a further statutory role that is frequently undertaken by nurses that was created in the 1992 legislative reform. This role entails assessment and investigation of a patient that may be suffering a mental disorder and may be a potential risk to themselves or others. This could involve arranging assessment by a medical practitioner and ultimately a possible commitment under the Mental Health Act (1992). It is the responsibility of the DAO for ensuring that the appropriate processes and client's rights are upheld during the process. Again, this is a role that carries a high level of responsibility and although training is required there is no standardisation of training across district health boards or criteria for nurses eligibility for the role (O'Brien & Kar, 2006).

The creation of the 'responsible clinician' role also occurred as a result of the legislative reform. This term is defined as "the clinician in charge of the treatment of the patient" (Ministry of Health, 2001). Although there is no disciplinary requirement within mental health legislation in New Zealand, this role is more frequently fulfilled by medical professionals (McKenna et al., 2006). Interestingly, this role has been undertaken in Australia by nurses for some time (Hurley & Linsley, 2007). McKenna et al (2006) found that in New Zealand nurses filled only 2.6% of responsible clinician roles. This study also surveyed experienced nurses (n=107) about the role and found a degree of ambivalence about attaining it. Potential barriers that were identified included concern that the

increased responsibility would not be reflected in remuneration, existing heavy workloads and concern about the impact it would have on existing nursing roles (McKenna et al., 2006).

The use of enforced treatment in mental health care provides a distinct difference to other areas of health where individual choice and consent about treatment is assumed. The MHA (1992) provides the basis for enforced treatment within the New Zealand setting and mental health nurses have key statutory roles which come with high levels of responsibility. It has also been suggested that such roles may propose challenges for nurses in terms of the therapeutic relationship.

Risk Assessment and Management

A number of studies that examine nursing roles identify risk assessment and management as a core component of mental health nursing practice (Bishop & Ford-Bruins, 2003; Cleary, 2003b; Fourie, et al., 2005). It is acknowledged that risk assessment and management is an essential part of mental health nursing however it also is considered a leading discourse in practice that proposes special challenges for nurses. The New Zealand guidelines for risk assessment and management acknowledge that risk has become a principal discourse in clinical practice and that there is a burden on the mental health clinician to assess and manage risks in a way that stand up to scrutiny from the public (Ministry of Health, 1998).

Media representations have a considerable influence on the general public's perceptions and there is a general consensus in the literature that media portrayal of those suffering from mental illness is misleading (Anderson, 2003; Carlo, 2007; Cutcliffe & Hannigan, 2001; Stickley & Felton, 2006). A common theme is the depiction of those suffering from mental illness as being dangerous and violent (Anderson, 2003; Carlo, 2007; Cutcliffe & Hannigan, 2001). Along with this, there have been several high profile cases that have portrayed an inadequacy of the mental health system's ability to effectively manage care (Crowe & Carlyle, 2003). Inevitably, political and societal influences such as these, can lead nurses into practising in a way that is over-reactive to perceived risks and subsequently not therapeutic or in the interests of the people that receive care (Godin, 2004; Stickley & Felton, 2006; Woods & Kettles, 2009).

Most comprehensive risk assessment frameworks provide information on collecting information from various sources about historical, current and future factors that impact on risk status and formulating such factors to create a management plan (Ministry of Health, 1998; Woods & Kettles, 2009). However, the expectation that clinicians are always able to accurately assess risk is unfair because it is not possible to identify and eliminate risk entirely (Stickley and Felton, 2006; Ministry of Health, 1998). Clinical risk assessment has even been compared to weather forecasting; there are times when adverse events occur even in a situation where clinicians have thoroughly applied risk assessment and management systems (Ministry of Health, 1998).

Therapeutic risk taking refers to having the opportunity to take a course of action that may have an adverse outcome (Stickley & Felton, 2006). In order to attain therapeutic gain, risk taking is sometimes required (Ministry of Health, 1998; Stickley & Felton, 2006). This can mean enabling a person to make decisions for themselves and acknowledging an individual's expertise in their own life process. It can have the positive effect of promoting individual responsibility and ultimately recovery. Some clinicians have anxieties about exposing the people they work with to higher levels of risk due to concern about potentially negative outcomes and professionals can feel obligated to protect individuals from such failures (Stickley and Felton, 2006). However, Stickley and Felton (2006) argue that risk taking is part of everyday life and the potential for the creation of hope and opportunity sometimes outweighs the potential for risky outcomes.

Risk assessment and management is acknowledged in the literature as being a principle discourse in current mental health practice. Societal expectations place a high level of responsibility on mental health clinicians to assess and manage risk in a way that holds up to the scrutiny of various parties even though it is deemed impossible to eliminate risk. Such pressures can result in clinicians being over reactive to perceived risks. Mental health nurses have the responsibility to balance societal expectations to manage risk and at the same time uphold their therapeutic responsibilities that were earlier described.

Responsibility within Multidisciplinary Teams

Ambiguity around responsibilities within multi-disciplinary teams has been cited as an issue within the literature (Elsom, Happell, Manias & Lambert, 2007; Hammond, Bandak & Williams, 1999; Herman et al., 2002; Norman and Peck; 1999; Onyett, 1995; Savage & Moore; 2004). Historically a medical practitioner has been considered

responsible for a patient at all times, however this does not sit comfortably with modern health care practice (Vize, 2009b). In insisting that doctors are responsible for all clinical activities even though they may not be carrying them out or have any control over them is not considered reasonable (Vize, 2009a). A professional cannot be held to account for another professional's actions except in part by poor delegation or unsuitable referral (Onyett, 1995). The perception of psychiatrists having clinical responsibility for the practice of nurses, or other disciplines, is a myth and has no basis in law or health policy (Herrman, Trauer & Warnock, 2002; Norman & Peck, 1999; Onyett, 1995). In the case of nurses implementing or administering treatments that are prescribed by a medical practitioner, they are still entirely responsible for the decision to carry out that intervention (New Zealand College of Mental Health Nurses, 2004; Nursing Council of New Zealand, 2007).

There does however remain a perception that psychiatrists maintain supreme responsibility within healthcare teams (Elsom et al., 2007; Herman et al., 2002). Elsom et al's (2007) study that investigated psychiatrists' views on expanding practice roles for community mental health nurses found that psychiatrists considered that they retained ultimate responsibility for treatment outcomes. For this reason, they were reluctant to delegate any responsibility for assessment, diagnosis or intervention. A further study by Hammond et al (1999) explored various discipline perspectives of responsibility within multidisciplinary teams and found that although nurses valued collaborative practice and shared responsibility, psychiatrists believed that they had more authority over care delivered. Vize (2009b) considers the perceptions surrounding medical responsibility and comments that it could be in part due to the history of medical power and status but also perhaps related to other disciplines' tendency to relinquish responsibility.

If health professionals are individually responsible for the care provided, questions arise in regard to multi-disciplinary team decision making. Norman and Peck (1999) consider a multi-disciplinary team as a resource for professional decision making but state that ultimately individuals must make their own decisions. A team may assume collective responsibility however the team as a whole has no legal responsibility (Hermann et al., 2002; Norman & Peck, 1999; Savage & Moore, 2004). This highlights the need for mental health nurses to have an awareness of their responsibilities when working within multidisciplinary teams.

The literature is clear that each individual in a multidisciplinary team is responsible for their own practice however it is unclear whether this is understood by the clinicians within these teams. Ambiguity about responsibilities within multidisciplinary teams emphasises the importance for further clarification about mental health nursing clinical responsibility.

The Southland Report

In 2001, an inquiry by the Health and Disability Commissioner, Ron Patterson, was conducted on the care provided to a Mr Burton by Southland inpatient mental health services in New Zealand. The following section of this review will use this case as an example of how nursing responsibilities are reviewed in the context of adverse outcomes within the New Zealand setting. This review was conducted following a complaint made by Mr Burton's family that the care that was provided to him during an inpatient stay was not of an appropriate standard. One day following his discharge from this service Mr Burton killed his mother and was later found not guilty by reason of insanity. A number of issues were highlighted in this inquiry including issues within the organisation, management and other disciplinary roles. However, the focus for this study is the issues found that related to the care provided by Mr Burton's primary nurse on the unit.

The nurse's practice was reviewed in relation to the guidelines earlier discussed including the NCNZ competencies and the NZCMHN standards of practice alongside the local policies that were relevant to the nurse's position and key nurse responsibilities. Areas of poor performance identified included assessing, planning and evaluating care, coordinating care whilst on trial leave, discharge planning, directing and supervising an enrolled nurse and consistency in quality of care (Paterson, 2002a).

Issues related to the nurse's knowledge of her key responsibilities were identified along with issues related to her understanding of her accountability. In the report of findings the nurse's response to the identified areas of poor performance indicated a defensive approach where she stated that she was in fact unaware of the extent of her responsibilities outlined in the policy. She also emphasised that the policies were not consistent with the practice operating at the time in the inpatient mental health unit. The commissioner accepted that the nurse was constrained by the faults of the system within which she was working however commented that:

“Health professionals working within a poorly functioning system cannot abdicate all responsibility for maintaining appropriate professional standards... aspects of her practice indicate a failure to exercise the independent professional responsibility reasonably expected of a registered comprehensive nurse in the circumstances at the time” (Paterson, 2002b, p. 58).

Additional concerns were raised at the lack of evidence of the nurse critically appraising her practice following the event in the initial stages of the inquiry. However, following the provisional opinion the nurse advised that she had learnt a great deal about her practice from being involved in the process and that she had made some changes to her practice and was engaged in professional development (Paterson, 2002b). Mitchell (2001) similarly found in a study that explored how mental health nurses deal with critical incidences that nurses learned about their roles and responsibilities through the process. In addition to this, issues were also raised about participants’ understandings of their accountability.

The Commissioner concluded that the nurse should have been aware of the need to take a more proactive approach to ensuring nursing standards were being properly met and co-ordinated. He also reiterated that health professionals must demonstrate independent judgement and assume professional responsibility within their area of expertise (Paterson, 2002b). The findings in this inquiry cannot be completely generalised given it is based on one nurse’s understanding in the context of a particularly stressful situation. However, it does highlight the need for further investigation of the topic of mental health nursing clinical responsibility.

Conclusion

Somewhat surprisingly there is scarce research available that is specific to the topic of clinical responsibility in the mental health nursing context. However, current policies and guidelines provide some limited information to nurses about what is expected of them in practice alongside some research that explores nursing roles. It has been identified that mental health nurses carry a high level of responsibility in practice particularly in terms of their therapeutic responsibilities to the people whom they work with. This is somewhat complicated by statutory roles, enforcement of treatment and risk management responsibilities which all place an onus on mental health nurses to effectively manage this facet of mental health care. Within the literature that explores the functioning of

multidisciplinary teams it is identified that individuals within the teams are responsible for their own practice. However, ambiguity around this remains and some studies have identified that there is a belief that psychiatrists maintain final responsibility. The use of a landmark health and disability inquiry was used as a way of identifying how mental health nursing practice is evaluated in the event of an adverse outcome. This case, alongside one other study, highlighted that there may be issues related to mental health nurses' understandings of their clinical responsibility. There is a suggestion therefore that further exploration of the topic of mental health nursing clinical responsibility is needed.

Chapter Three: Methodology

Introduction

This chapter will provide an overview of the methodology used to conduct this research study. This will include an overview of the qualitative descriptive design along with the rationale for its use and theoretical underpinnings. Ethical considerations will be provided along with specific information pertaining to the application of the chosen methods which include purposeful sampling, semi-structured interviewing and thematic analysis. Lastly, rigour will be addressed.

Qualitative Research

The inability to quantifiably measure some phenomena has led to the interest and acceptance of using qualitative measures as a way of discovering knowledge. There is no one single definition for qualitative research that aptly describes it as a whole as it is a field of inquiry that is concerned with a number of interrelated complex terms and concepts (Denzin & Lincoln, 2000). However, Gerrish and Lacey (2006) provide a very basic definition that states: it is research that is concerned with generating non-numerical data based on an interpretive philosophy. Its aim is to gather an in-depth understanding of human behaviour and thought through investigation and interpretation of the reasons behind such human phenomena.

This study is concerned with the mental health nursing *perspective* of ‘clinical responsibility’. It seeks to explore these perspectives and identify relevant influencing factors. The research methodology needs to be consistent with the topic and the overall objectives of the study. There are some obvious differences between quantitative and qualitative approaches that help to highlight the benefits of a qualitative approach for this study. Qualitative methods are believed to get closer to participants’ perspectives through detailed data collection methods. It can be argued that quantitative methods are far less likely to identify participant perspectives due to the restrictions of empirical methods. Qualitative data collection methods allow for rich descriptions (Denzin & Lincoln, 2000) which are particularly valuable when little is known about a topic. The data is able to emerge unrestricted rather than being constrained or predetermined by more specific enquiry (Liamputtong, 2009). The other clear benefit relates to the examinations of relevant influencing factors. Responsibility can be considered a social construct that has a

number of complex interwoven influencing factors. The topic sits in a context of various political, organisational and social factors which are likely to influence the mental health nursing perspective. Qualitative research considers and allows for each participant to have an individually situated context that influences the individual's subjective world and perspective (Munhall, 2007). It is also more likely that qualitative research will confront the kinds of influences described and allow for the incorporation of these factors in its findings (Denzin & Lincoln, 2000).

Qualitative Description

Within qualitative research there is an assortment of highly theoretically developed methodologies that can be used such as phenomenology, grounded theory or ethnography. In comparison, qualitative description as a methodology is considered by some as less sophisticated however it is because of its more simple form that it is argued to be a useful and necessary methodology (Sandelowski, 2000; Thomas, 2003). A descriptive qualitative approach is arguably one of the most frequently employed approaches of qualitative research in practice (Sandelowski, 2000), which is used under various disguises. This method of research can also be referred to as “interpretive description” (Thorne, Joachim, Paterson, & Canam, 2002), “generic qualitative research” (Caeli, Ray, & Mill, 2003; Merriam, 1998) or “basic or fundamental qualitative description (Sandelowski, 2000).

Qualitative descriptive studies have been acknowledged as an appropriate form of methodology in qualitative research (Caeli et al, 2003; Sandelowski, 2000; Thomas, 2003). Caelli et al, (2003) consider this more generic approach as a way of addressing the characteristics of qualitative research without focusing the study through a specific lens of a more specific methodology. Sandelowski (2000) provides a basic outline of the qualitative descriptive research process that researchers can use as a method which was used as a guideline for this study. This method includes a well considered combination of sampling, data collection and analysis techniques which will be explored further in this chapter however firstly the reasons for its use will be discussed along with some theoretical underpinnings that are relevant to the study.

Descriptive studies are less theoretical, which can be considered as an advantage as it allows for findings to emerge from the raw data without being restricted by imposed methodologies or predetermined theories (Thomas, 2003). This is done by staying close to the raw data and to the surface of words and phrases used by the participants and

providing comprehensive findings in the everyday language of the participants (Sandelowski, 2000). Thomas (2003) comments that key themes can often go unnoticed by imposing deductive methods that are used in structured methodologies as the data is moulded to pre-existing theories and philosophies rather than being presented in a more true form. Therefore descriptive studies are especially helpful when straight descriptions of phenomena of interest are required (Sandelowski, 2000). The topic is broad as it considers what mental health nurses perceptions are on the topic. Given this, a broad approach was considered as appropriate for this initial study to provide some foundational descriptive information as a starting point to the topic. Sandelowski's (2000) overview of descriptive studies suggests that the outcome of such studies as a straight descriptive summary of findings can be a valuable end-product in itself but also useful as an entry point for further research that may use a more specific mode of methodology. In consideration of this qualitative description was chosen for this initial study with the possibility of it informing of areas for further more specific research in the future.

Theoretical Underpinnings

Although qualitative descriptive studies are less theoretical than other qualitative designs it is still important to consider underlying theory and assumptions that are relevant to the study. Interpretivism (Denzin & Lincoln, 2000), naturalistic enquiry (Sandelowski, 2000) and the theoretical positioning of the researcher (Caelli et al, 2003) are considered in relation to this study and design.

Interpretivism is an approach or theory that underlies qualitative research in general. It refers to the belief that human beings constantly interpret and make sense of their surroundings (Gerrish & Lacey, 2006). In other words, to find meaning in an action, or to say one understands what a particular action means requires that one interprets it in a particular way. Interpretivists argue that it is possible to understand the meaning of others even when it is not explicitly described and to do so in an objective way. Within the qualitative research process, the researcher is able to interpret the data they collect but not misinterpret the original meaning of someone through the employment of a method of analysis that allows them to step outside their normal frames of reference (Denzin & Lincoln, 2000). Given this is a descriptive study the interpretation is low inference, in that it will not describe the findings in terms of a conceptual or philosophical framework (Sandelowski, 2000). However, it does involve a degree of interpretation as this cannot be

avoided based on the underlying assumptions of interpretivism as a basis for qualitative research.

Sandelowski (2000) considers qualitative description to generally draw from naturalistic enquiry. Naturalistic enquiry refers to studying a phenomenon in its natural state or to the extent in which it can be studied in its natural state. This form of enquiry is not only related to qualitative research but also forms of behavioural research. In a naturalistic study there is no pre-selection or manipulation of variables along with no prior commitment to a predetermined theoretical view of the topic (Sandelowski, 2000). There is an element of naturalistic enquiry in this study given the absence of predetermined variables and the less theoretically restricted framework of a descriptive study.

Within qualitative research it is important to acknowledge the impact the researcher has on the research and vice versa (Clarke, 2006). Qualitative methods consider the researcher as an inherent part of the process instead of regarding them an intervening variable. The researcher needs to demonstrate an awareness of possible bias and consider the impact of oneself on the data and analysis by sharing their perspective (Munhall, 2007). Caelli et al (2003) suggest that in qualitative descriptive studies the theoretical positioning of the researcher should be made explicit. The theoretical positioning of the researcher can be addressed through describing the researcher's disciplinary affiliation, what brought them to the research topic and any assumptions they make about the topic of interest. This is in the thought that such factors shape an inquiry in the absence of a predetermined philosophical framework and through the provision of this information the reader is better equipped to evaluate the research (Caelli et al, 2003).

Given this it is important to acknowledge the researcher as a mental health nurse, and one that although is not working in the specific areas sampled is part of the local mental health nursing culture. Within the researcher's local work area the researcher had been privy to informal discussions amongst nurses about nursing responsibilities within practice which prompted the general interest in the topic. The researcher's experience as a mental health nurse has created some assumptions on the topic of interest. The main assumption identified by the researcher is that mental health nurses carry a high level of responsibility within their practice. The second assumption is that nurses' perceptions of their clinical responsibilities impact the way mental health nurses carry out their practice.

Now that the researcher's assumptions have been made clear ethical factors will now be addressed.

Ethical Considerations

This study received ethical approval from the Upper South A Regional Ethics Committee as well as local approval from the area sampled. The local process involved having discussion with a pukenga atawhai or Maori mental health worker, a privacy officer and the local nurse consultant. Approval was then made by the general manager.

Information sheets were provided to all potential participants prior to meeting with the researcher usually via email. The information sheets included information about the purpose of the study, the researcher, what participation would involve, confidentiality, study approval and contact details for a health and disability advocate (see Appendix one). A further paper copy was provided and discussed prior to interviews and signed informed consent was obtained from all participants (see Appendix two). Informed consent forms included a clause about the potential of confidentiality to be broken if serious concerns were raised about professional conduct and/or patient safety during the interview process, no issues of this type occurred. Given the researcher worked within the local mental health area, some participants had a prior working relationship with the researcher. McEvoy (2001) considers possible relationships between the researcher and participants as potentially creating some issues about freely informed consent. The risk of this was reduced through sampling via advertising where participants independently volunteered. In addition to this, it was raised on the information sheet as a potential issue and participants were encouraged not to volunteer if they felt uncomfortable about knowing the researcher (see Appendix one).

The digital data was stored in a secure file on the researcher's computer and paper versions used during analysis were kept in a locked draw when not in use. Following the completion of the study the data was stored securely with the university. The transcriber signed a confidentiality agreement (see Appendix three). Participants' names and identifying details were removed from records prior to analysis and pseudonyms have been used in this report. Special consideration was given to the use of narratives and parts of narrative were removed to ensure participant, other staff and patient confidentiality.

It is important that the researcher is mindful of the impact that interviews can have on participants (Clarke, 2006). Given the sensitivity of some of the discussion during the interviews the researcher was aware of the need to build rapport, act as a sympathetic listener and gave special consideration to how the interviews were finished. During all of the interviews there was no indication to suggest the interview process had caused distress to any of the participants.

Aim

The aim of this study is to identify mental health nurses' perceptions of clinical responsibility. The following research questions were used to guide the formulation of the study.

- What are mental health nurses' perceptions of clinical responsibility?
- What influences nurses' perceptions of clinical responsibility?
- And how do mental health nurses' perceptions of responsibility impact on their practice and decision making?

Design

As already stated, a qualitative descriptive approach is a well considered combination of sampling, data collection and analysis techniques. Sandelowski (2000) provides information concerning appropriate methods to use that fit a qualitative descriptive design including purposeful sampling, semi-structured open-ended interviews and content analysis. The use of these methods in this study will now be discussed.

Sampling

Within qualitative studies the researcher often seeks to identify a group of participants that will provide a rich source of data therefore non-probability sampling is often employed (Gerrish & Lacey, 2006). Sandelowski (2000) considers any purposeful sampling techniques as appropriate for qualitative descriptive studies. A purposeful convenience sample of the accessible local mental health nursing population was used. Convenience samples are considered appropriate in qualitative studies as they enable a relationship between the researcher and the areas being sampled (Gerrish & Lacey, 2006).

Participants were recruited via advertising in nursing staff rooms of the local inpatient mental health wards and community mental health services (see appendix four).

The researcher works in a specialised area of community mental health which was not part of the sample population. Nursing managers and/or nurse specialists were approached by the researcher in the areas being sampled and given a brief overview of what participation in the study would involve so that this information could be passed on to any potential participants. The advertisements were then placed in the nursing staff rooms. The majority of nurses expressed their interest in participating via email and were then sent the information sheet. They then replied confirming they wanted to participate and a time was arranged for the interview. Whiting (2008) considers a good informant as someone who is willing to talk about the topic of interest. This was considered as an advantage of participants independently volunteering through advertisement as this indicates a general interest and willingness to participate. Once satisfied that saturation had been achieved in interviews the advertisements were removed from the sample areas. How saturation was identified is further discussed in the data collection section.

Data Collection

Semi-structured interviews are considered the most common form of data collection within a qualitative descriptive design (Sandelowski, 2000). They are also considered as the most appropriate form of enquiry when participants' perspectives about a particular topic are sought (Crouch & McKenzie, 2006). This type of interview is organised around a set of predetermined questions with the flexibility of following participant's responses when further avenues of enquiry emerge from the dialogue (Whiting, 2008). This is considered a benefit of this type of interviewing as it allows for the researcher to produce rich data which is desired in a qualitative design (Crouch & McKenzie, 2006).

Within this study the interviews were conducted by the researcher. Some of the participants were known to the researcher through prior working relationships. Potential consensual issues related to this have been discussed in the ethical section of this chapter however the implications of such during the interview process are yet to be explored. Both disadvantages and benefits of this were considered in relation to this study. Firstly, the tendency of interviewees and the researcher to take common experiences for granted creates the potential of missing relevant data. Alongside this is also the possibility for participants to be reluctant to share sensitive information with a co-member of a culture (McEvoy, 2001). Some argue however that having a prior relationship with interviewees can in fact enhance the quality of interviews. McEvoy (2001) provides a case study that

demonstrates that shared experiences between interviewer and interviewee can produce a deeper depth of inquiry as long as the researcher is mindful of how the participant could be sensitive to the collegial relationship during the interview process. Within this study the researcher was aware of this being a potential issue which allowed for a reflective approach to the interviewing. The participants that were known to the researcher reported feeling comfortable with knowing the researcher and appeared to be open about their perceptions and experiences during the interview process. During the interview participants made statements such as ‘*you know*’ and ‘*you get it*’ that indicated a mutual understanding. Participants were also frequently asked to expand, explain in full or provide examples to ensure relevant data was not missed.

The interviews took place at a location that was convenient for the participants. This usually was in a room arranged by the researcher close to the participant’s place of work. All interviews were audio recorded. Audio recording interviews is a preferred method as it provides an accurate record of the interview for analysis along with freeing the researcher from the distraction of constant note taking (Whiting, 2008). The participants were asked a set of six predetermined open ended general questions on the topic (see appendix five) and then the researcher followed the responses of the participants as avenues of enquiry. Given the conceptual nature of the research question participants were often asked to provide clinical scenarios to help demonstrate how clinical responsibility influenced their practice. As described earlier the concept of saturation refers to the point in which no new data or themes are being discovered in the data (Guest, Bunce & Johnson, 2006). It was noted that saturation was probably reached around the eighth interview when the researcher became aware that information was being repeated in participant’s responses and no new responses were being identified. A further two interviews were conducted to confirm that saturation had occurred. Smaller sample sizes are considered appropriate in qualitative research (Crouch & McKenzie, 2006). The recorded interviews were between forty and sixty minutes in length. The interviews were later downloaded and then transcribed verbatim providing written data ready for analysis.

Thematic Analysis

Qualitative research results in large amounts of rich data that must be organised and reduced down to describe a phenomenon of interest. One commonly used way of doing this is thematic analysis; a process of encoding information. Through identification and

interpretation of themes large bodies of data that may otherwise seem disparate or unrelated are brought together to form a complete picture of combined experiences or perceptions. It can be used as a “way of seeing” or a way of systematically observing or understanding the perspectives and insights of a culture or a group which otherwise may have been missed (Boyatzis, 1998).

Thematic analysis was chosen for this study as it fits with the descriptive qualitative methodology and provides a structured process of analysis. Having a clear process for the analysis such as this enables the researcher to increase the accuracy in the interpretation of qualitative information (Boyatzis, 1998). This is particularly important given it is the first piece of research conducted by the author. A process of implementing thematic analysis is provided by Boyatzis (1998) in his book; *Thematic Analysis and Code Development: Transforming Qualitative Information*. This book was used as a guideline for analysis in this study.

The process of analysis includes three steps, identifying themes, encoding them and then interpreting these codes. There are some key terms that need to be defined. The encoding of data needs a clear specific code. A code is a list of themes with indicators and qualifications. The word theme refers to patterns that have been identified in the information. There are two levels at which themes can be analysed which include manifest and latent. Manifest refers to the analysis of visible or apparent content. And latent refers to the researcher looking at the underlying meaning of different aspects of the data. Latent-content analysis enables the essence or meanings of others experiences and thoughts to come out of the data. This approach is more interpretive than the first. When a researcher is analysing data a combination of the two levels of themes can be used (Boyatzis, 1998).

There are three different ways of developing a code; i) theory driven, ii) prior data driven, or iii) inductive or data driven. If a study is the first in a series of explorations about a phenomenon, the researcher may not be clear about what type of insight is being sought or why. In this instance, inductive analysis is indicated which is also fitting with the qualitative descriptive methodology. This approach is different to the others as it involves selecting a subsample that is first used to search for themes. The themes identified from this smaller sample are later applied to the rest of the data. Within this study four transcripts were used as the subsample for initial development of themes, these were the first four made available following transcription.

Before code development begins the researcher reads the data a number of times to get a feel for it. Then the raw information needs to be reduced. The material or transcripts are each read and then a synopsis is created for each. Through this process further familiarity is made with the raw data as the researcher is able to consciously process the information. This was the first step taken in this study. The transcripts were read and then re-read and an outline for each was written which included all relevant points made by the participant.

The second step is identifying themes within the subsamples that have been selected. This involves comparing the summaries and looking for similarities. The researcher must have an openness and flexibility to perceive these patterns. Knowledge relevant to the phenomena of interest is crucial as it provides insight about where to look and what to look for. At this stage the researcher also needs to be very aware of one's tendency to project their own beliefs when analysing data. That is reading into or attributing something to another person that is your own value, emotion or attitude. Through having awareness of projection the researcher is better able to avoid it and create themes that are true to the original data.

The process of comparing and looking for similarities was carried out on the subsample. Emerging themes were written down and narrative was highlighted in various colours according to the emerging themes. A number of themes began to emerge. The following table provides an example of the naming process and emergence of themes.

Table 1: Example of emerging themes

Narrative	Naming It	Theme
<i>"I take my job so seriously probably too seriously some times and so I generally won't take risks outside of you know"</i>	Risk aversive practice	
<i>"if there's a risky decision to be made I think you're foolish to try and make it without consulting somebody else"</i>	Sharing risk	Accountability
<i>"I'm very comfortable documenting what my clinical rationale is and as long as I always have a sound clinical rationale underpinning my intervention and I can justify"</i>	Justifying practice	

*that and that's very clear then
I'm ok"*

Once themes have been identified a code can be created. However, the researcher needs to first return to the raw data with the themes and further assess and clarify the fit. Once satisfied, each theme is given a definition, indicators or flags, examples along with any other special considerations or information that will help future encoding. It is essential that this is done carefully and frugally. For example if a code contains large amounts of different themes it becomes too difficult to accurately search other data for all of those themes. Inevitably information that could be categorised will be missed as the searcher will not have all the themes in their mind. Once themes have been identified and the code created, it is applied to the rest of the raw data. Data or narratives that relate to the themes identified are categorised. If the data fits then the code is validated (Boyatzis, 1998) which was the case in this study. The following is an example of a code developed.

Table 2: Example of a code

Theme	Definition	Indicators or Flags	Examples
Accountability	The mechanism in which clinicians practice and decision making is assessed and reviewed. This is often in the context of an undesirable outcome.	<ul style="list-style-type: none"> *Risk management *Considering accountability in practice *Defensive practice *Looking for blame *Sharing risk *Coroners court 	<p><i>"I take my job so seriously probably too seriously some times and so I generally won't take risks outside of you know"</i></p> <p><i>"if there's a risky decision to be made I think you're foolish to try and make it without consulting somebody else"</i></p>

The final step is combining and cataloguing related themes together, which is described by Boyatzis (1998) as "forming clusters". This final step allows for the coherence of ideas. If the thematic analysis is part of an early stage inquiry, as is this one, the researcher tends to decide the way in which the themes are organised as there is no

previous research to be guided by (Boyatzis, 1998). The following table provides an example of how the themes were categorised in this study.

Table 3: Example of clustering themes

Narrative	Naming it	Subtheme	Main Theme
<p><i>“I take my job so seriously probably too seriously some times and so I generally won’t take risks outside of you know”</i></p>	<p>Defensive practice</p>	<p>Accountability</p>	
<p><i>“if there’s like a major change in presentation or major change in risk factor I probably would consult with the doctor if I was unsure yeah, just to protect my butt basically, not for anything else”</i></p>	<p>Abdicating responsibility</p>	<p>Accountability</p>	<p>Conflicting Nursing Responsibility</p>
<p><i>“Yeah, yeah and actually being very honest and being accountable and putting your hand up if you’ve made a mistake or an error or you know you might of come from left field and owning that and sometimes that can be more than clinically swung”</i></p>	<p>Accepting responsibility</p>	<p>Responsibility for own practice</p>	

Rigour

Rigour is concerned with the strength of a research design in terms of adherence to procedures, accuracy and consistency (Gerrish & Lacey, 2006). Trustworthiness refers to whether a researcher has made the studies procedures clearly visible and therefore auditable (Rolfe, 2006). Given this relates to the entire study trustworthiness is not able to be fully addressed in the methodological chapter but can be made explicit throughout the written report (Tobin & Begley, 2004). Background information has been made clear in the introduction of the study and the researcher’s position has been clearly identified in the methodological section. Sufficient information pertaining to the methods has also been

provided. Confirmability is enhanced by the use of an audit trail of the process of theme development. Quotes from the transcripts are presented to enhance the ability of the readers to follow the process of interpretation. The inclusion of the raw data from the transcripts has also enabled the reader to evaluate the procedure and the findings and assess their applicability to other settings. As the interviews were only conducted by one researcher consistency in the data collection was ensured. The analysis of the data was also completed by the one researcher which allowed for further consistency however the application of this process was reviewed in discussion with the researcher's supervisor to ensure accuracy.

Conclusion

This chapter firstly provided an overview of qualitative research and more specifically qualitative description. The rationale for the use of this methodology was that it allowed for the straight description of the phenomenon of interest because little else is known about the topic. The theoretical underpinnings of the research that were identified included interpretivism, naturalistic enquiry and the theoretical positioning of the researcher. Ethical considerations were described including the approval process, information provided to participants and gaining informed consent. Confidentiality was ensured with the secure keeping of data, and the removal of identifying data from the transcripts. Distress triggered during the interviewing process was considered as a potential risk however no issues of this sort arose during the data collection stage. The methods chosen were consistent with the qualitative descriptive design which included purposeful sampling, semi-structured interviews and thematic analysis. The analysis of the data was demonstrated using examples from the narrative. Lastly, the rigour of the study was further addressed by providing an explanation of trustworthiness, goodness and consistency.

Chapter Four: The Findings

Introduction

The aim of the study was to explore mental health nurses' perceptions of clinical responsibility. The three themes that emerged from the data will be presented in this chapter with the use of direct transcription from the interviews to illustrate them. The three themes were; patient responsibility, medical responsibility and conflicting nursing responsibility. Pseudonyms have been used to provide participant confidentiality and patient or other identifying information has been removed or changed. Patient is the word that was most frequently used by the participants therefore it has been used in this chapter. Interviews were labelled from [A] to [J] which has been identified at the end of each narrative.

I) Patient Responsibility

In considering one's responsibilities the nurse considered others that held responsibility alongside them for clinical outcomes including the patient. 'Patient responsibility' refers to the obligations of the patient. It is expected that patients do take responsibility however the level of expectation varies depending on various factors. This theme consists of two subthemes including self responsibility and the patient's ability to take responsibility.

Table 4: This illustrates an overview of the first theme 'Patient Responsibility'.

Patient Responsibility	
<i>Self Responsibility</i>	<i>The Patients' Ability to Take Responsibility</i>
<ul style="list-style-type: none">• Fostering independence• Keeping themselves safe• Sitting with the discomfort	<ul style="list-style-type: none">• Acuity of symptoms• Diagnosis and responsibility• Judgements and unrealistic expectations

a) Self Responsibility

This aspect related to the patient's obligations and the belief that the patient needs to accept the consequences of the choices that they make. The nurses believed that they could not be entirely responsible for the people they worked with as they were not able to control the behaviour of others: "*there is a point where you can't take responsibility for somebody else's behaviour so you can only do everything that you can in order to help that person.*" [E] And as a result the nurses rationalised that some outcomes were not a fault of their own rather a result of the choices that the patient had made; "*we almost lost her six times, five or six times whilst she was with us and not one of those times was I thinking bugger it was my fault, no I always thought what a shame that you've made this decision*" [I]. Instead the nurses spoke of what they were able to do to help people make better decisions.

Fostering independence

Fostering independence refers to the nurses encouraging patients to take responsibility. Most of the nurses spoke about developing independence and determination in the people they were working with by giving them information and teaching them skills to allow for this to occur:

"For me the responsibility is more around I don't even know how to explain it... it's working with them to foster that sense of being able to start to take on board some ideas and some ways of being that might you know enable them to manage better stress or whatever in a much more coping kind of a way so I guess in that way then I begin to build their sense of self responsibility which I always think goes with their sense of independence and self efficacy" [E].

Through the process of facilitating independence it was felt the patient was better able to take on responsibility. However, by providing the information an expectation was created that the patient would follow through on the information received. This is demonstrated by the following narrative:

"For example working within the treatment plan set out for them which you do in conjunction with that patient and you are supposed to get them to sign it so for example if medication is prescribed you know you do expect the consumer

to take the medication as prescribed, if they're advised to cut down on alcohol you'd expect that to happen, they're given information on accessing support for example accessing depression support over the internet or anxiety support, you know you do expect that to happen and it's difficult if those don't occur"[C].

However, this nurse considered there to be some issues in regards to assuming patient responsibility once information has been provided to them because it created the assumption that the patient understood and agreed.

"I heard one woman say I educated them three times and they still didn't understand, I didn't say anything I thought you didn't educate them at all, you gave them information that's what you did but they weren't able to assimilate it now that is where the breakdown is" [H].

The nurses also revealed the rationale for allowing patients to take responsibility was also because the alternative lead to other difficulties such as restrictive practice. This nurse provides an example of how they consider allowing patient responsibility in practice to avoid a more restrictive outcome:

"Just encouraging personal responsibility for a start and probably knowing the patient like if I, like if someone runs out the door and I think they're going to run out in front of a car well you know I'll probably tackle him but if I don't think they're likely to run in front of a car I'm thinking I'll make an assessment at that time what you know what's the pro's and con's involving the Police and you know being involving a stranger when in the end they're probably likely to cool off in 10 minutes and come back or half an hour or you know they've gone for two days and as long as they're alive at the end of the day it's you know, but it's probably the last thing we want to do is restrain someone and seclude them that's often if we start going down that track that's where you end up in difficulties"[B].

Fostering independence refers to the nurses providing the patients with input and information that enables the patient to take responsibility therefore avoiding more restrictive practice. The nurses also considered patient responsibility in relation to them being able to keep themselves safe.

Keeping themselves safe

Patient responsibility is frequently considered in the context of self harm and suicide. Most of the nurses referred to the patient having responsibility for keeping themselves safe from self harm particularly in the context of the patient with a personality disorder. This belief guides the care that they provide:

“For me I enjoy working with people with personality disorder strangely, and so when like the patient is talking about self harming a feeling like maybe going to self harm or when they’re saying that they’re suicidal and this in when clinically suicidal I am very clear that my clinical responsibility is not to increase my surveillance on them, it’s not to go out and do a room search, it’s not to going to take away their responsibility in that, if they say that they’ve got a petrol and a lighter because they’re going to set themselves alight with fire or later on in the evening that’s not my responsibility to go and look for it, it’s not my responsibility to restrain them, to seclude them, to prevent that from happening” [I].

The belief about giving the patient the responsibility to keep themselves safe and the resulting approach to care is rationalised by the nurses as having better outcomes for the people they are working with. The nurses felt that when practising in this way the outcomes were better than if they had taken a more restrictive approach to care:

“We have a woman here who has a complex diagnosis and part of herself responsibility is if she self harms she takes herself to ED or she dresses her wounds, we don’t get involved. We will support her to the ambulance and drop her off if needed but we don’t stay with her and if she chooses not to go down we don’t step in and at this point of time it has worked successfully, well she hasn’t been out but I suppose that’s what you’d describe successfully” [F].

Although the nurses limited restrictive interventions to allow for individual responsibility they did believe they had a duty to assist the patient in other ways. The nurses assessed and contemplated what their responsibilities were in regards to the people who were at risk of self harm. The nurses reported that their role was to assist the person to consider alternative options to self harm:

“My responsibility is to explore options that the patient has, options in coping and to clearly to talk with that patient and to say, to express my emotions like I’m really sad to hear you talking like this or I’m sorry that you are in this place with pain that you are contemplating self harm or suicide, I really am hoping that you will make good decisions today around what we’ve been talking about here that at the end of the day this is your choice, let’s talk about some choices that you can explore that will help you come through really difficult periods that your experiencing”[I].

When the nurse has felt that they have done this they generally do not consider themselves responsible if the patient makes the choice to harm themselves:

“You know if they self harm that are not my absolute responsibility I don’t feel like I will have done something wrong... I guess I don’t know if I was working with a patient that suicided and in that style with the self harm I guess you know I would question and be quiet but I don’t see it as my total responsibility”[E].

The patients were considered to have responsibility for keeping themselves safe from self harm and suicide and the nurse’s role was considered to help them facilitate this responsibility. This was thought to result in better outcomes for the patients. Allowing the patient to be responsible for their own safety however does create some discomfort for the nurse.

Sitting with the discomfort

Although there was a consensus that patient responsibility is essential and that patients need to have a level of responsibility in terms of their own safety, there are times that nurses feel apprehensive about this. Sitting with the discomfort describes the anxiety in nurses that is created from allowing the patient to have responsibility and the ability of the nurse to take therapeutic risk rather than acting defensively in fear of a poor outcome. One nurse gave a clinical example of how this discomfort can be created and how they can internally decrease their anxiety:

“If they want to self discharge and sometimes you know these people self discharge and you think oh that you know I don’t really feel comfortable with that but, and if you felt really uncomfortable with that you could change it and

you know, they could suicide or you know but you know there's always ways around it but I think what comes with experience and knowing the person you actually know how uncomfortable that's going to be and you look at the big picture and often you know they haven't, something has managed to keep them safe" [F].

Although sitting with the discomfort was considered as essential at times there are times when this can very difficult for the nurse. When pressure is created to intervene and reduce the patient's responsibility the discomfort can increase and lead to a more defensive approach. When nurses are unable to manage the discomfort more restrictive practice can occur.

"Staff just find it extremely uncomfortable and want to just make it go away and part of it is just being able to just sit with that, this crying, the yelling, the abuse for all of their emotion all those chaotic emotions and the threats and I think the staff just, it would be easier to just lock them up or put them under the Act, do a room search, put a 1 to 1 on them rather than just sit with it yeah" [I].

The nurse needs to consider the management plan in terms of what is best for the patient and provide rationale for continuing to allow the patient to have the responsibility for safety. The decision to intervene or not intervene needs to stand up to the scrutiny of their peers.

"I've had to work really hard as a leader to get people all on the same page with me. Some people are naturally there from the start but for most people I'd say that it's been hard for them to come on board with that management plan and I've had people at some stage begging me look really they seriously are suicidal you've just not seen it we need to lock them up tonight and just to keep them safe and I say I've not seen that and to continue" [I].

As mentioned earlier the nurses did not feel responsible for outcomes that were out of their control. However, on reflecting why the discomfort is created nurses did acknowledge that feeling responsible may be a possible cause of distress for some. In addition to this, nurses' urge to reduce others distress were also reflected upon. *"I think we care it's that whole counter transference those terms of issues and if we, I think that*

somehow we take on that rescuing role and we think that we're responsible in that the client shouldn't be making the choices for their lives" [I].

Allowing and facilitating patient responsibility created some anxiety and apprehension for the nurses and they discussed the need to be aware of this to avoid defensive and rescuing approaches. In considering self responsibility the nurses discussed fostering the responsibility, keeping themselves safe from self harm and sitting with the discomfort that this can cause. Further to this the nurses considered what factors influence their perception of the patients' ability to take responsibility which will be explored in the next subtheme.

b) *The Patients' Ability to Take Responsibility*

As described in the introduction the level of responsibility that the patient can take depends on various factors. This subtheme describes the nurses beliefs about patients ability to take responsibility and why. The nurses describe the factors that they take into account when considering patient responsibility in practice. These views tended to be subjective and there was at times a lack of clarity for nurses about why they perceived some people to be capable of being responsible: *"it's going to be individual judgement and I suppose it's a clinical call as well like you know. People are either obviously psychotic or obviously operating on their own free will; I mean it might be a bit of a grey area sometimes" [B].*

Acuity of Symptoms

This section refers to the nurse's perception that the acuity of symptoms was an indicator of a person's ability to accept responsibility. The nurses considered that inevitably the patient's levels of responsibility are reduced at times of illness;

"The whole idea of various roles we play in life and someone who becomes a patient is actually accepting that they are ill you know.... and so that kind of role shifts the responsibility of taking care of themselves just changes slightly you know that the job whatever, you take on this role that other people will say to them well you know you need to do this, you need to do that and accept that role and that is the patient role" [H].

Alongside the notion that responsibility decreases for the patient when they are unwell, the expectation to be accountable for their actions also decreases: *“if somebody’s clearly psychotic or severely depressed or severely anxious I don’t think they can be expected to take responsibility for their actions”*[C]. The acuity of symptoms affected the person’s insight and judgement. If the patient is perceived as being more settled mentally the nurse is better able to trust their ability to make safe decisions: *“it comes down to you know like that level of insight, level of awareness and you know and you can trust that they’re going to make safe judgements I suppose”* [B].

The nurses considered the patient to have reduced responsibility and accountability when they were more acutely unwell. However there was less clarity when considering this in relation to a person’s diagnosis.

Diagnosis and responsibility

Diagnosis and responsibility refers to the relationship between the patient’s diagnosis and their ability to be responsible. The nurses believed that the person’s diagnosis was one of the more significant factors in gauging the level of responsibility that the patient could be expected to have: *“I think it depends very much on what illness they’re presenting with to what level of self responsibility I think they should have”* [G].

The main comparison that the nurses made was the patient with a psychotic disorder compared to the patient with a personality disorder. The expectation of the patient for taking responsibility that was experiencing psychosis was less compared to the patient with a personality disorder.

“People with psychosis we see ourselves and we can make decisions you know, we put them under the Act, we make them take medications to call it bluntly or insist that they take medications but people with borderline personality disorder even though I believe they still have a mental health illness they are not psychotic and they can be making those decisions for themselves” [I].

Diagnosis also affected the nurse’s perceptions of whether the patient should be accountable for their actions. Again the patient experiencing psychosis was less likely to be considered accountable. *“Like I’d never get the Police involved if the patient assaulted if they were psychotic and unwell but if it was intentional and they were not psychotic and in their right mind and punched me I would involve the Police”* [B].

Although there tended to be a perception of decreased responsibility for the patients that experienced psychosis the nurses still felt that there were times that they were capable of holding responsibility however being able to define this was unclear for the nurses:

“I mean there are grey areas and it's not that people who have a psychosis can't take responsibility for their behaviours because they totally can... yesterday somebody was talking about that and someone said do you for all assaults with people with psychosis do you go to Police so that Police will lay charges and one of the nursing consultants said no it's just about really really psychotic people letting them off” [I].

A person's diagnosis was considered significant in consideration of their ability to take responsibility and be accountable with the main comparison being between the person who suffers from psychosis to the person who has a personality disorder. However how they quantified it was subjective and they had difficulty defining when a patient should be responsible for their own actions. Alongside this the nurses considered assumptions and judgements that may be inherent in this concept.

Judgements and unrealistic expectations

This refers to the judgements that can be underlying when there is an expectation that the patient needs to take responsibility. Although the nurses felt that patient responsibility was important it was also felt that the concept in itself made some assumptions and that it at times risked blaming the patient along with creating unrealistic expectations.

“I think that telling someone that, that you know their responsible for their behaviour is a very value laden kind of statement and I think that that creates an expectation factor for us that the person was able to come and ask what they need or stop themselves in some way from doing something” [E].

When reflecting on why these judgements occurred the nurses considered the difficulties inherent in their work. When working with someone with complex needs the nurse can become vulnerable to placing blame due to burn out. This nurse describes how this can occur. *“That those people with the borderline sort of traits are draining and hard to work with, they take lots of energy and lots of creative thinking and sometimes it easier I guess with some to get into a much more blaming culture” [E].*

This nurse thought about patients and their history to enable a better understanding of a person's capabilities. This nurse considers the patients' backgrounds and how this has affected them and their ability to take responsibility.

“People we work with for no fault of their own often have had really bad unpleasant childhoods and I think myself that they are extremely sensitive and have never been able to build these areas that we have and that's left them open and fragile and so I guess people with you know schizophrenia or bipolar or whatever are compromised from being able to take a level of responsibility” [H].

Some nurses also reflected on the patient's perspective to increase their empathy and understanding as way of avoiding blaming them. This nurse considers the patient's perspective and how the patient would prefer something better if they felt they were able.

“I mean I always say you know don't you think they would if they could, like do you think that they really want to do this if they could live a different life and not be kind of living in such a way that is this self destructive do you think that people would choose something like this?” [E]

The nurses described an awareness of potential judgements when considering patient responsibility and that reflecting and thinking about it critically enabled them to avoid this.

Conclusion

This theme explored the nurses' perspectives of patient responsibility as an important aspect in considering nursing responsibilities. Although it is accepted that there are times when nurses need to take some of the patients' responsibility they are not able to control all aspects of the care or the choices that the patients make. Given this the nurses considered their role was to provide the patient with the information they needed to make informed decisions. Within this theme self harm and suicide were considered as part of the patients' responsibility and although this caused some nurses discomfort it was believed that increased patient responsibility in this area lead to more successful outcomes. In considering what the patients' responsibilities were in their treatment the nurses also reflected on what factors affected the patient's ability to take responsibility which created the second subtheme. The person's ability to take responsibility was considered dependent on their mental state and the diagnosis was also referred to frequently when the nurses

were describing how they evaluated a person’s ability to take responsibility. The most frequent comparison was the patient experiencing a psychotic disorder versus a patient with a personality disorder, the general perception was that there was a lower expectation of a person experiencing psychosis to take responsibility compared to someone with a personality disorder diagnosis. The concept of patient responsibility was also explored in regards to potential underlying assumptions and judgements that may come into play when nurses are assessing a patient’s ability to take self responsibility.

II) Medical Responsibility

The second theme covers the responsibilities that the nurses ascribe to the medical members of the multi-disciplinary team. The medical members that are most frequently referred to include the consultant psychiatrist and the psychiatric registrar. Within this theme the nurses considered the doctors responsibilities and how this influenced their perceptions of their own responsibilities within practice. There are two subthemes within this section which include ultimate medical responsibility and the nurse doctor relationship.

Table 5: This table illustrates an over view of the theme ‘Medical Responsibility’.

Medical Responsibility	
<i>Ultimate Medical Responsibility</i>	<i>The Nurse Doctor Relationship</i>
<ul style="list-style-type: none"> • The Doctor feels responsible • Decision making • The Doctor will be accountable 	<ul style="list-style-type: none"> • Communication • Who knows the patient better?

a) Ultimate Medical Responsibility

Ultimate medical responsibility denotes the perception that the doctors have final responsibility over the treatment and care that is provided for patients and in turn the outcomes. The nurses perceived that ultimately the doctor is responsible as described by this nurse:

“I think in a perfect world we’d all have equal responsibility but I think who are the ones that sign the mental health papers you know, often they are the person who is legally responsible and in court they would be the first to be challenged... I think the medical model is still quite strong, it's the consultant psychiatrist that ultimately holds the power” [F].

In considering why the doctor holds the greater responsibility this nurse considers the wider influencing factors. He considers that the general public tend to come from a scientific perspective and that there is a preference for the doctor to take control.

“It’s like if someone was dying of a terminal illness you know, I mean I don’t care what the polytech tell us, it's better coming from the doctor about the disclosure of it... I’m saying I don’t think everybody’s got the same kind of agenda and we work in a medical model and you know we work in a world that says science is best” [H].

It was considered by the all the nurses that the psychiatrist had ultimate responsibility for patient care and outcomes. Within this subtheme the nurses considered this in regards to the doctor feeling responsible, the doctor having final authority on decision making and the doctor being ultimately more accountable for patient outcomes.

The doctor feels responsible

The nurses perceived that the view that the doctor is ultimately responsible within mental health care is in part related to the doctor taking the responsibility. The nurses believed that the doctors felt that they were ultimately responsible as described by this nurse: *“They’re always aware that the can stops with them and so it's all very fine for you pushy nurses wanting this and that but it's me on the line you know we get that feeling a lot” [J].*

This also included the perception that the doctors believed they were the head of the multi-disciplinary team and therefore accountable for adverse outcomes: *“I’ve worked with doctors who have really taken very seriously as heading the MDT... and some who really see their neck as being on the chopping block if something happens ”[D].*

The general perception was that the doctor who the nurses worked with considered themselves ultimately responsible. In addition to this aspect the nurses considered the

doctors to have the most power in major decisions related to treatment as illustrated in the following section.

Decision making

This aspect relates to the perception that the doctors make the final decisions about treatment. Some nurses perceived that the doctors made all the major decisions; “*Well we’ve got the doctors that make all the decisions*” [A], whereas others considered them to have the final say on decision making: “*I do think that there’s a slight hierarchy in that the doctors will make the final decision, it always come down to that that the doctors will make the final decision*” [E]. The following nurse provided a scenario which illustrates this with a clinical scenario. She describes nurses tentatively making decisions about treatment following an assessment of a patient but that the doctor could change the treatment plan if they disagreed.

“I saw a woman yesterday who had taken an overdose, I assessed her risk to be low and felt there was no need for follow-up however it's our policy and protocol now because of a suicide that occurred, for any patient that has made a deliberate self harm or suicide attempt that requires medical intervention has to be seen for a face to face review the next day. Which is good, so for that woman yesterday I saw it was discussed in rounds in the morning with the multi disciplinary team which is consultant psychiatrist, a registrar and the other front line clinicians... so each case is reviewed and input is given if necessary and so for example if the nurse saw somebody and didn't think they needed further psychiatric care but the consultant did then that would be implemented” [C].

Two areas that were frequently identified as medical decisions included leave status and observation levels. The nurses considered these decisions to be an area of medical responsibility and that the nurses’ role was related to implementing them. This nurse describes the doctor being responsible for these decisions and that the nurses carry out the interventions.

“The doctor has overall sort of clinical responsibility and will you know decide if an level of observation can be decreased, approved leave that kind of thing

in an inpatient setting but the nurses here have to deal with that on a 24 hour 7 day a week basis” [D].

Some nurses believed that a doctor having full responsibility in some areas was unnecessary and that this was a view that was shared with some of the doctors they worked with. This nurse describes this in relation to the doctors’ responsibility to grant leave for inpatients.

“I’ve worked with a doctor here who every time I hand the doctor the form the doctor giggles and goes how ridiculous is this you know actually we’ve just made this decision as a team but this is just bizarre and I’ve got other doctors who I’ve worked with that hold onto that form like it’s their thing” [E].

Although the nurses perceived the doctors as the ones that made a lot of the decisions about patient’s treatment they also felt that they strongly influenced such decisions by providing information or their opinion: *“Even though the doctors do make the decisions it’s usually heavily influenced by what the nurses are reporting or what they’re saying” [A].* However, the nurses considered that regardless of the nurse’s influence the doctor remains accountable for the decisions that they make.

“Like a psychiatrist, well they might say I don’t think that the patient can go out on day leaves today and the whole team will go, oh go on it’s only a night and that psychiatrist might change their mind and so if the client went out and killed themselves that night or assaulted somebody or whatever, it’s the psychiatrist name on that form that said overnight leave, I mean he or she might of been influenced by the team and should be influenced by the team but at the end of the day it’s a legal document that leave form and the psychiatrist signed it” [I].

The nurses believed that the doctors held the greatest amount of power in regards to decision making about patient care and that they tended to be the ones that had the final say. Given this the nurses also felt that there was a general perception that the doctors were also ultimately accountable for those decisions.

The doctors will be accountable

This section refers to the nurse's belief that the doctor's are considered to have the highest level of accountability within the team. Although the nurses considered themselves accountable they perceive that the doctors hold more accountability when an adverse outcome occurs, *"I think in the perfect world we'd all have equal responsibility but... often they are the person who legally and in court are first to be challenged"* [F]. Some nurses also perceived that the doctors were also more likely to attend the coroner's court following a sudden death. *"I've been told that at the end of the day it's the consultants that go to the coroner's court"* [D].

However this perception was not considered to be the case by all of the nurses interviewed. Some believed that this was actually a myth and that there was more of an equality in terms of accountability in adverse outcomes.

"So you know they [doctors] will often say now if the shit hits the fan were going to be the ones that have to address it which isn't the case we know that nowadays but there's still that sort of belief that because they are the doctor they are the ones most accountable. We've seen that with... [removed] that murdered...[removed] who had been into our service and both the nurse and the consultant were called into court so you know I think that's old school stuff but it's still a perception and that's sort of supported within the philosophy of the DHB" [G].

The perception that the doctors hold the majority of accountability can create a vulnerability for them which can lead to risk averse practice. This nurse describes involving additional people in decision making to protect the doctor from such feelings:

"I think that sometimes the psychiatrists, well at the end of the day it is their neck on the line like if it came to a coronial inquiry or something like that and that's why I like to have for where there is a huge amount of risk involved I like to have the clinical director sign off so as a service we know that we decide and that the psychiatrist doesn't feel like they're carrying the can" [I].

The impression was given by the majority of nurses that the doctors were considered the most accountable although some perceived that accountability was shared. This was considered in the subtheme of doctors having ultimate responsibility which also included

the perception that doctors felt ultimately responsible and that they had the most authority over decision making. In consideration of medical responsibility the nurses contemplated the relationship between themselves and the doctor and how this affects the levels of responsibility between the two clinicians which is described in the next subtheme.

b) *The Nurse Doctor Relationship*

This subtheme considers the relationship between the nurse and doctor and how this influences the nurses' perceptions of responsibility being distributed between the two disciplines. The relationship is considered as quite pivotal in gauging the extent in which the doctor will include the nursing perspective in treatment planning. *"Well I see it really that it's pretty largely driven by the doctors in terms of ultimate authority. I often feel that I guess at the end of the day it comes down to the relationship you've got with the particular consultant whether they value your input or they don't"* [J]. Within this subtheme three aspects will be explored including the communication between the nurse and doctor and consideration of who knows the patient best.

Communication

The nurses described ways in which they perceived how the information they shared with doctors was received along with ways in which they adapted the way they delivered information to reduce the incidences of opposing viewpoints. This nurse's description demonstrates a less assertive approach were they consider their role is to provide the doctors with information to make decisions about care.

"I think, most of the consultants will give you a hearing but I feel ultimately they're going to go their own way and they've made their own decisions unless you can introduce some radically new dimension which they've never even seen, heard or considered before.... the feedback that you give them is useful in that it fills in some gaps or supports what they want to do and honestly sometimes you bring up stuff that really doesn't fit with their agenda and it gets sort of quietly pushed to one side" [J].

The nurses described giving special consideration to the way in which they communicated information to the doctors. Some nurses described being assertive in the way they communicated with doctors particularly if they did not agree with a decision being made: *"I'd keep voicing my opinion and keep voicing it and keep voicing it you*

know and then document it.” [A]. However some nurses also contemplated how they would be perceived if they were assertive or advocated strongly. This nurse considered that female nurses in particular were often at risk of being perceived as being aggressive if they were assertive in their communication style with doctors and that in turn it was easier to be more passive in the nursing role.

“Another factor that influences the clinical responsibility is the gender... I think women who are assertive and want to take that clinical responsibility and want to advocate strongly to the doctors are often seen as aggressive... I think in my experience of working in inpatient/outpatient different settings that that gender thing has always been a really big issue and you know if you do push forward your right to be responsible and to share in the decision making your often labelled so sometimes it's easier to be passive... you know why put yourself out there and get that label and have those battles when I could just go and do my job and stay under the radar” [G].

When reflecting about this the nurses described altering the way in which they communicated with the doctors to avoid being perceived as aggressive and still being able to achieve what they thought was best for the patient. *“... So you know I think in practise that the best way forward and sometimes being manipulative about how you do that and strategic rather than challenging head on” [G]. This nurse described avoiding consulting with the doctor when it was felt the outcome of doing this would not be beneficial to the patient. “I will do my utmost to sort of work with people as far as I possibly can without getting the consultant involved if I think it's going to be an opposing viewpoint and not beneficial to the patient” [G].*

The nurses gave special consideration into the way they communicated with the doctors. Some perceived that when nurses tried to take responsibility that were perceived as aggressive therefore they became more strategic in their approach to doctors.

Who knows the patient better?

Who knows the patient better refers to the nurses questioning whether the doctor was in fact always the best person to make the major decisions. The nurses expressed some discomfort over the power imbalance in decision making particularly when they felt

they knew the patient better. *“I don’t know like if it’s a doctor that doesn’t know the patient and is making the decisions I don’t know that we feel so comfortable about that because I think we still feel like our practise is going to be pulled into question”* [E]. Different nurses address this in different ways, some preferring to accept the doctor’s decisions and others left feeling frustrated. This nurse expresses her frustration at sharing responsibility with the doctor even though the nurse believes she is in a better position to make decisions.

“I think that the issues I have mainly is around when I believe that something is in the patient’s best interest but it needs to be taken to the consultant for risk and maybe they see it differently to that so that’s where my frustrations come into its kind of I think I have huge conflict with and frustrations around you know sometimes having to share that responsibility when the other person may not have the understanding of the patient that I might have so somebody that sees you know the consultant they might see the patient you know once every six months making decisions and not really hearing what myself and the family are saying with a person and then taking that responsibility away” [G].

This nurse goes on to give an example of when there has been disagreement in decision making in patient care and she has been left feeling powerless. One option for nurses is to document that they disagree with a decision that has been made as evidenced in this example.

“The consultant who in my mind wasn’t a very good consultant made the decision to you know discharge within a couple of days and I thought that was too soon and no matter what I said to him he was the consultant making the decision so you know I was frustrated and pissed off and felt powerless really all I could do was actually document that I disagreed with the decision and made it clear to them that was what I was going to do, so I was supposed to you know in some ways you do have some power in regards to what we want but in decision making I don’t think we have, you know at the end of the day its theirs” [G].

In consideration of documenting a disagreement about care the nurses took different approaches. This nurse describes the preference to verbally express their disagreement but not to document it in the clinical notes.

“I think if I felt strongly I’d say well you know it’s ultimately up to you, you’re going to make the decision but I actually don’t think it’s the best and leave it at that, I’m not going to go on, I’m certainly not going to go on a campaign to undermine them or you know keep on. I guess I’d feel as long as I’d made my point I would be happy with that without feeling the need to take it and put it in writing anywhere” [J].

The nurses expressed some discomfort in the doctor having ultimate authority over decision making given they felt they may have a better understanding of the patient. Some nurses also expressed some frustration that when a disagreement occurred that it was the doctor’s decision that was implemented.

Conclusion

Similar to the theme of patient responsibility, the nurses also considered the doctor’s responsibility in relation to their own. The first subtheme explored the nurses’ perception that doctors have ultimate responsibility for the patients. They considered that this perception was also held by the doctors which in turn meant that they would make the final decisions about the treatment and care provided to the patients. Given this the doctors also were more often perceived as being more accountable than the nurses and more likely to attend proceedings following adverse outcomes. However this point remained unclear as some nurses considered this to be a myth and that there is actually more equality in review processes. The second subtheme explored the nurse doctor relationship and how this influenced the nurses perceptions of how clinical responsibility was distributed within the teams they worked in. Communication between the nurse and doctor was considered significant and the nurses reported careful consideration over how they delivered information to doctors. The reasons for this was to avoid being perceived as aggressive and confrontational as well as being strategic to achieve the outcomes that they felt were best for the patient. In addition to this the nurses expressed some discomfort and frustration in the doctors making decision when they felt they were better informed because they knew the patient better. When they disagreed with decisions made they then took further deliberation over whether to document their opinion given the implications that this may have.

III) Conflicting Nursing Responsibility

This theme refers to the narrative that relates to the nurses’ responsibility. There were two major subthemes of ‘accepting responsibility for own practice’ and ‘accountability’. Within the narrative of this theme the subtheme of accountability arose which competes with the nurses’ acceptance of their responsibility. The competing discourse of accountability created the conflicted position.

Table 6: This provides an overview of the theme ‘Conflicting Nursing Responsibility’ and the arrow demonstrates the discord between the two themes.

Conflicting Nursing Responsibility	
<i>Accepting Responsibility for Ones Practice</i>	<i>Accountability</i>
<ul style="list-style-type: none"> • Taking nursing responsibility • Reflection 	<ul style="list-style-type: none"> • Defensive practice • Defensive practice and the organisation • Feeling blamed • The coroners court • Abdicating Responsibility

a) Accepting Responsibility for One’s Practice

This first subtheme importantly refers to the narrative that indicates the nurses accepted responsibility for their own practice and professional conduct. “*I think we’re all responsible for our own practice essentially, if it went right down we are all responsible for our own practise*” [A]. It also refers to the nurses recognising they are accountable for their actions and the treatment that they provide. This subtheme explores two different aspects including taking nursing responsibility and reflecting on it.

Taking responsibility

Taking responsibility refers to nurses acknowledging they have responsibility for their practice, the treatment that they provide and for the patients that they work with. The

nurses recognised that they were responsible for their practice and accepted accountability for their actions and decisions. *“It’s putting your hand up and accepting that you basically take responsibility for the things that you do and don’t expect to be able to pass the buck if things get tough or you’re uncomfortable”* [J].

As part of this the nurses also considered themselves to have responsibilities regarding patient safety. The following nurse provided a clinical scenario that indicates an awareness of responsibility and accountability for all involved in a patient’s care including the nurses.

“Well you know people have, there’s one person who killed himself here in the unit like they hung themselves and you know I wasn’t involved and I wasn’t on that shift but the Police came they took statements it was time in court, and everyone you know everyone had to explain for their actions you know so in reality you are responsible” [B].

As earlier reported the nurses considered the psychiatrist or doctors to be ultimately responsible for major decisions related to treatment. However, the nurses voiced an awareness that this did not equate to them being responsible for the practice of others such as nurses. *“I would envisage that if a clinician does something wrong I don’t see why the consultant psychiatrist would be held accountable”* [C]. Rather that each clinician including nurses were responsible for their own practice.

“I think everyone needs to be responsible for their own practise and their own risk management and assessment and their own you know their own procedures and everybody will come from a different perspective depending on the disciplines which they’ve known but ultimately you have to be responsible for your own professional conduct” [D].

The nurses also discussed this in relation to doctors making advance directives regarding care of patients out of hours. The nurses had awareness that regardless of prior directions from a psychiatrist that in a particular moment they were accountable for the decisions that they made and for the potential outcomes.

“Personally at that particular moment it’s the person dealing with the person, that’s what I think that’s what I say to our team, you’re the one that’s going to be hauled up in front of the nursing council for letting that patient walk out the

door if you weren't sure so whether the consultants directed that person to be able to go or not you need to make sure that that it sits within your level of comfortable kind of practise and I always say if in doubt you know get a review you know make sure that it sits within your own professional sense of what you need to do" [E].

The nurses accepted that they were responsible for the care and treatment that they provided and ultimately that were accountable for this also. Considering their responsibility and accountability created reflection which will also be described.

Reflection

Reflection refers to the nurses considering their responsibilities following an intervention or period of care. The nurses described assessing their practice and overall feeling confident in the care that they provided. *"I'm very comfortable with my risk assessment and my psychiatric assessments. I trust that what I've seen at that time even if it's changed later is what I saw at that time yeah" [D].*

The nurses also often reflected about their responsibilities in the context of a patient suicide. They described a period of reflection that took place where they analysed the care that they had provided, whether it was of an appropriate standard and whether they could have done something differently to change the outcome.

"I think whenever there's a suicide it always leaves people feeling uncomfortable you know and if you're the clinician involved you will always go through it you know did I do everything right, should I have done this, should I have done that and you see everybody doing that, every single clinician that's been affected and everybody has bound to be affected by it, it's you know it's the nature of the beast really" [C].

When the nurse perceives that they may have made poor decisions or that their actions may have contributed to an adverse outcome in some way they can be left with feelings of guilt. This nurse considers this type of scenario and perceives that the nurse would feel responsible for the outcome.

"If you really felt you'd been neglectful or you hadn't done things you really should of done or you hadn't seen things that you should of done and perhaps

you know thinking well oh if I think back on that you know, that guy was really this, this and this or worse than that you know someone had been admitted and was seen as a high risk and you hadn't really bothered to treat him as a high risk and you'd sort of oh he's not too bad and something would of happened well then you'd feel pretty awful I guess, you'd feel responsible for it and you would probably be seen as being responsible and be sanctioned in some way" [J].

Further to assessing whether they had upheld their professional responsibilities they also reflected on their feelings of personal responsibility. This nurse differentiates professional responsibility from his own feelings of personal responsibility. As already described the nurses reflect following adverse outcomes and ask themselves did I do everything right. However, even when the nurses feel assured that they had done what they were able they can still be left with feelings of guilt following the loss of a patient.

"Well I mean there's I guess there's two sides there isn't there, that your own personal feelings about your level of responsibility for them and the sort of technical responsibility. I guess I would feel really responsible if I felt that some of the things I have done weren't appropriate or perhaps putting it another way I hadn't done all the things I should of done then I would of be a lot more self blaming and I would feel more responsible and accept whatever came out of that process, whatever enquiry took place or whatever but even if you feel you've done everything that you should of done and you look back and you can't see anything that was particularly remiss on your part or an oversight or something you should of done but neglected to do, you'd still feel a certain amount of responsibility, it's a kind of personal level of responsibility because you're looking after that patient and something went wrong or something happened" [J].

The nurses often reflected on their responsibilities particularly following adverse outcomes. They described going over the care that they provided and considering if they could have or should have done anything differently.

b) Accountability

This subtheme refers to the narrative that indicates how the nurses' perceptions of accountability affect their practice and decision making about treatment. Accountability caused some internal conflict for nurses in practice when making decisions. This nurse describes the conflict between wanting to cover one's self from being held accountable and doing what's right for the patient.

"I see that accountability again is about what's in the patients' best interest and I guess in terms of risk management you know weighing that up between wanting to cover yourself and wanting to do what's right for the patient" [D].

Different aspects will be explored within this subtheme including defensive practice, the organisation in which they work and defensive practices, the potential for blame, the coroner's court and abdicating responsibility.

Defensive Practice

Defensive practice refers to a practitioner considering their accountability in practice or giving priority to self protection from blame over the best interest of the patients. Treatments and interventions that are not always in the patient's best interest occur because clinicians feel that they have little other choice or because of anxiety about how it might be perceived if something went wrong. The nurses gave examples from practice which described defensive practice occurring. This nurse describes a clinical scenario involving a patient with a personality disorder being treated in an inpatient setting. She described the patient's presentation becoming worse over time yet the staff continued with the prolonged hospital stay against their better judgement due to their fears over her high suicide risk status.

"There was a patient with very severe borderline personality disorder and antisocial personality who had been admitted to us for rehab and unfortunately it got worse you know it ended up that staff were threatened, that staff felt that they were professionally compromised because she was self harming on the ward and nearly dying, that we were having to resus her, that she was bringing weapons into the ward, she was on the ward unruly, intoxicated, challenging behaviours which sometimes would lead to then seclusion incidents and then off ward which is actually going against I believe best practise in regards to these clients there was her responsibilities to herself were taken away and you

know pressured back into a corner and you don't want to be secluding people with personality disorders that's not, it's in the policy, you can read the policy and procedures and it's a contraindication but her behaviour sometimes would lead to that and you know there was a lot of complex case conferences and meetings and things and actually you know the situation just escalated it got worse and worse and worse and worse and this went on and on and I think a lot of that was around you know being high profile patient, no one really knew what to do with her, she was getting involved through the justice system, she had a very supportive family, quite a vocal family, she herself was very aware of her rights and that which was absolutely fine but I think that people felt threatened and clinically did not act in her best interest instead of having clinical rationale of why they were going to discharge her or have intensive community support but not have admission or whatever, I think a lot of that was around fear because her risk of suicide is very significant” [D].

In addition to fears about suicide the nurses also considered the fear of being accused of inappropriate behaviour when looking after patients. This also had the potential to influence the way in which they provided care. This nurse describes having a reluctance to shower a patient with a history of sexual abuse and how she feels documentation protects her from future allegations.

“I think it's vital because something might come up in the future that could, we've had patients come through who have accused staff of being potentially inappropriate and sometimes we get patients who accuse staff of having an agenda so you know you have to make sure everything's documented... I helped a woman shower a few weeks ago and I just found out that she was badly abused and I had no idea so I documented everything and after that I never showered her again but if I did I would of had another female staff member present” [A].

The nurses described other practices that were defensive in nature. This nurse talks about how the objective of a complex case conference is to do this and that the benefit to the patient is secondary.

“I've been involved in a case where this young person was of you know she had borderline personality disorder risky, risky behaviours there was a

complex case conference around her and you know complex case conferences are always about risk and maintenance and about how we show that what we've done to manage her risk you know I mean hopefully they're about the young person as well but they are about it, how we manage risk, prove we've done it or we've had a complex case conference and we've talked to all those people and at the end of the day we've done what we can" [E].

The nurses also referred to the importance of documentation when considering accountability in practice. They reported documentation as a vital factor in protecting themselves in the case of an adverse outcome. This nurse describes some apprehension over the need to ensure everything is documented to protect himself from blame should something go wrong.

"I'm always conscious that ultimately it's what's written down that carries the weight which worries me a bit you know were always obsessed with that to the extent that your even apprehensive, well I mean you know if I was to approach... in the corridor and say you had someone that I'd been looking after and is it alright for them to go home for the afternoon or the weekend and she was to give you a verbal yes and it never got written in the pink form, you know the leave status thing, I'd be comfortable with that I mean I'd write it in as per discussion with doctor because I know she's not going to run for cover but you know if there was someone less senior perhaps I didn't know well, yeah a bit ambivalent but I'd still probably be fine as long as I document because I'm always aware that if you do stuff and it goes wrong and it's not been written somewhere that's when you get all the nods come out, you just live in this environment now where you know if it's not written somewhere it didn't happen you know" [J].

The nurses provided examples of considering accountability in everyday practice including being involved in treatment that was against their better judgement in fear of patient suicide, or fear of being accused of inappropriate behaviour. They described practices such as complex case conferences and documentation as being part of defensive practice.

Defensive practice and the organisation

The nurses described the organisations in which they worked as being part of the defensive nature of practice. They described the culture of the wider organisation to be risk averse which created practices that were possibly not in the best interests of the patients.

“I think that there are, that our DHB is very risk adverse, yeah were very much into I don't know if you can call it but covering but when our practice is driven by fear rather than this patients best interest then you're on therapeutic shaky ground” [I].

The nurses provided examples when policies and protocols were created as a result of adverse outcomes which changed the way they practiced. This nurse describes a policy that was put in place following a patient suicide.

“Each case is reviewed at rounds in the morning so for instance I saw a woman yesterday who had taken an overdose, I assessed her risk to be low and felt there was no need for follow-up however it's our policy and protocol now because of a suicide that occurred, for any consumer that has made a deliberate self harm or suicide attempt that requires medical intervention has to be seen for a face to face review the next day” [C].

The organisation protocols and procedures for some nurses were regarded as helpful and provided comfort that they were safe from blame if they were followed. This nurse describes not feeling comfortable practising outside of any of the organisational protocols and considers her registration as potentially being on the line if she was to do so.

“It is my registration no matter how little it is you know so even if it was just giving someone a smoke when you're not supposed to you know so, because the policy on our ward is to give a patient a cigarette they have to have an hour or more leave and has to be off the grounds and I'm real rigid with that I won't do it but there are lots of staff who will and I don't have a problem with that... but no I don't think I'll ever deliberately do anything outside of what I thought were the rules you know just, no I'm pretty new at this game and so those sorts of things are pretty important” [A].

Other nurses described some discord with the organisation prescribing protocols about how they practiced. Some protocols were considered unnecessary and defensive. This nurse provides an example by discussing prescribed protocols around observations.

“One of the things is they wanted us to be checking people 15 minutes, we fought that very hard and got it you know changed to observed hourly or some of us are saying oh for god sake we do see our patients every hour but you know and there was all this tick and charts and stuff like that and we managed to get it changed that you know we can it's our practise so we document, observed hourly as per protocol and that covers our butt but I don't know if anyone's actually ever tested that out and said well did you see them hourly, they don't even know the patients and you know the ones that you see every 10 minutes if you need to see them or not, so and that sort of ensures that people actually sort of started taking responsibility so you know if someone goes haywire actually you can tell I know they went at 12 minutes past 7 you know, so and that's part of butt covering” [F].

The nurses describe defensive practice as being innate in the organisation in which they worked and that often practices and protocols were derived from a risk averse perspective. Some nurses found such protocols helpful were as others disagreed with them.

Feeling blamed

This section refers to the narrative that relates to the culture of blame that can occur following the loss of a patient. The nurses described feeling that mental health professionals were often seen as at fault when a patient suicided and that nurses frequently took the main impact of this. This nurse reports that nurses are often looked at first following these events and that this can influence the way they practise.

“I think that people are too heavy on mental health services in regards to when there is an inquest or when there is an unfortunate sudden death and that we don't always recognise chronic mental illness as sometimes very risky and that actually it's not always the health professionals fault it just is what it is... but there's a lot of blame that often gets pointed towards nurses and words like negligence and stuff are being bandied around so there is definitely that feeling

that should my notes need to go somewhere that I want to know that I have documented as thoroughly as possible the situation and my assessment yeah” [D].

Further to this, some nurses considered that they would have little protection from nursing organisations when these sorts of situations occurred and that such organisations also played a part in looking for some to hold accountable. This nurse feels strongly that nursing organisations play a part in blaming nurses for such outcomes.

“I do know that I believe that the nursing council aren’t our friend and if anything goes wrong the nursing council will want to point the finger and I know that the Nursing College of Aotearoa are the same because I went with what they had to say around the Burton case when he was discharged and what a knee-jerk reaction. I believe they had to instead of seeing staff numbers being an area that needed to be looked at and other areas were working ok, it was like well right across NZ and there were some really awful things said about enrolled nurses and nurses and it was hard to believe that everybody could be so arrogant as the Nursing College of Aotearoa... you know it was taking the high ground there was no compassion there at all” [H].

The possibility of potential blame can encourage mental health professionals including nurses to act in a defensive manner following an adverse outcome. This nurse reports the belief that nurses alter their accounts of what happens to avoid being the ones that are held accountable for adverse outcomes.

“There’s definitely a feeling I think in both nurses of being scape goats for each other and being scape goats for doctors in coroners court, well whether that’s fairly accurate I don’t know I did say nurses hang other nurses out to dry clinically and alter stories and alter what actually occurred in situations to cover themselves” [D].

The nurses also provided examples of when they had felt that they were held responsible for a patient suicide. This nurse describes their experience of this and reports feeling that other clinicians avoided blame which in turn portrayed them to be a fault. However, ultimately the nurse found comfort in knowing that they had done all that they can do.

“I was involved where someone did suicide and I was looking after that person. There was some question about who said what, when, how and you know there was a bit of running for cover and it was in terms of what was said opposed to what was written... Yeah so I mean I do feel there was a bit of you know duck shoving if you like... the doctor I felt did a lot of scurrying for cover when the whole coroner’s investigation took place... it was all a bit disputatious and unpleasant stuff... the whole risk aversive thing was very much for the fore in people’s minds I think. I felt to some extent I was left carrying the can but ultimately I feel quite comfortable in my own mind that I did all the things I should have done” [J].

There was a general perception that nurses often were at risk of being blamed when an adverse event occurred and that this could come from each other or the doctors. It was also felt by some that they were not supported in these instances by the bigger nursing organisations.

Coroner’s court

When considering clinical responsibility and accountability the nurses frequently referred to the coroner’s court. Out of the 10 participants interviewed one indicated that they had testified in the coroner’s court; *“Well having gone through a coronial enquiry myself knowing how stressful it is, it’s a real risk that you take” [C]*, and another had been involved in an inquiry. However, all the nurses seemed to have a strong awareness that this could occur to them which had an influence on how they practiced. *“Well I guess just around you know doing right and crossing your t’s and in the back of people’s mind there is the coroner you know” [D]*.

The nurses tried not to practise in a defensive way due to fear of a coronial inquiry however they admitted that it did occur at times. This nurse considers that she would not consider a coronial inquiry when making risk assessments but does believe that it happens.

“So yeah, yeah not for me, I wouldn’t think... too much around oh my god I’m responsible for this patient I could be up in the coroners court da da da therefore I need to make sure this risk assessment is da da da, so I wouldn’t do risk assessments in a risk adverse manner but I do know that that happens” [E].

The nurse's descriptions also indicated that there was some consideration of how treatment would be perceived if it was reviewed in the coroner's court when making decisions as a team. This nurse referred to the coroner's court during the discussion and when asked directly if the coroner's court was considered when making decisions she somewhat reluctantly agreed that there were times when it did.

"It has had some weight, yeah it does have some I don't know that it does have, it certainly doesn't have the majority of weight but there probably are certain cases where you might discuss that and you consider a risk assessment but I would hope that it doesn't but I'd be probably lying to say that I have not been involved in conversations where that's been raised" [E].

The nurses also considered the likelihood of a coronial inquiry in regards to others practice and felt that it had impact on doctors' decision making. This nurse talks about how he is surprised that another nurse he works with has not ended up in a coroner's court due to their style of practice. In addition to this he considers that the threat of the coroner's court frequently influences doctors' decisions.

"I mean I've worked with a guy recently whom I really like I mean he was a real cowboy and you know I said god I wonder how you haven't managed to end up in a coroners court before but you know what I mean because he'd be quite wide open you know, it's sad to think that you have that in the back of your mind quite a lot... and I'm sure a lot of the doc's think like that, they seem to think like that in their decision making process it's the old, what if things went wrong and I was in the coroners court and that always seems to you know" [J].

Consideration of the coroner's court was very common in the nurses' narratives which appeared to add to their fear. The potential for being involved in a coronial enquiry effected practice in a defensive way.

Abdicating Responsibility

Abdicating responsibility refers to the occurrence of nurses giving up their responsibility. This can occur due to avoidance of accountability or reducing the fear of

blame. The nurses admitted that ultimately they did not always want high levels of responsibility and that this in turn protected them.

“Yeah I think we get away with it quite easily really I think it's more we can mouth on about we want equality and that but we don't really because we don't want to have to step up to the mark totally in it's all fine when the goings good but when the goings rough it's a little bit different” [F].

The inpatient nurses commonly referred to the end of shift being the end of their responsibility until they were back on. They found some comfort in knowing that they could hand over the care. *“At the end of the day it's an 8 hour shift thing it's my responsibility I really it finishes at the end of the shift when I hand over to the next shift which I really like, I like to be able to have that” [B].* But at the same time acknowledged that this was only when they had completed all of their duties properly for the day. *“At the end of the day I think yeah I think they are in many ways once you've signed off and walked away then it's for the next shift then the only thing you can do is make sure that all what you've done is right” [H].*

The nurses also described consulting with other members of the team and more often doctors as a way of reducing their accountability should something untoward happen. This nurse considers it foolish to not consult with others and is reassured when someone else agrees with her.

“If there's a risky decision to be made I think you're foolish to try and make it without consulting somebody else... generally I probably try and get someone else to agree with me that would be sensible, I don't like throwing down my butt in that situation, I'd discuss it with someone else if I could” [B].

When the nurses have high levels of responsibility they can feel quite vulnerable and open to being blamed. Some nurses felt that formalised responsibility was often avoided. This nurse explains this is because of fear of being blamed if something goes wrong.

“I think a formalised responsibility might make people run for cover too much I mean we work in a really risk aversive environment and everyone gets really worried that about taking on that role if they think oh it's going to get shifted home to me if they do something wrong I'm in it you know I think formal

responsibility in that sense would have people all putting their hands down”
[J].

This vulnerability is also created when the nurses feel that they cannot share the responsibility with other members of the MDT. This nurse expressed feeling vulnerable when she is unable to share risk with a MDT. She describes referring to other services to help share the risk.

“It's quite autonomous which at times can leave you feeling a little bit vulnerable because there's not that shared risk the same in terms of being able to share it out with the MDT... I have had a recent last week actually a clinical scenario where I was quite concerned about acute risk, chronic risk that had become acute risk and ended up liaising with SPOE just to try and sort of share that risk out and refer him back to sector base for acute assessment”
[D].

There are also areas of work that are avoided by nurses due to the high levels of responsibility. This nurse reports that there are a number of nurses that prefer not to work in emergency services due to the high levels of risk. *“I mean there's a lot of nurses that don't want to work at Psych Emergency and when you talk to them about why it's because of that level of risk”* [C].

The nurses described scenarios where nurses avoided making decisions that they were capable of and in a position to make. Some nurses gave examples of situations where nurses sought out others to assist them to make decisions about nursing care. This nurse provides an example of when she was sought out by a senior nurse to make a relatively simple decision about patient care.

“In decision making like are you solid in your decision, like a really simple example was just the other day I happened to be working late a senior nurse on, brand new grad and one in-between the new grad wishingly had allowed a patient with borderline traits to watch horror movies... and was watching that with a psychotic kid. Now the rule on this unit is actually no horror movies at all, now the senior nurse come to me and said I don't know what to do about this should we take them off, I don't want to upset her, and wasn't comfortable in making the decision because the other girl might escalate and where would

this go and all of that so it's not a dramatic example of big stuff but so you know I just very clearly said well actually no this isn't ok and if you're not confident enough to do it then I'll just go and get it done... so I don't know if that answers it but that's really a classic example of whereas if there had been different staff on it would of been very black and white" [E].

The nurses also provided examples where they allowed doctors to make decisions because it was assumed that they were in charge even though such decisions were not necessarily the doctors to make. This nurse provides an example where the doctor took charge of a situation and how she allowed that to happen. However this was against her better judgement because she was aware that it was a nursing decision that she was capable of making.

"We had a client and he had gone on his medication and become, I don't think I've seen anybody so mentally unwell... and on this particular occasion he had put his fist into a reinforced glass door and one of the registrars was over with us and they said we'll need to put this person in stitch gear and then under seclusion and I said I'm just happy to sit here and you know and talk with this person, you know not talk but just sit quietly with this person and she said oh well I suppose we could do that so we were doing that and the person was still responding and I wouldn't say that they were elevating but they weren't quietening mind you they have not quietened ever since they've been in with us and she said no we need to seclude him, and I think I made another verbal attempt and then she said I'm just going to seclude him and I should of said no, I'm happy to sit here with the patient and we'll just wait it out and I didn't so I upended that responsibility when you know it was my responsibility yeah, and I bitterly regret it and I use it in our in-service as an example of how not to act that we need to be strong and hang onto what we know as being right even when we've got somebody who we think might have responsibility for that situation when in fact it is with us, we know the patient, were the ones nursing and managing them and that's yeah, that's my call" [I].

The nurses admitted to feeling vulnerable when they considered themselves responsible and described using other clinicians including doctors to decrease their levels

of responsibility in decision making. However some nurses also described displeasure when responsibility was taken of them by others.

Conclusion

The final theme creates the largest section of the findings and refers to how the mental health nurses view their own clinical responsibility. It has two facets including accepting responsibility and the competing theme of accountability. The first subtheme covered the narrative that indicated that the nurses accepted responsibility for their own practice and that they had an awareness that they were accountable for the treatment that they provided. Part of this included the nurses reflecting and analysing their practice in the event of an adverse outcome. The second subtheme explored narrative that related to accountability. This theme referred to the narrative that described defensive practice which was also described as being promoted by the organisation in which the nurses worked. The nurses spoke about feeling vulnerable in regards to blame for adverse outcomes occurring. They frequently referred to coronial enquiries which also attributed to this fear of blame. The last subsection referred to the nurses abdicating responsibility. 'Conflicting nursing responsibility' refers to the position in which the nurses described themselves. Their acceptance of clinical responsibility was at odds with their perceptions of accountability which created the conflicting position in which they described the topic.

This chapter reported on the findings from the studies participant interviews. It described the three main themes that emerged including 'patient responsibility', 'medical responsibility' and the main theme 'conflicting nursing responsibility' with the use of narrative by way of illustration. These themes will now be synthesised in the following chapter along with discussion in conjunction with relevant literature.

Chapter Five: Discussion

Introduction

The last chapter reported on the findings from this study which produced three themes; ‘patient responsibility’, ‘medical responsibility’ and ‘conflicting nursing responsibility’. This chapter will firstly address the limitations of the study. It will then be demonstrated how the three themes relate to one another which is followed by a discussion about the findings in conjunction with relevant literature. Lastly, the implications for nursing are set out.

Study Limitations

Recruitment bias was possible given self selection, the sites in which the study was advertised and because the study was conducted on one site. Further to this, interviews and analysis being conducted by one researcher may have also lead to bias however this also provided consistency. It is also acknowledged that the researcher’s professional identity may have been influential in generating the findings. The sample size was relatively small however saturation was reached and small sample sizes are considered more appropriate in qualitative research.

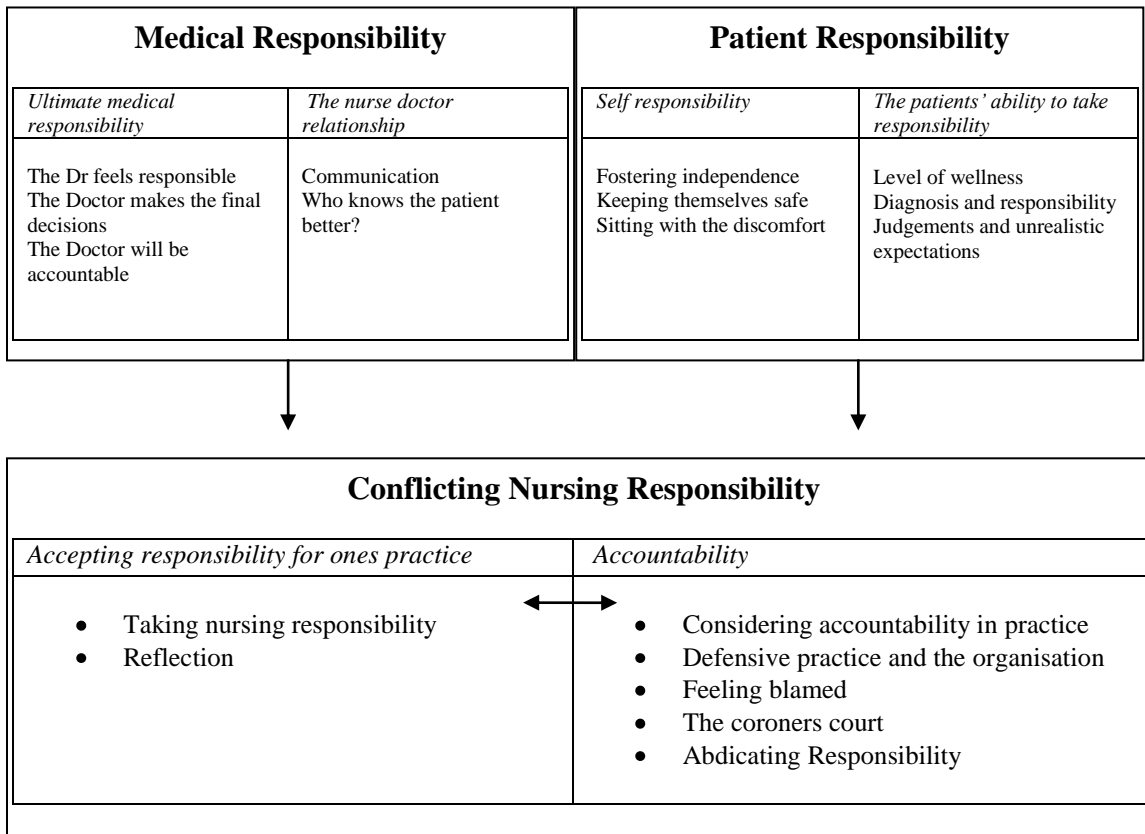
Despite these limitations the study has strengths. The methodology has been applied rigorously. The findings could have only been generated by using a qualitative approach and the qualitative descriptive design allowed for the findings to be described in a form close to the raw data which was essential given it was a relatively unexplored topic. The main strength of the study is that it has explored a topic that has not been addressed previously in mental health nursing literature and that it exposed areas for future research.

Synthesis of Findings

While a discourse analysis was not conducted, the in-depth analysis of the findings identified that the core of the conflict that nurses were experiencing appeared to be related to competing discourses. As described in the summary of findings the nurses’ descriptions indicated competing factors that affected their responsibility. Although they accepted that they held responsibility they described or referred to various discourses that impacted on their clinical responsibility. ‘Conflicting nursing responsibility’ refers to the nurse’s

uncertain disposition towards their responsibility because of the competing discourse of accountability that they described.

Figure one: This diagram illustrates the relationship between the three themes. The arrows indicate how conflict is created for the nurses by the competing discourses.



The conflict was reinforced by the discourses embedded in the first two themes as they describe additional competing models. The discourse from which patient responsibility emerged could be regarded as the consumer rights and the recovery model which values patients having self determination and control over their own treatment and decision making. This discourse impacts on the process the nurses used when considering decisions in practice. Further to this, the nurses described the hierarchy of care in which medical discourse predominates. The medical model has a high level of influence and power in practice which can be considered as a further competing discourse that impacts on nursing responsibility. All of this sits in the context of the wider culture of managerial

discourse which promotes an organisational culture of risk management and risk aversion that sets up the conditions for defensive practice.

The various discourses that include the consumer rights discourse, medical discourse and a managerial discourse that promotes defensive practice can all be regarded as factors that set up a conflicted position in which the nurses regard their own responsibility.

Discussion

The discussion will first explore the consumer and medical discourses in relation to relevant literature followed by literature relevant to accountability and the risk management discourse.

The consumer discourse

The findings presented referred to patient responsibility and empowerment as a factor that impacted on mental health nursing responsibility. One of the more significant changes in mental health care over the past forty years has been the increasing expectation that consumers have a more active role in treatment and decision making (Lammers & Happell, 2003; Tomes, 2006). The historical basis for this began in the consumer/survivor rights movement in the 1970's at the time of deinstitutionalisation and expanding patient rights legislation. It arose from the oppressive treatment experienced by people including forced treatments, damaging interventions, and social exclusion (O'Hagan, 2009). The claim of having special insights into mental illness from the lived experience was a novel concept at the time however it provided a basis for patients to have the entitlement to speak on their own behalf (Tomes, 2006). Since this time there has been growing effort by mental health providers to understand and incorporate the perspectives of consumers in treatment, and the concepts of consumer empowerment and self responsibility have become a more accepted part of care.

The nurses in the study did not perceive themselves as entirely responsible for consumer outcomes as they accepted that they were unable to control others' decisions and actions. Rather they perceived their role as providing information and teaching skills to enable self responsibility and foster independence which is consistent with aspects of the recovery model. The recovery model is a contemporary version of the consumer rights

movement principles. The concept of recovery in mental health differs to the general definition that relates to the resolution of symptoms. Although it may still include an improvement in functioning it refers more to a person finding a new sense of themselves following the development of mental illness and becoming self-directed in returning to a meaningful life (Mental Health Commission [MHC], 2011). Self determination and choice for consumers is considered essential in this model rather than optional given it is accepted that people need to learn to live and deal with a condition themselves. However, for a person to be able to assume primary responsibility over their life and treatment they need to be provided with opportunities to make choices, to succeed and to fail (Davidson et al, 2005). The nurses considered providing the opportunity for choice in the context of self harm. Although it was acknowledged that this could cause discomfort for the nurses they still believed that the patient held responsibility in this area. This also transferred to the belief that the patient held responsibility for undesirable outcomes such as self harm. Having choice about treatment is a predominant principle of the consumer movement and the majority of people who experience mental illness express the desire to be involved in treatment decisions however evidence suggests that this may not occur in current practice (Drake, Deegan & Rapp, 2010). The nurses had difficulty distinguishing when a person is able to take responsibility. The acuity of symptoms and diagnosis were cautiously considered as potential factors in this judgement however a level of uncertainty about this was conveyed. There remains a legitimate argument that at times of cognitive impairment or acute illness consumers demonstrate poor judgement and require health professionals to protect them from causing harm (Bellack, 2006). On the other hand, there is an equally legitimate argument that even at times of illness consumers' decisions can be reasoned (Bellack, 2006) and better made by those that live with the illness as they can evaluate the outcomes (Drake et al, 2010). Bellack (2006) rightly states that health professionals, family members and consumers have different priorities in treatment, along with different underlying values based on different perspectives. This needs to be evaluated by nurses when deliberating about a person's ability to retain responsibility in treatment.

The consumer rights and recovery perspective are important considerations for mental health nurses. Within this study the nurses identified patient responsibility as being an important aspect that is related to mental health nursing responsibility. The nurses considered the patients as having responsibility for their own outcomes and accepted that they were unable to control their decisions. The right to choice is an important aspect of

the consumer rights and the recovery model perspective and mental health nurses need to contemplate the influence that this discourse has on individual nursing clinical responsibility and how it impacts decision making in practice. The nurses' narratives indicated a need to protect the principles of consumer rights by endorsing individual responsibility through empowerment but at the same time uphold their own perceived responsibilities.

The medical discourse

Traditional relationships in healthcare have been slow to change and the professional norms of the hierarchy still exist. Doctors still hold essential power and responsibilities for certain aspects of care and nurses perceive their contribution as less powerful (Fagin & Garelick, 2004). Within any system power is wielded in language, it is not what is said that has importance; rather how it is said that wields power. Through language the dominant discourse preserves its power at the top of the hierarchy and keeps competing discourses subordinate (Stickley, 2006). The medical model in which psychiatry is entrenched is an obvious example of a dominant discourse. It is through the power of language, knowledge and by virtue of alleged superior training that psychiatry maintains its authority. It is unsurprising then that the nurses described psychiatrists as retaining the position at the top of the hierarchy albeit in a softened form than it has historically. The nurses felt that this in part was related to doctors considering themselves as ultimately responsible as well as deeming themselves accountable for outcomes.

The hierarchy also promotes authority in medical decision making. This was upheld in the nurses' descriptions when they reported that doctors make final decisions about treatments. The nurses described doctors having final authority over the treatment decisions that the nurses had tentatively made and they clearly identified leave and observation levels as being the domain of the doctor. It has been questioned whether doctors are actually in any more of a position to make such decisions other than the standing of their perceived expertise and higher level of training. What's more nurses actually could be in a better position to make such decisions given the amount of time spent with patients (Fagin & Garelick, 2004). The nurses found that the power imbalance in decision making could sometimes lead to frustration particularly when they disagreed with decisions about patients they knew well. The nurses described two approaches that they undertook when this occurred; some simply accepted that they were not the ones

assigned to make some decisions, where as others felt increasingly frustrated and tended to document their disagreement as way of protest.

The medical model of mental illness has been critiqued as being restrictive in various ways. Firstly, this model assumes that a person's illness is a result of biological anomalies which excludes the full consideration of cultural, social or familial aspects. It also relies heavily on diagnoses which are made from an objective perspective that moves away from a person's lived experience (Barker, 2001). Health professionals also tend to focus on the diagnosis rather than the person and as a result the relationship between health professionals and patients is further distanced. Within this model of care further tensions are also created for nurses as it only allows for very limited nursing roles. For example, practice that is restricted to the delivery of medical interventions or instruction such as observations or the administration of medications.

One of the key findings of a review of accountability conducted by the Mental Health Commission in the late nineties was that there is uncertainty regarding the roles and responsibilities within mental health multi-disciplinary teams (Chiplin, Bos, Harris & Codyre, 1998). Within this study the nurses identified the psychiatrist as having "ultimate responsibility", which is consistent with findings of other studies that found psychiatrists held a similar perspective (Elsom et al., 2007; Herrman et al., 2002). For clarification of this point The Royal Australian and New Zealand College of Psychiatrists (2002) put out a position statement on psychiatrists as team members. Position statement [47] states that because each team member is responsible for the maintenance of their individual skills and standards of care the concept of "ultimate" medical responsibility for the actions of the other team members is not applicable. Rather that clinical responsibility rests with every health care professional and that psychiatrists remain responsible for their own professional conduct and care that they provide.

This study's findings indicate that the hierarchy in mental health teams remains, which is a likely reflection of the dominant medical model discourse. The nurses perceived the doctor as being ultimately responsible which they believed to be a view shared by the doctors themselves. This view was considered as being created by the belief that doctors consider themselves as being the ones that are held accountable for outcomes. This view was also reinforced by the belief that doctors held a greater level of responsibility for decision making in practice. This creates some difficulties for nurses in

regards to their clinical responsibility as it promotes medical decision making and restricts consumer perspectives and nursing roles. In addition to this current policy indicates that individual responsibility is more relevant than the notion of ultimate responsibility.

Risk management discourse

The findings of this study indicate the discourse of risk management as having a profound influence on mental health nursing practice and a distinct influence on how nurses perceive clinical responsibility. This is consistent with the literature that acknowledges risk management as a principle discourse in contemporary mental health practice (Crowe & Carlyle, 2003; Ministry of Health, 1998; Stickley & Felton, 2006). There is a strong emphasis on the management of potential violence and suicide risk posed by people living with mental illness which is a result of societal pressure for services to provide protection from such risks. The media portrayal of people living with mental illness as being dangerous along with perceived deficiencies in the mental health system have clearly attributed to public perceptions (Anderson, 2003; Cutcliffe & Hannigan, 2001).

The notion that society is at high risk of violence by people experiencing mental illness is not wholly accurate as the majority of people that suffer from mental illness pose no risk to the community. In fact some surveys have shown that people that suffer from mental illness are more likely to be victimised than to victimise others (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006). However, it remains a public concern that nurses need to take into consideration particular in regards to their responsibilities for risk management; so what are the risks of more serious violence? A New Zealand study that aimed to provide information about the contribution of mental illness to homicide rates found mentally abnormal homicides accounted for eight point seven percent of the total homicides committed between the years 1970 and 2000 and that this rate was decreased to five percent in the year 2000. The rate over time decreased although the total number of homicides increased significantly over that time and did not increase with the expanding population. These results were considered consistent with similar studies in other countries. The authors surmised that deinstitutionalisation was not associated with an increased risk of homicide (Simpson, McKenna, Moskowitz, Skipworth & Walsh, 2004). Other authors consider the incidence of homicides by those that are mentally ill relatively

low especially when compared to common causes of death such as motor vehicle accident, drowning or accidental falls (Szmukler, 2000).

In addition to concerns about violence, issues related to the risk of suicide are also dominant in mental health services. This was also identified as a major concern in this study when considering nursing clinical responsibility. Health professionals' potential liability for patient suicide is different to other areas of medical misfortune given the ultimate outcome is the result of the actions of the patient. The view that mental health professionals are responsible for suicide could be based on the belief that suicide is a direct result of a diagnosed underlying condition that affects a person's ability to make free choices. However for this to be entirely accurate a person would need to be considered so mentally ill that they had no control over their actions (Appelbaum, 2000). Some authors question whether the patients' actions should be more recognised when evaluating such outcomes (Appelbaum, 2000; Hobbs, 2001). Appelbaum (2000) describes a case where a family sued a doctor following a suicide, the court ruled in the doctors' favour and stated that to rule otherwise would mean health professionals would become absolute insurers when caring for a suicidal patient. This seems fair when it is considered impossible to predict suicide in any one patient (Goldney, 2000). These factors were recognised by the nurses in this study and they accepted that they had limited abilities to protect people from the risk of suicide. However, what became important following the death of a patient to suicide was a process of reflection about whether they had upheld their professional responsibilities.

Regardless of health professionals' limited capabilities to protect people from risk, risk management continues to be a dominant feature in the delivery of mental health care. The nurses described working within an organisational culture of risk aversion. Because of outside pressures the organisation must be seen to actively be working to reduce risk and as a result the continual reviewing and updating of risk management guidelines and policies is seen. This in turn creates the proliferation of treatment and risk guidelines which reduce clinicians' abilities to make critical decisions (Mullen, Admirall & Trevena, 2008) and further promote coercive treatments that discourage consumer responsibility. These types of practices can be described as defensive which have become commonplace in practice. This was represented in the nurses' defensive views of clinical responsibility in that their focus was on what they were accountable for rather than what they are professional responsible for.

In 1998 The Mental Health Commission put out the results of a review conducted that sought to seek clarification around issues of accountability. This review found that health professionals felt increasingly vulnerable in relation to issues of accountability and as a result felt obligated to practice in a defensive manner (Chiplin et al, 1998). This resonates with the findings of this study where the nurses described various aspects of defensive practice that occurred due to concerns about accountability. A study that sought to assess the extent of defensive practice amongst psychiatrists and psychiatric nurses in the New Zealand setting found that defensive practice was widespread. The nurses in this study perceived more practice as defensive compared to the psychiatrists and the authors surmised that this could be because the nurses were subject to more regulated protocols and that they perceived themselves as more vulnerable in the event of an adverse outcome (Mullen et al, 2008). This could be accurate given the high level of exposure perceived by nurses in this study, namely feeling blamed by the public for adverse events, being unsupported by nursing organisations, and being scapegoats for doctors and even other nurses. A study that found high levels of defensive practice in the treatment of borderline personality disorder had similar results in that the participants attributed their defensive practice to the broader system such as organisational managers, coroners, media and government health departments (Krawitz & Batcheler, 2006).

Generally, in places such as the USA defensive practice is attributed to the fear of litigation however within New Zealand no-fault legislation means that practitioners are seldom sued (Mullen et al, 2008). However, a number of avenues of inquiry can occur. These are conducted by various organisations and agencies including but not limited to; the employing authority, professional organisations, the coroner, the health and disabilities commissioner, the human rights commissioner, the district inspector and the minister (Hobbs, 2001). Indeed these findings suggest that these types of inquiries can have a similar impact for nurses as litigation can in other countries. The prospect of being involved in a coronial inquiry was frequently referred to as being of concern to the nurses and it was conveyed that this had an impact on everyday practice and decision making. The purpose of a coronial inquest is to establish the cause of death and make recommendations or comments that may reduce the likelihood of a similar event occurring, it is not to assign fault or blame (Paterson, 2008). However this did not seem to be the understanding held by the nurses. There is very little literature that addresses the impact of coronial inquiries on practice and nothing specific to the nursing perspective.

This is surprising given the results of this study indicate that it may be a significant factor for mental health nursing practice in the New Zealand setting. However, what literature is available suggests that there could be some issues that are inherent in the process.

Goldney (2000) provides a report that reviews the findings of an Australian coronial inquiry into six various suicide and homicides associated with mental illness. These findings are also compared to a much larger United Kingdom report which produced similar findings. The recommendations were at large simply recommending what standard psychiatric practice should include. However some of the recommendations stood out as potentially challenging for nurses when considering their responsibilities related to patient empowerment and less coercive practice and a clear inclination towards the medical model of practice is seen. Some examples of this include:

- “There is a need to remain focused upon the primary illness, and to provide effective treatment for it, rather than becoming pre-occupied with the symptoms and effects of the illness, such as socio-economic factors”.
- “The side effects of such medication should also be considered and treated where possible, but should not deter aggressive attempts to treat the patient’s illness”.
- “The health legislation should allow for the enforcement of treatment of high risk patients who are at risk of relapse even in the absence of clear signs of relapse”.
- “Stigma: Information from such reports should be used to inform the public about the risks posed by people with severe mental illness to themselves and to others”.

(Goldney, 2000, pp. 143-145)

The question could be raised about whether a coroner is the best informed to make such recommendations given they have less experience than the clinicians involved in the review. Hobbs (2001) states that coroners can come to odd conclusions particularly if they have not employed a clinician to assist them. For example, the fictitious belief that medication is the sole solution to mental illness. This assumption relies heavily on the medical model of care as well as creating a simplified avenue of causation of events. In addition to this The Mental Health Act is often offered up in inquiries as if it is the answer to prevent such events (Hobbs, 2001). The introduction of The Mental Health Act (1992) in New Zealand was supposed to protect the rights of the patient and reduce compulsory treatment. However, this is questionable given the broad interpretation of The Act’s definition of mental disorder and its subsequent application in practice since (Hobbs,

2001). In other countries such as the UK concerns have also been raised about the benefits of inquiries. These include the apparent focus on the role of mental health services, hindsight bias, and the focus on mental illness as the main factor. Potential negative effects have also been identified such as the re-traumatising of victims and families, the reinforcement of the lunatic stereotype, the humiliation of mental health services and the increasing focus on risk management and subsequent enforcement of coercive practices (Scmukler, 2000). What has been demonstrated in this study is the significance of the coronial process and subsequent recommendations as it seems to carry a lot of weight in practice for mental health nurses.

As described earlier the focus of coronial inquiries is to establish cause of death and make recommendations to prevent similar events occurring again but the focus is not solely on the health professionals' practice. However, Health and Disability inquiries are another avenue of inquiry in New Zealand that investigate the actions of health care providers if their action is or appeared to the Commissioner to be in breach of the Code of Patient Rights (Paterson, 2008). This is another important area for discussion given it is a significant part of accountability processes for mental health nurses in this setting. It is important to highlight that similar to a coronial inquiry health and disability inquiries cannot sanction health professionals by removing their ability to practice in the way professional bodies such as the Nursing Council can.

The role of the Health and Disability Commission is regarded as having an educational role where complaints can improve the overall quality of care in health services through learning from such inquiries (Paterson, 2008). This is done through making reports from inquires public via the media, internet or through copies being sent to professional bodies, usually with health professionals remaining anonymous (Paterson, 2002a). It is agreed amongst health professionals and the inquirers, that complaint and inquiry services such as this are essential and have an important role in health care (Paterson, 2008; Cunningham; 2004b). However, it seems that inquiries into complaints are not always regarded as positive particularly by clinicians who can be left feeling like villains.

Within this study the nurses described defensive practice due to an increased awareness of being held accountable for a poor outcome. It is acknowledged that there is a perception that inquiries such as those investigated by the Health and Disability

Commission have the objective of holding someone to account. As a result inquiries can occur in a hostile environment where clinicians are abetted with lawyers and bristle at any criticism of care (Paterson, 2008) because of the potential for blame for outcomes considered as out of their control (Cunningham, 2004a). Cunningham & Dovey (2006) explored the effects complaint processes have on doctors in the New Zealand setting and found that such systems may also cause doctors to practice defensively. A further study done by Cunningham (2004a) found that receiving a complaint can have a significant negative emotional impact on doctors and potentially impact the doctor patient relationship.

The Health and Disability Commissioner suggests that complaint processes are about learning rather than lynching (Paterson, 2008); however the findings of this study and some others demonstrate that clinician perceptions of these types of processes may be the latter. Nonetheless, the commissioner suggests that practitioners in New Zealand should still recognise that it is one of the safest places to practice in, that the complaints process is not punitive and that very little result in disciplinary action (Paterson, 2002a). Therefore the question remains how to bridge the gap between clinicians' perceptions and fears of blame and the potential learning opportunities that are proposed.

Implications for Nursing

There were a number of dynamic and sometimes competing factors that came into play in considering clinical responsibility for the nurses in this study. The challenge for the nurses that was highlighted is the balance between competing discourses in practice. Nurses need to promote individual responsibility, delicately manage the medical hierarchy, satisfy organisational and societal expectations to manage risk and maintain their own clinical responsibility.

In considering the discourse of consumer rights and the discourse of medicine a power imbalance between the two discourses is apparent. The professional language of those considered to be at the top of the hierarchy tends to prohibit the inclusion of those that have not been exposed to the language though education and consumers could be considered as particularly disadvantaged in this regard (Stickley, 2006). Historically consumers have sought power through integrating themselves in teams and learning the language of the dominant system as a way of climbing the hierarchy. However some authors argue that this is a deception as these actions are always interceded by those

already in control to ensure it conforms to their agenda (Stickley, 2006). Additional tension between these two discourses is also apparent in that the medical model moves away from a person's lived experience by reducing it down to commonly occurring parts to form diagnosis. This practice distracts from hearing a person's experience which is considered as a common form of disempowerment (Barker, 2001).

There are additional tensions for nurses in advocating for consumer responsibility, the most obvious point of controversy being risk management and the ongoing use of enforced treatment. The dual role of services to facilitate recovery as well as manage risk are conflicting (O'Hagan, 2009; Chiplin et al, 1998) and clearly pose special challenges for nurses. The Mental Health Commission review of accountability identified that clinicians found it very difficult to balance the need to address the increasing emphasis that has been placed on consumer empowerment and still address the strong onus that has been placed on clinicians to assess and manage risk (Chiplin et al, 1998). Mead and Copeland (2000) argue from the consumer perspective that risk is inbuilt in the experience of life and that it remains up to the consumer to make choices about taking risks and not up to the health professional to protect them. They believe that they need to be accountable for their own behaviour and decisions not unlike anyone else. This leads to the concept of therapeutic risk taking which refers to taking a course of action that may create the opportunity for risk but also for learning. It involves clinicians taking a non-expert position and recognising the experience and expertise of those living with the illness to make decisions (Stickley & Felton, 2006). Through providing sound rationale for decisions nurses are better able to take therapeutic risks.

Historically nurses have adopted medical knowledge as a basis for nursing education and practice to increase their power in the hierarchy however it has more recently been acknowledged that nursing as a caring profession with strong links to the therapeutic relationship is equally valuable. Nurses are becoming more confident in their knowledge and nursing philosophies and as a result are more likely to stand on an equal footing to doctors (Fagin & Garelick, 2004). Despite this, nurses are still required to manage the relationship between nursing responsibility and the powerful medical discourse. One way in which the nurses described doing this was through communication style with doctors. Fagin & Garelick (2004) describe this as the 'doctor-nurse game', where nurses adhere to social rituals and etiquette and use subtle techniques to guide doctors into decisions in order to not undermine their authority.

Although there is not a clear answer as to how all of the competing discourses can be managed it is critical that mental health nurses have an awareness of societal and organisational factors that influence practice and decision making. Nursing awareness of such factors could be enhanced by opportunities for nurses to discuss the competing discourses that affect their perceptions of clinical responsibility. Such discussion could be facilitated in informal or educational settings or within clinical supervision. This knowledge will better inform decisions in practice to ensure that they are true to nursing therapeutic responsibilities and less likely to be based on misconceptions of accountability. Mental health nurses are in a unique position as they are placed between the first two competing models and with an awareness of influencing discourses they could act in a facilitating role in practice by providing a critical perspective.

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