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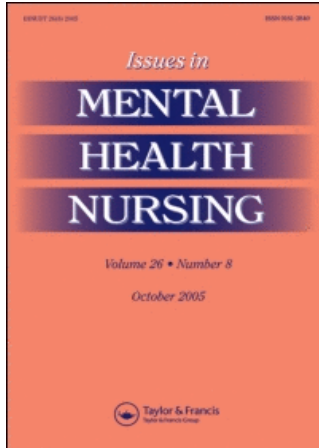
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Mona M. Shattell^a

^a University of North Carolina at Greensboro, School of Nursing, Greensboro, North Carolina, USA

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COMMENTS, CRITIQUE, AND INSPIRATION

THE DISAPPEARANCE OF “ONE-TO-ONES” IN ACUTE PSYCHIATRIC CARE

Mona M. Shattell, PhD, RN

*University of North Carolina at Greensboro,
School of Nursing, Greensboro, North Carolina, USA*

Do you remember “one-to-ones” in acute care? A “one-to-one” (not to be confused with “one-on-one,” an individual staff member who closely monitors a patient at all times) is a concept that may be unfamiliar to nurses who entered acute care psychiatric/mental health nursing within the past 10–15 years. One-to-ones are uninterrupted, lengthy, individual sit-down nurse-patient interactions. These one-to-ones were once an expected, necessary aspect of psychiatric/mental health nursing practice. Acute care psychiatric/mental health nurses were supposed to have at least one, one-to-one interaction daily with each patient he or she was assigned to. Nurses who worked in psychiatric settings when this was the norm and continue work in acute care now know that one-to-ones have all but disappeared.

Psychiatric/mental health acute care in the United States, now often called “behavioral health,” has dramatically changed—patients are more acutely mentally and physically ill, hospitalizations are short, documentation demands are great, the medical model dominates, and the mode of treatment has moved from an individual to a group format. Staffing in acute care environments is often inadequate to handle these changes, which have resulted in low morale, stress, and burnout for acute care psychiatric/mental health nurses (Higgins, Hurst, & Wistow, 1999; Jenkins & Elliott, 2004).

Education and experience speak to the value of interpersonal interactions—talking and listening, or counseling—but today’s acute care environments do not allow for these, certainly not to the extent they once were used. Extended interactions seem to be an artifact from the past. Patients have noticed. Higgins et al. (1999), who studied acute

Address correspondence to Mona M. Shattell, University of North Carolina at Greensboro, School of Nursing, P.O. Box 26170, Moore Building 320, Greensboro, NC 27402. E-mail: mona_shattell@uncg.edu

psychiatric care in the United Kingdom, found that patients reported few if any interactions with nurses and, in fact, spent only 4% of their time with staff. These findings are consistent with a U.S. study of the acute care psychiatric/mental health environment (Thomas, Shattell, & Martin, 2002) that found that nurses spent relatively little time with patients in these settings.

Many nurses who “grew up” with the ethos of one-to-ones are disturbed by the changes in acute psychiatric/mental health care. For the most part, nurses have a desire and need to interact with patients to help them work through problems. Nurses struggle to work in settings where their inclination to practice as they once did is suppressed. Due to various time, organizational, and structural constraints, they are not allowed to practice as they were taught, causing professional role dissonance, frustration, anger, anxiety, and burnout. This can lead to a loss of experienced psychiatric/mental health nurses to other areas of nursing or other non-acute psychiatric/mental health care settings. Acute care may lose its most experienced nurses because of the gap between the way it used to be and the way it is.

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