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Lived Experiences of Nurses Caring for Persons with Mental Illnesses and Chronic Health Conditions

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This is to certify that the doctoral dissertation by

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2024

Abstract

Lived Experiences of Nurses Caring for Persons with Mental Illnesses and Other Chronic Health Conditions

by

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MScN, Walden University, 2014

BScN, Ryerson University, 2008

RN-Diploma George Brown College, 2003

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Persons with mental illnesses are susceptible to complicated chronic physical illnesses, such as cardiovascular disease, end-stage renal disease, and diabetes. Hence, their life expectancy is reduced compared to the general population. Studies have been completed on health disparities of persons with mental illnesses; however, no studies have examined the lived experience of nurses who provide care for persons with mental illnesses and other chronic health conditions in urban hospitals in Canada. Framed by Watson's human caring theory and Rogers' theory of person-centered care, the purpose of this hermeneutic phenomenological qualitative study was to explore the lived experiences of Canadian nurses who provide care for persons with mental illnesses. Rich data were collected from nine registered nurses through semistructured interviews. Saldana's in vivo manual coding strategy was used to generate categories and salient themes. Themes were : the importance of respect, autonomy, and empathy, positive environments for healing and communication, importance of advocacy, and support for nurses. Future studies are needed to explore nurses' experiences involving care of patients with mental illnesses in other urban hospitals in Canada. Study findings have the potential to inform nursing practice and contribute to positive social change in terms of the care of persons with mental illnesses as they seek medical and mental healthcare.

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Chapter 1: Introduction to the Study

Mental illnesses such as depression, anxiety, bipolar, and schizophrenia affect persons of different races, socioeconomic statuses, age groups, and gender (World Health Organization [WHO], 2022). Persons with mental illnesses face a greater risk of having preventable chronic health conditions, such as cardiovascular disease, diabetes, pulmonary disease, and cancer, when compared to persons who do not have mental illnesses (Miles et al., 2022; Rivera-Segarra et al., 2019). These preventable illnesses are sometimes due to decreased screening and oversight of physical diagnosis (Miles et al., 2022; Rivera-Sagarra et al., 2019). Consequently, life expectancy for people with mental illnesses is 10 to 20 years less than persons without mental illnesses (Miles et al., 2022; Schneider et al., 2019).

Persons with mental illnesses often perceive that their health concerns are not addressed because clinicians do not listen to them attentively or speak to them respectfully, and make assumptions about their illnesses; hence, their physical illnesses are sometimes overlooked or undertreated (Miles et al., 2022; Rivera-Segarra et al., 2019). Also, patients with mental illnesses and other chronic physical illnesses experience the highest readmission rates among the general population of admitted patients (Gentil et al., 2021). Furthermore, Sporinova et al. (2019) posited persons with mental illnesses are associated with substantially higher resource use and healthcare costs among patients with chronic diseases.

Nurses are often the healthcare providers who see clients in their early encounters in the health system and continue to spend time with clients while providing care; hence, they are uniquely positioned as healthcare professionals and can have a positive effect in terms of improving health outcomes of persons diagnosed with mental illnesses (Chiang et al., 2021). This positive impact is primarily due to their strategic position and expertise in terms of providing care to influence positive patient outcomes (Chiang et al., 2021). Therefore, my study was aimed at gaining knowledge from nurses' lived experiences that may help inform future nursing mental healthcare practices. By improving nursing practices, changes may be initiated to support positive health outcomes for this vulnerable population in diverse communities. In Chapter 1, the background, purpose of the study, theoretical framework, nature of the study, and significance of the study are explained.

Background

Although persons living in Canada are among the healthiest people in the world, not all experience equitable healthcare because their medical health conditions are often overlooked and treated as mental illnesses (Missiuna et al., 2021). Furthermore, one in four Canadians is affected by mental illnesses (Miles et al., 2022). Worldwide, persons with mental illnesses are 2.2% more vulnerable to having chronic health conditions than persons without mental illnesses (Miles et al., 2022; National Institute of Mental Health [NIMH], 2019; Poucher et al., 2021; Schneider et al., 2019). 8 million or 14% of people worldwide with mental illnesses die yearly (Miles et al., 2022; National Institute of Mental Health [NIMH], 2019; Poucher et al., 2021; Schneider et al., 2019).

Cardiovascular disease and diabetes are two of the most preventable chronic illnesses that are experienced by persons diagnosed with mental illnesses (Chiang et al., 2021). Frequently, these preventable diseases are undertreated due to clinician oversight (Miles et al., 2022; Rivera-Sagarra et al., 2019; Solmi et al., 2021). Consequently, decreased treatment and fewer diagnostic interventions for persons with mental illness increases risks of them experiencing adverse and decreased health outcomes (Miles et al., 2022; Rice et al., 2019; Solmi et al., 2021).

The life expectancy of persons diagnosed with mental illnesses is 10 to 20 years less than those without mental illnesses (Chiang et al., 2021; Emma et al., 2021; Kumar et al., 2022, Marten et al., 2023).

The nursing profession has the largest number of healthcare professionals who work in diverse areas of healthcare based on their level and knowledge of expertise (Ryan et al., 2021). Therefore, nurses are well-positioned to care for persons diagnosed with mental illnesses (Ryan et al., 2021). By further exploring knowledge and experiences of nurses who care for persons with mental illnesses, greater insight was achieved, and knowledge can be used to inform nursing practices.

Problem Statement

Extensive research has been completed on health disparities encountered by persons with mental illnesses (see Rice et al., 2019; Ryan et al., 2021; Santori, 2021; Solmi et al., 2021). However, the problem was that lived experience of nurses who provide care for persons with mental illnesses and other chronic health conditions in urban hospitals in Canada was not explored. Nurses provide the most hands-on treatment in most healthcare organizations, often impacting positive patient outcomes (Ryan et al., 2021).

The physical health of persons diagnosed with mental illnesses is often not taken seriously (Missiuna et al., 2021); hence, physical symptoms are often overlooked and treated as symptoms of mental illnesses (Rivera-Segarra et al., 2019). Solmi et al. (2021) posited patients with mental illnesses are screened less for cardiac disease, increasing their risk of experiencing preventable adverse health outcomes.

Nurses work in various healthcare environments to provide care directly and indirectly for patients with mental illnesses (Foye et al., 2020; Miles et al., 2022; Rivera-Segarra et al., 2019; Ryan et al., 2021; Tranter & Robertson, 2019). Therefore, nurses working with persons who are diagnosed with mental illnesses are considered key healthcare providers who are well-positioned to understand how patients with severe mental conditions are treated (Miles et al., 2022; Rivera-Segarra et al., 2019; Tranter & Robertson, 2019). Information provided by nurses can potentially help other nursing colleagues advocate and become change agents to assist persons with mental illnesses in terms of improved health outcomes (Foye et al., 2018; Miles et al., 2022; Rivera-Segarra et al., 2019; Ryan et al., 2021; Tranter & Robertson, 2019).

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore lived experiences of nurses who provide care to persons diagnosed with mental illnesses in a general hospital within urban Canada. Researchers have investigated health disparities regarding decreased health outcomes in persons diagnosed with mental illnesses (see Rivera-Segarra et al., 2019; Romero-martin & Gomez-Salgado, 2019; Tranter & Robertson, 2019). However, lived experiences of nurses working with patients with mental illnesses who have other chronic conditions in an urban general hospital in Canada and how they can assist persons with mental illnesses in terms of achieving increased health outcomes was not explored. Therefore, I explored these experiences to understand more about factors contributing to patients with mental illnesses and decreased health outcomes. I focused on understanding how healthcare professionals such as nurses can help understand and differentiate oversight of nonmental health ailments such as cardiovascular disease among patients diagnosed with mental illnesses. New knowledge can be used to support and inform nursing practices. Concepts of interest were lived experiences of nurses, disparities of care, and persons diagnosed with mental illnesses in urban Canada.

Research Question

What are the lived experiences of nurses who provide care for persons diagnosed with mental illnesses who are admitted to general hospitals in urban Canada?

Theoretical Foundation

The theories and concepts that grounded this study were Watson’s theory of human caring, which involves patient care that is built around holistic care and human dignity, and Rogers’ theory of person-centered care, which indicates relationships with patients are essential to maximizing positive outcomes. Watson posited the importance for nurses and patients to have a one-to-one connection to understand patients’ goals and help meet their unique needs. Instead of the tone of a lecturer or manager, nurses should speak to patients in an appropriate manner that encourages therapeutic relationship building (Watson, 2008). Caring for patients includes meeting their mental, physical, and spiritual needs in a harmonized and holistic fashion (Watson, 2008).

Person-centered therapy includes seven principles that characterize the approach of person-centered care. In this research, a special emphasis was placed on the seventh approach of Rogers' theory, which was the principle of empathy. Rogers' seventh principle indicates that therapists must be nonjudgmental listeners and view the world through clients' eyes. Treating persons uniquely encourages improved patient health outcomes (Rogers, 1965).

Theories in this qualitative study were used to construct open-ended and followup questions based on nurses' responses. This approach involved gathering rich data that generated the best answers. Knowledge from this research can be used to inform nursing practices that can positively change health outcomes of persons with mental illnesses.

Nature of the Study

A phenomenological-hermeneutic approach was used to explore and gain an understanding of lived experiences of nurses who provide care to persons diagnosed with mental illnesses who were admitted to a medical unit in a general hospital in urban Canada. Semistructured interviews with open-ended questions were used to generate data that were thick and rich. Participants were selected for interviews through purposive sampling of a medical unit. Prospective participants who met inclusion criteria received an announcement email via the hospital's intranet and interviewed. Participants were registered nurses (RNs) who worked more 3 three months in the general internal medicine or cardiology units and provided care for persons with mental illnesses. I excluded RNs who worked in the general internal medicine or cardiology units for less than 3 months as well as those who never provided care for patients diagnosed with mental illnesses.

The hospital's intranet served as the primary platform for soliciting participants from the general internal medicine and cardiology unit because this platform is predominantly used for nursing-related communications. Emails and flyers were sent to all nurses in the RN group in the general internal medical and cardiology units inviting them to participate in the study. The flyer included a description of the study, the interview process, my contact information, and information about audio recording. The organization oversaw the data collection process and served as the ethics committee of record for this study. They preapproved all communications that were sent to nurses, and interviews were conducted according to protocol.

Prospective participants were notified of intended strategies to keep their personal information confidential. RNs were informed they could withdraw from the study at any time during the research process, with no penalties or obligations. Prospective participants were notified information they provided would be tape-recorded with their permission.

According to Creswell and Poth (2018), phenomenological studies usually involve three to 10 participants. I aimed to select the first seven to 10 nurses who met inclusion criteria. Data collection was discontinued when saturation was achieved. There is no need for researchers to continue collecting data if information does not provide new arguments or value (see Creswell & Poth, 2018).

Verbatim data were collected from recordings and transcribed using Microsoft Word and then Excel. I used the in vivo approach and manual coding to develop codes, categories, and themes. According to Ravitch and Carl (2021), researchers should read and reread data carefully while ensuring they are free from biased answers.

Definitions

Key concepts and terms in this study were defined as follows:

Chronic health conditions: Physical or mental conditions impacting functioning for at least 3 months. These conditions include but are not limited to bipolar disorder, posttraumatic stress disorder, schizophrenia, diabetes, end-stage renal disease, and fibromyalgia (Allemang et al., 2021; Dai et al., 2023).

Disparities of care: Inequitable care and biased treatment of vulnerable populations. Quality of care usually impacts adverse health outcomes (Artiga et al., 2020; Miles et al., 2022).

Persons with mental illnesses: Persons with mental illnesses experience one or more emotional, behavioral, or cognitive disorders that prevent them from functioning effectively in terms of daily activity. Some of these symptoms can range from mild to severe and affect persons of various ages and backgrounds.

Phenomenological-hermeneutic approach: Strategy to explore meaning of a phenomenon and commonality of participants’ lived experiences (Creswell & Poth, 2018; Patton, 2015).

Assumptions

Assumptions are claims about the study. One assumption I made before my prospectus was approved was that participants provided honest information that would best answer my research question if interviews were held in a convenient environment for participants. It is important for researchers to implement strategies to ensure participants' privacy and comfort are optimally maintained, as this encourages feeling safe and comfortable in order to provide crucial information.

Scope and Delimitations

The phenomenon was health disparities among persons with mental illnesses. Nurses are well positioned to influence quality of care that patients receive because they have the most hands-on engagement in terms of patients with different diagnoses (see Alvarenga et al. 2021; Avery et al., 2020). I used a qualitative design to explore lived experience of nurses who provide care for persons with mental illnesses, which offered the opportunity to gain meaningful knowledge that can impact positive health outcomes for this population.

Nurses who participated had experience providing care for persons diagnosed with mental illnesses. Nurses who did not work in the medicine or cardiology unit, nursing students, and people in other health disciplines were excluded from this study.

Providing patient-centered care is one of the most pivotal strategies that can be used to ensure patient care should be tailored to meet the unique needs of patients (Rogers, 1965; Watson, 2008).

The phenomenological approach is used to provide rich data based on strategies to create and ask meaningful questions and prompt followup questions (Ravitch & Carl, 2021). Thematic analysis was used to knowledge that can be transferred to inform meaningful nursing practices and promote positive patient outcomes.

Limitations

Gaining access to participants for interview sessions can be challenging (Carter et al., 2021). According to Carter et al. (2021), geographic parameters can create social and financial burdens for researchers and participants. Due to geographic parameters, it can become costly and inconvenient for both researchers and participants to meet at strategic locations (Carter et al., 2021). Social limitations, challenges, and barriers can also occur. Challenges encountered by participants can increase their stress levels (Carter et al., 2021). Solutions that are used to mitigate geographic challenges and barriers include virtual platforms and interviews over the telephone for synchronized interactions.

Participants' ability to purchase Internet services can also be an issue, in addition to computer literacy (Carter et al., 2021). For this study, participants opted to use the telephone instead of Zoom because they were more comfortable using the telephone, and some had technical difficulties.

Significance

This study is significant because persons diagnosed with mental illnesses often experience diminished health outcomes related to chronic illnesses such as diabetes and heart disease. Nurses working with persons with mental illnesses are vital healthcare providers who are positioned to advocate and become change agents for persons with mental illnesses. Through this study, I explored nurses’ lived experiences as they provide care to persons diagnosed with mental illnesses in medical units in a general hospital in urban Canada.

New knowledge can be disseminated to diverse communities to effect positive social change for persons diagnosed with mental illnesses.

Summary

In Chapter 1, I introduced the phenomenon of interest and study relevance. The research question was addressed. The theoretical frameworks that were used to guide the study were defined as well as the qualitative hermeneutic phenomenological approach. Furthermore, the nature of the study, assumptions, and envisioned limitations were also addressed. In Chapter 2, I address the literature review. Theoretical frameworks are explained in detail.

Chapter 2: Literature Review

Canada has one of the best healthcare systems in the world; however, persons with mental illnesses encounter more significant health disparities than the general population (Missiuna et al., 2021). The problem is that lived experiences of nurses who provide care for persons with mental illnesses and other chronic health conditions in urban hospitals in Canada were not explored.

Exploring nurses' lived experiences is crucial because nurses provide the most hands-on treatment in most healthcare organizations, often impacting positive patient outcomes (Ryan et al., 2021). This chapter includes strategies that were used for the literature review, theoretical frameworks, key concepts, and a summary and conclusion.

Literature Search Strategy

I used the following databases: APA PsycArticles, Google Scholar, CINAHL Plus with Full Text, Medline with full text, and Embase. Search terms were: *person-centered care*, *empathy*, *holistic care*, *respect*, *mental illness*, *nurse*, and *chronic illness*. Many articles were generated during the search. I selected articles that were published between 2019 and 2023, except for articles with critical data that added value to the study.

Theoretical Foundation

Watson (2008) postulated patients should be cared for by nurses in a holistic fashion where the mind, body, and soul are assessed and cared for, after which healing can be achieved. If patients are respected, they will be able to express themselves, their unique needs will be articulated, and their health outcomes can be positively impacted.

Rogers (1965) posited that empathic therapy that is provided to clients allows them to gain autonomy over their care and facilitate clients to achieve self-actualization, leading to positive outcomes. If clients are given nurturing environments to thrive, they may actualize their maximum potential. Therefore, positive outcomes are expected when clients are given a nurturing environment.

Lewis et al. (2019) posited person-centered care benefits patients, practitioners, and healthcare organizations. Lewis et al, (2019), noted patients on a hemodialysis unit in urban Canada expressed they did not feel they had autonomy over their care because their voices were not heard; hence, they had minimal input in the care their received. Voices of individuals who are main advocates and recipients of care need to be heard to result in positive health outcomes, especially among the mentally ill. Tranter and Robert (2019) indicated nurses can effectively assess patients as whole beings and not just focus on admitting diagnosis but rather conduct a holistic assessment to promote positive health outcomes for patients with mental illnesses who seek healing.

Both theories indicate that focus of care should be based on patients' individual needs and not just one general treatment that is applied to all. Concerns voiced by care recipients are essential, and care should be tailored to meet holistic needs through person-centered care.

I used hermeneutic phenomenology to understand participants' lived experiences regarding the phenomenon of interest. Manookian (2019) indicated that phenomenology is an integral tool that can be used to capture and interpret lived experiences involving a phenomenon of interest. According to Patton (2015), the function of hermeneutics in qualitative studies is to assist with interpreting the context of interest. This can be presented in the form of text or art (Patton, 2015). Banerjee et al. (2021) indicated dignity should be preserved via a holistic care approach because patients also have a voice in the direction of their care. Empathy and respect are two of the key concepts that need to be acknowledged by healthcare providers so that persons in need of care may obtain positive outcomes (Rogers, 1965; Watson, 2008).

By using Watson's human caring theory and Rogers's person-centered theory to guide my study, I understood lived experiences of nurses who care for persons with mental illnesses. Knowledge from this study can be used to inform nursing practice to lead to positive health outcomes for this vulnerable population.

Literature Review Related to Key Concepts

The literature review was organized to address key concepts to establish the background and foundation for my study. The key topics I covered in this section are person-centered care, empathy, human caring, holistic care, respect, health disparities, mental illness, and chronic illness.

Person-Centered Care

The concept of person-centered care was noted multiple times in exploratory qualitative studies using thematic analyses, indicating that person-centered care occurs when the care provided to patients is tailored to meet the patient's individual unique needs (Gang et al., 2022; Khullar & Coughlan; 2019; Lewis et al., 2019; Ringer 2023). Not only in the nursing discipline, person-centered have been noted, but also in doctoral physiotherapy education programs where students are taught the importance of person-centered (Renger, 2023)

Patients experienced improved health outcomes, and increased knowledge and heightened confidence are noted in students' insight on providing care for themselves as a whole being (Renger, 2023). Skoglund et al. (2019) aimed to find the difference between patient-centered care and person-centered care.

Though the meanings of the two concepts were slightly different, the ideas of person-centered care and patient care had the potential to improve patients' health outcomes (Skoglund et al. 2019). Gradually, healthcare organizations are transitioning from patient-centered care to person-centered care to address the needs of patients based on the patient's preferences (Skoglund et al., 2019). Nurses utilizing the person-centered concept will decrease healthcare organizations' financial burden and increase patients' positive health outcomes (Tranter & Robertson 2019).

Empathy

It was noted in exploratory qualitative and mixed-method analyses that empathy is frequently noted as the genuine expression shown by the healthcare providers indicating their understanding of how important the person's expressions/concerns are as they listen attentively and advocate for the person without changing the context or meaning while paraphrasing (Braillon & Taiebi; 2020; Farber et al., 2022). Hammarstrom et al. (2019) posited that when a nurse expresses empathy to patients, it allows them to feel that someone understands their point of view; it also becomes easier for the nurse to gain greater insight into the patient's unique needs. Banerjee et al. (2021) added that, in a qualitative study completed, the thematic analysis indicated that empathy demonstrated patient was one of the merging themes that implicated increased positive patient outcomes. Rogers (1965) and Watson (2008) postulated that a therapeutic relationship can be achieved by expressing empathy to a person who seeks help. Furthermore, exploring what the person is experiencing could generate greater knowledge/understanding of optimizing positive patient outcomes. On the contrary, when an empathetic relationship is not developed between the patient and the healthcare provider, the opportunity for healing may become futile (Foster, 2006; Rogers, 1965; Watson, 2008). The concept of empathy is necessary in our healthcare system to assist in building therapeutic relationships between healthcare providers to increase positive patient outcomes (Kang et al., 2022).

Human Caring

Human caring is the human-to-human interaction that facilitates a healing environment (Oehlert, et al., 2022; Wei, & Watson, 2019). Human caring is used in health organizations specifically for nursing disciple and throughout other health disciplines and universities where healthcare students are trained (Wei & Watson, 2019; Kou et al., 2022). Evidence indicates that healthcare providers exhibit confidence in practice when performing practices that emulate those that will encourage a healing atmosphere, and also positive patient outcomes are noted (Wei & Watson, 2019; Kou et al., 2022). Other caring theories used in the healthcare industry, such as Swanson's caring theory, have positive implications for improving patient health outcomes (Wei et al., 2018). Shahpar et al. (2023) indicated that nurses with lived experience in providing care for persons diagnosed with mental illnesses find it challenging. Therefore, an organization that facilitates a healing environment for its staff will promote good health for healthcare providers (Wei et al., 2018; Shahpar et al., (2023).

During the geopolitical event of the Covid-19 pandemic, patients and staff experience immense stress and burnout (Oehlert, et al., 2020). Hence caring theories were used to assist in fostering positive and nurturing environments for patients and healthcare providers so that they can feel energetic and hopeful to experience positive health outcomes (Dzau, et al., 2018; Melnyk, 2022; Oehlert, et al., 2020; Wei, et.al., 2020). The concept of human caring helps promote confidence in healthcare providers and assists healthcare, inducing positive health outcomes for the nurse and the persons seeking help (Watson, 2008).

Holistic Care

Holistic nursing care occurs when the interaction between the nurse and the person promotes a therapeutic relationship and healing occurs (Dossey & Keegan, 2016; Blaszko, et al., 2022; Frisch & Rabinowitsch, 2019; Hamilton, 2022). Holistic care provided by the nurse encompasses care that is tailored toward meeting the person's unique needs and includes healing physically, mentally, emotionally, and spiritually (Blaszko, et al., 2022). Each patient to whom care is provided possesses good qualities; hence, they should be allowed to maximize their potential as a whole being (American Holistic Nurses Association [AHNA] 2021; Blaszko et al., 2022). Positive health outcomes can only be achieved if the humans' biological, psychological, social, and spiritual elements are in sync (Kaya et al., 2022). Furthermore, the absence of any of these components will likely promote disease or poor health outcomes (Kaya et al., 2022).

Mixed methods, qualitative, and quantitative researchers have posited that the effective execution of holistic care provided by student nurses and advanced nurse practitioners increased nursing practice confidence and improved positive patient health outcomes (Eriksson et al., 2018; Kaya et al., 2022). The concept of holistic care implies that it is important for healthcare providers to meet patients' needs and tailor them to their unique needs to create positive health outcomes.

Respect

Respect is the dignified actions that should be displayed during interaction with a person, which should not be based on biases against the person's health condition, socioeconomic status, and ethnic background but instead should be based on regard for humanity (Hosseini et al., 2019; Liddell et al., 2023; Sampaio, 2017; Santori, 2021; Werdofa et al., 2023). Treatment for persons needing help should not be withheld or unexplored but executed promptly (Werdofa et al., 2023). Maltreatment and disrespect based on the person's gender, ethnic background, socioeconomic status, and diagnoses are contraindicative to the premise of healthcare providers providing respectful and holistic care (Carlström & Gabrielsson, 2021; Liddell, 2023; Werdofa et al., 2023). Lack of respect for vulnerable populations and ignoring the need for holistic care increases health disparity as persons in need of healthcare should be treated as their family (Liddell, 2023; Sampaio, 2017; Santori, 2021). The concept of respect indicates that a healing atmosphere should incorporate respect to encourage therapeutic relationships and increase health outcomes for the users of healthcare services (Carlstrom, & Gabrielsson 2021; Hosseini, et al., 2019; Symons; 2021; Werdofa et al., 2023).

Health Disparity

Health disparity can be broadly classified as the inequitable treatment received or accessed by a vulnerable population that induces poor health outcomes. Factors that usually lead to health disparity are sometimes based on the person's race, geographic location, socioeconomic status, age, gender, and physical or mental conditions (Edward et al., 2023; Mustanski & Macapagal, 2023; Savela et al., 2022; Wahid et al., 2022; Walters et al., 2023). Plethora work has been done and continues to hinder or minimize barriers that often prevent vulnerable populations from achieving their maximum potential (Savela et al., 2022).

Healthcare providers attending to persons who fall among the most vulnerable populations should assess and advocate to bridge the gaps in healthcare needs so these vulnerable populations can experience increased health outcomes (O'Brien et al., 2019; Mangione et al., 2022). This concept is vital to be explored because strategies must be implemented to increase positive social changes and health outcomes experienced by people who encounter health disparities in various communities (O'Brien et al., 2019; Jernigan et al., 2020; Mangione et al., 2022).

Mental Illnesses

The term mental illness refers to a condition that affects the individual's emotional, behavioral, or cognitive ability and prevents the person from functioning effectively with daily activities (Bhugra et al., 2013; Martínez-Martínez et al., 2020;

NIMH, 2019; Tse & Haslam, 2023; Rivera-Segarrnvia et al., 2019). Some of these symptoms can range from mild to severe and affect persons of various ages and backgrounds. Common mental illnesses are bipolar disorder, depression, anxiety, posttraumatic stress, schizophrenia, eating disorders, and addictive behaviors (Bowins, 2016; WHO, 2022). Mental illnesses occur within various age groups, socioeconomic status, gender, ethnicity, and geographic locations (Bhugra et al., 2013). Peter et al. (2021) posited that mental illness also had a broad definition encompassing personality or substance use disorder. Additionally, Huggard et al. (2023) had definitions that excluded substance abuse, neurological disorders formed during development, suicide, mental resilience, or quality of life.

Chronic Illness

Chronic illness is defined by Lebel et al. (2020) as an illness that persists on a long-term basis and can increase in severity as time progresses. Due to its often worsening effects, they are usually considered incurable, and an emphasis is placed on treatment/management of symptoms. This coincides with the definition provided by Jin et al. (2023), which stated that chronic illnesses persist longer than a year and that chronic illnesses reduce daily activities. Furthermore, the provided definition also outlines that chronic illness requires continual treatment. However, Nazarov et al. (2019) gave a more specific description when paraphrasing the World Health Organization. In this definition, chronic illnesses are non-communicable and persistently long. These diseases are derived from various factors, or a combination of factors which include genetics, behavior, environment, or the individual’s psychological state.

Summary and Conclusions

Extensive literature was conducted to define the theoretical frameworks for this study. Healing for the body, mind, and soul is crucial for promotion of increased health outcomes. Healthcare providers who provide care based on patients' preferences and unique needs are expected to promote person-centered care. Ensuring that patients are treated with respect regardless of ethnicity, age, gender, and physical or mental conditions is one strategy to prevent health disparities in order to improve positive health outcomes in vulnerable populations. My plan was to gain insights regarding lived experience of nurses who care for people with mental illnesses so knowledge may inform nursing practice and lead to positive health outcomes. Chapter 3 includes information about the research method I used for this study. The chapter includes information about the participant recruitment procedures, data collection, and data analysis.

Chapter 3: Research Method

A qualitative phenomenological study was conducted to gain an in-depth understanding of lived experience of nurses who provide care for persons with mental illnesses in an urban hospital in Canada. In this chapter, I outline strategies to execute sound and meaningful research. I explain my role as the researcher and provided details on methods to collect and code data as well as conduct a thorough analysis. I also include information about trustworthiness and ethical procedures.

Research Design and Rationale

A qualitative inductive phenomenological study was used to answer the following research question:

What are the lived experiences of nurses who provide care for persons diagnosed with mental illnesses who are admitted to general hospitals in urban Canada?

Patton (2015) posited that a phenomenological approach is used to explore how human beings make sense of their experiences; researchers are encouraged to use a phenomenological approach to understand individuals' perspectives. The hermeneutic phenomenological approach was chosen for this study because my aim was to gain new knowledge based on nurses' experiences providing care for persons who were involved in the phenomenon of interest. Stories that are told directly by individuals who have firsthand experience regarding the topic of interest provides researchers the opportunity to interpret and achieve understanding of the topic.

The quantitative design would not have captured participants' subjective experiences because it involves a measurable objective and includes numerical data to analyze variables (see Creswell & Creswell 2018).

Mixed methods were not appropriate because mixed methods include qualitative and quantitative approaches. My research did not require quantitative data. Therefore, mixed methods were not necessary. Patton (2015) posited the phenomenological approach is used to explore how participants' lived experiences are interpreted into logical thought processes. Van Manen (2014) postulated gathering text for interpretation is one way to generate new meanings involving the unknown through participants' lived experiences. A hermeneutic phenomenological design was used to collect rich data from the participants via a manual thematic process.

Role of the Researcher

The researcher's role varies based on the type of research being done. In qualitative phenomenological studies, researchers are the primary instrument (Ravitch & Carl, 2021). In this study, I was the primary instrument and data collector, transcriber, and thematic analyst and interpreter.

Purposeful sampling was used in a setting that was known to me. To avoid bias, unit secretaries sent emails with flyers to prospective participants. Participants were selected based on voluntary responses. Through reflexivity, I ensured my biases did not impact my findings. Researchers need to be cognizant of their affiliation with participants, especially when they are closely associated with the researcher, to avoid a power imbalance or fear of social pressure (Creswell & Creswell, 2018; Patton, 2015).

Before commencement of data collection, I obtained approval from my supervising committee, the Research Ethics Board (REB) of participant organization, and the Walden University Institutional Review Board (IRB). My other ethical responsibility was to ensure the research process did not commence until participants received an informed consent form and agreed to participate in the study after reading the consent form. I received participants' verbal consent to participate in tape-recorded interviews.

Additionally, unique identifiers were used to label data, all data were kept confidential, and information was used solely for the intended research purpose. Lastly, participants were notified they could withdraw at any point during interviews, and there were no obligations or penalties. According to Patton (2015), researchers are responsible for ensuring participants fully understand expectations of the study and their rights during participation.

Methodology

My goal was to explore lived experience of nurses who provide care for persons with mental illnesses in an urban general hospital in Canada.

Participant Selection Logic

A phenomenological hermeneutic approach was used. I solicited RNs who worked in a general hospital in urban Canada.

Participants in a medical unit were selected for interviews. Nurses who met inclusion criteria received an announcement email via the hospital's intranet. Participants were RNs who worked for more than 3 months in the general internal medicine or cardiology units, provided care for persons with mental illnesses, and were willing to share their experiences. I excluded RNs who had not worked in the general internal medicine or cardiology units for more than 3 months, had never provided care for patients diagnosed with mental illnesses and chronic illnesses, or were not willing to share their experiences.

The hospital's intranet was the primary platform for soliciting participants from general internal medicine and cardiology units because this platform is predominantly used for nursing-related communications. In the email to participants, I included a description of the study, the interview process, and consent. Consent forms were sent to prospective participants after they had voluntarily responded to emails and expressed interest in participating in the study. Prospective participants were informed of measures that would be implemented to keep their personal information confidential. Participants were also notified that information would be solely used for the study, and their information would be labeled with a nonidentifiable code so that there would be no way their data could be identified. Participants were also informed they could withdraw from the study at any time during the research process with no penalties or obligations. Prospective participants were notified and made aware that information they provided would be tape-recorded, and permission was required.

According to Creswell and Poth (2018), phenomenological studies usually involve three to 10 participants. Nine nurses who volunteered matched inclusion criteria. Data collection was discontinued when saturation was obtained, and no new data were seen. There is no need for researchers to continue collecting data if information does not provide new arguments or add value to previously collected data(Creswell & Poth, 2018; Ravitch & Carl, 2021).

Instrumentation

Researchers using a qualitative design and phenomenological approach must ensure that the instrument used is equipped and performing optimally so that data can be successfully captured without the worry about technical difficulties/ malfunctioning issues or concerns or accuracy (Patton, 2015). To ensure that I was prepared to capture rich data during this study, I used an interview guide with seven open-ended questions to facilitate follow-up probing questions based on the responses from the participants so that thick/rich data were collected. One-on-one interviews with open-ended questions were conducted via virtual interviews, each lasting 30 to 60 minutes, to elicit rich data from each participant.

Functional tape recorders were used to preserve the information collected in case of technical difficulties (Microsoft Word and handheld tape). Ravitch and Carl (2021) postulated that using a second tape recorder allows the interviewer to participate more attentively during the interview, and the investigator maintains a reliable source of verbatim information to facilitate data accuracy. A writing pad and a pen were also used and found to capture essential notes to add relevance-rich data collected. Microsoft/Excel was used to organize the verbatim data collected from the recordings; then, manual coding was completed to generate codes, categories, and derivation of themes (see Dalkin et al., 2021; Elliott, 2021 & Saldana, 2016). According to Ravitch and Carl (2021), researchers should read and re-read data carefully while ensuring that collected, analyzed, and interpreted data are free from biased answers that can be induced based on their positionality.

Procedures for Recruitment, Participation, and Data Collection

Upon receiving approval from IRB approval number 11-28-23-0321049, I began the recruitment process of the study. The units' secretaries sent emails to potential participants using a flyer. Invitation emails were sent to all RNs working in the cardiology and general medicine unit to obtain voluntary responses indicating their interest in participating in the study. The flyer contained pertinent information, including the purpose of the study, inclusion and exclusion criteria, my email address, and telephone number for further questions regarding the research study before the data collection period.

Participation

Upon receiving voluntary acceptance from the prospective participants, I forwarded a letter via email to the potential participants, extending my appreciation for their interest in participating in qualitative research. This form included further details about the research. A consent form was also attached to this email for the participants' revision. The consent form was later reviewed with the participants before verbal consent was received before the commencement of the interview. (see Appendix B). I also reiterated that their information will be kept strictly confidential, and only people directly involved in the research process would have access to the unidentifiable information. Participants were reminded that they were not obligated to continue if they wanted to discontinue at any point. Also, they were reminded that there were no obligations or penalties to discontinue.

The offering of the honorarium was not mentioned until the end of each interview, as this probably would have impacted the participation or information disclosure. Even with the best intentions of offering, giving a reciprocal token can lead to a negative impact even before the data collection starts; hence, gift giving should be done cautiously (Ravitch and Carl 2021). Thus, at the end of the data collection session, I received participants' permission to email a digital coffee card valued at $20.

Data Collection

During this study, data was collected to better understand the lived experiences of nurses who provide care to persons diagnosed with mental illnesses while admitted to a medical unit in general hospitals in urban Canada. Ravitch and Carl (2021) suggested that during the introduction phase of a purposefully sampled interview, it is recommended that all participants complete a demographic questionnaire (see Appendix A). These demographic questions were embedded in the interview guide and asked before the first interview commenced. This procedure followed the organization's eREB department directive (see Appendix A). The semistructured open-ended questions interviews were conducted according to the interview protocol (see Appendix A).

Patton (2015) delineated that open-ended questions can allow researchers to probe further for thicker data that may best answer the research question. I allowed the participants to choose the virtual platform for their interviews based on their preferences for using the telephone or Zoom. Participants were encouraged to select a comfortable and private place for the interview to feel relaxed while divulging information in the 30 to 60 minutes session. The participants all chose to be interviewed via telephone. This virtual platform prevented the inconvenience of participants traveling many kilometers to a central location for the interviews, eliminating time lost during commute and travel expenditure, which could be a barrier to participation (see Carter et al., 2021).

The dialogue with participants was initiated with a greeting (Appendix A). I allowed the participants to express any concerns or required clarification. I reminded the participants how their confidential information would be secured for this research purpose only. Their privilege to leave the interview at any moment without any obligation/penalty was reiterated, and they were reminded that their consent to tape record their voices was required.

At the end of the interview, I expressed my gratitude to the participants. I allowed them to ask any questions or concerns or clarify information related to the research study that was not addressed. According to Roberts (2020), it is important that the participants receive reiteration of their integral contribution toward the research goal and the knowledge gained that may help inform practice and increase patients' health outcomes. I referred the participants to ProQuest for the final study once it is published. I also received their permission to provide them with a token of appreciation sent to their email at work: a $20 card for Starbucks or Tim Horton based on their choices expressed.

Data Analysis Plan

Audio-recorded data was obtained from RNs working on a medical unit in a general hospital in urban Canada. The plan was to better understand the lived experiences of nurses who provide care to persons diagnosed with mental illnesses. Data was transcribed verbatim to Microsoft Word and then uploaded to Microsoft Excel. The method used for storing data facilitated ease during manual coding and analysis and was also user-friendly for graphic generation (see Bree & Gallagher (2016).

During the coding process, meticulous attention was drawn to the demonstration by Dr. Marcus from Walden University, LLC. (2016) and Saldana's (2016) first and second-cycle coding process. Coding strategies were predominately collated as words, short phrases, and contents of summaries. Rubin and Rubin (2012) and Walden University, LLC. (2016) suggested that when coding is done manually, it allows the researchers to delve more intensely into the data so that richer/thicker interpretations that are closely aligned with the lived experience of the participants can be drawn. Patton (2015) posited that data interpretation is not just about describing the data; more importantly, the essence is about creating strategies to generate meaningful interpretations and make sense of the reality being portrayed. Cresswell and Creswell (2018) also posited the importance of categorizing: coding data into chunks/groups based on their similarities and then labeling them into identifiable categories, further leading to the generation of themes.

Issues of Trustworthiness

According to Patton (2015), and Pedley (2022), trustworthiness is one of the key concepts that help researchers guide their study in the path where findings delivered from research remain free from biases. Trustworthiness can be made possible through reflexivity (Patton, 2015). Triangulation is another strategy that can be used to achieve credibility (Patton, 2015). Kelly (2022) posited that qualitative research is rigorous and systematic, indicating the potential to produce trustworthy results.

Credibility

Cardwell et al. (2019) suggested that clinical credibility is often used broadly. Credibility, as it relates to qualitative research, considers the scientific process used by the researchers to reach their results or a conclusion (Cardwell et al. 2019). Credibility was demonstrated during and after the data collection and compared against the audio recordings. (see Creswell & Creswell, 2018; Rubin; Rubin, 2012). Because the research was completed in a familiar setting, I ensured that reflexivity was utilized to ensure that my positionality did not cause my bias to skew the data collection and analysis process. I liaised weekly with my committee lead and committee members because they are experts in the field of research; hence, I relied on their insightful guidance.

Transferability

Qualitative results are not considered transferable because the generation of qualitative results is based on the unique interpretation of the researcher (Stahl & King 2020). Stahl and King (2020) further elaborated that each research result is different; even if a different researcher explores a similar phenomenon of interest, the results generated may differ as the results are based on the unique subjective interpretation of the researchers. Therefore, transferability in this research was justified through the documentation of detailed data collection strategies and the rigorous methods used during the analysis process to generate the best answers for the research question. Hence, during this purposeful sampling, I was able to explore the lived experience of nurses who provide care for persons diagnosed with mental illnesses and other chronic illnesses as I probe for rich/thick data from open-ended questions in the one-on-one interviews. Collated data was transcribed, coded, and used in a constant-comparative process to compare emerging themes against the audio recordings so that categories and themes were generated to identify the best answers for the research question (see Ravitch and Carl 2021).

Dependability

According to Tuval-Mashiach (2021), audit trails are vital strategies used in qualitative research to capture, log, and interpret data to maintain dependability. Furthermore, Korstjens and Moser (2018) and Ravitch and Carl (2021) identified research dependability as involving researchers scrutinizing findings. During this study, I used the currently recommended, most robust processes for data collection and maintaining documentation of the process through journaling. I liaised with my committee chair and other committee member for assistance as I relied on their expertise and support whenever there were any questions or concerns with the study proceedings. Also, I continued exploring the literature to better understand the work completed in this discipline related to my topic. According to Patton (2015), it is prudent for novice researchers to liaise with seasoned researchers to receive assistance; it is important not to reinvent the wheel but to continue the work done by previous scientists and to add new knowledge to the discipline.

Confirmability

According to Tuval-Mashiach, (2021), confirmability examines the extent to which the researcher's work can be confirmed. Researchers often use audit trials to verify the work's confirmability by examining the processes (see Korstjens and Moser, 2018). Therefore, I ensured that the data collection process continued until no new insight was noted in the additional data collected. Reflexivity was another strategy incorporated during the data collection and analysis session. The research study was completed in an organization that was familiar to me. Therefore, I was cognizant of my positionality, so that my biases did not interfere with the data collection or analysis process. Hence, with the inclusion of reflexivity, power imbalance and the risk of data compromise were eliminated/ minimized (see Rubin & Rubin 2012).

Ethical Procedures

During this research study, it was integral that my role as a researcher bears no ethical pitfalls; hence I abided by the ethical guidelines of Walden University's IRB Protocols. The organization of my prospective participants also has a Research Ethics Board (REB) department; hence, I must receive REB approval from the organization. Therefore, no data was initiated, and no research activities with the organization started; for example, no contact was made to potential participants until I received the REB approval from the organization and Walden IRB's approval. Because I am familiar with the organization where the participants were selected, I constantly remind myself of my positionality through reflexivity.

To ensure that power conflict does not impact the data collection or interpretation, I incorporated reflexivity into my research plan. Therefore, I was more cognizant of my biases and created strategies to prevent my biases from being held separately from the data interpretation in which the in vivo coding approach allowed me to use the verbatim statement from the participant to validate the research finding. Therefore, the inductive approach used helped me with the interpretation of data that was aligned with the live experiences of participants. No data was collected unless the volunteered participants met the inclusion criteria and provided verbal consent.

Information gathered from participants was without identifiable labels that could align with the participant’s identity. The participants' data were uploaded to a secured network to preserve their confidentiality. This network was uniquely password-coded and can only be unlocked by me due to the unique code. Notes taken were also shredded. Data will only be kept until the minimum expected time for which a researcher should keep the document. Then, all documents will be deleted permanently in the minimum expected time to be stored.

Summary

A detailed plan was developed to explore nurses’ lived experiences regarding care for persons diagnosed with mental illnesses in a general hospital in urban Canada. The phenomenological approach was used to guide this study. My roles as the researcher were established, followed by methodological strategies to find best answers to the research question. I addressed the participant selection process, instrumentation, data collection strategies, and data analysis and interpretation. I also addressed trustworthiness as well as ethical procedures.

Chapter 4: Results

The purpose of this qualitative phenomenological study was to explore lived experiences of nurses who provide care to persons diagnosed with mental illnesses in a general hospital within urban Canada. Researchers have investigated health disparities regarding decreased health outcomes in persons diagnosed with mental illnesses; however, lived experiences of nurses who provide care for patients who are diagnosed with mental illness have not yet been explored. In this chapter, I address the setting, participant demographics, data collection, data analysis processes, trustworthiness, and study results.

Setting

Upon obtaining the organization's REB approval and Walden University IRB approval to collect data, purposeful recruitment was used to recruit RNs from medical units in an urban hospital in Canada. The organization granted permission for potential participants to be contacted via email. Nine participants volunteered via email. All nine participants met inclusion criteria for the study.

Interviews took place virtually during convenient dates and times for participants. All nine participants elected to be interviewed over the telephone versus Zoom. Interviews took place virtually in environments that were most conducive for participants. Before initiation of data collection, participants were reminded that all information would be kept confidential. Also, they were not obligated to continue the study if they wanted to discontinue at any point.

Though this study was considered low risk study in terms of participant harm and all interviews were done over the telephone, as the principal investigator, I attempted to identify distress that could be heard in participants. However, there was no indication of distress from participants. Instead, participants sounded enthusiastic and expressed a profound interest in the phenomenon of interest. The average time of interviews was 35 minutes.

Demographics

Demographic questions were embedded in the interview guide as it was consensual information. Interview questions were also designed to determine participants’ eligibility to participate in interviews.

Data Collection

A phenomenological approach and purposeful sampling were used with nine participants who met inclusion criteria and volunteered to participate in the study. Participants were allowed to choose dates, times, and places that were most convenient and comfortable for them.

The research question that guided this study was: What are the lived experiences of nurses who provide care for persons diagnosed with mental illnesses who are admitted to general hospitals in urban Canada? Consent to participate in the study was verbally obtained through audio.

Semistructured interviews were conducted with open-ended questions, providing opportunities to probe further for richer data based on participants’ responses. Data collected from participants during interview sessions did not include identifiers such as their names, clients' names, or name of organizations.

During interviews, participants' rich data were captured using a handheld audio recorder. Data were transcribed in a secure network that had a unique password and could only be accessed by me for analysis. Saturation was achieved after collecting data from the first 6 participants. However, P7 provided new information. Hence, I explored additional participants for similarities and commonalities. Data from P8 and P9 was reviewed and aligned with P1, P2, P3, P4, P5, and P6, which indicated participants required increased knowledge involving mental health management skills, increased education, and support to provide positive outcomes for persons with mental illnesses.

Data Analysis

Collated data were transcribed and coded via constant comparison to compare themes. Verbatim transcribed data were used with audio recordings so that categories and themes were confirmed. Inductive data analysis was completed using Saldana's in vivo coding with first and second-cycle coding methods to thoroughly analyze participant data. I developed categories using Saldana's splitter method versus the lumping coding strategy, which led to theme generation. There were four major themes from data analysis: respect, autonomy, and empathy, healing environment and communication, advocacy, and support for nurses. Quotes from participants were used to support generated themes.

Evidence of Trustworthiness

During this study, multiple strategies were used to ensure trustworthiness was upheld.

Credibility was maintained throughout this study as generated themes were captured directly from audio. A constant-comparative process was completed to compare emerging themes against audio recordings.

Reflexivity was used to ensure my bias did not skew the data collection and analysis process. Also, there was no deviation from the methodological design as outlined in Chapter 3. I captured rich data related to lived experiences of nurses who provide for persons with mental illnesses.

Transferability was maintained during this study to ensure there were no deviations from methodical strategies as outlined in Chapter 3. Therefore, transferability research was justified through documentation of detailed data collection strategies and rigorous methods during the analysis process that generated best answers for the research question. Thick and rich data from participants were collected. Collated data were transcribed, coded, and used via a constant-comparative process to compare emerging themes with audio recordings to generate categories and themes to identify the best answers for the research question.

During this study, vital strategies were used to ensure dependability was achieved. Data included semistructured interviews with open-ended questions to facilitate probing questions. Accurate documentation was maintained throughout the process via verbatim transcription and journaling.

Furthermore, the coding process was aligned with consistent guidelines, hence generating dependability. Expert scrutiny from my committee lead and committee member was encompassed throughout the entire process from the collection of data to the analysis of data. These actions, executed to maintain dependability, are also aligned with the postulation of Tuval-Mashiach (2021).

Confirmability through reflexivity was one of the fundamental strategies that was incorporated in this study to ensure that confirmability was achieved. While collecting rich data, cognizance of the effects of positionality was embedded throughout the study processes. Therefore, a greater emphasis was utilized to achieve reflexivity as one of the main tools used in collecting and analyzing the participant data.

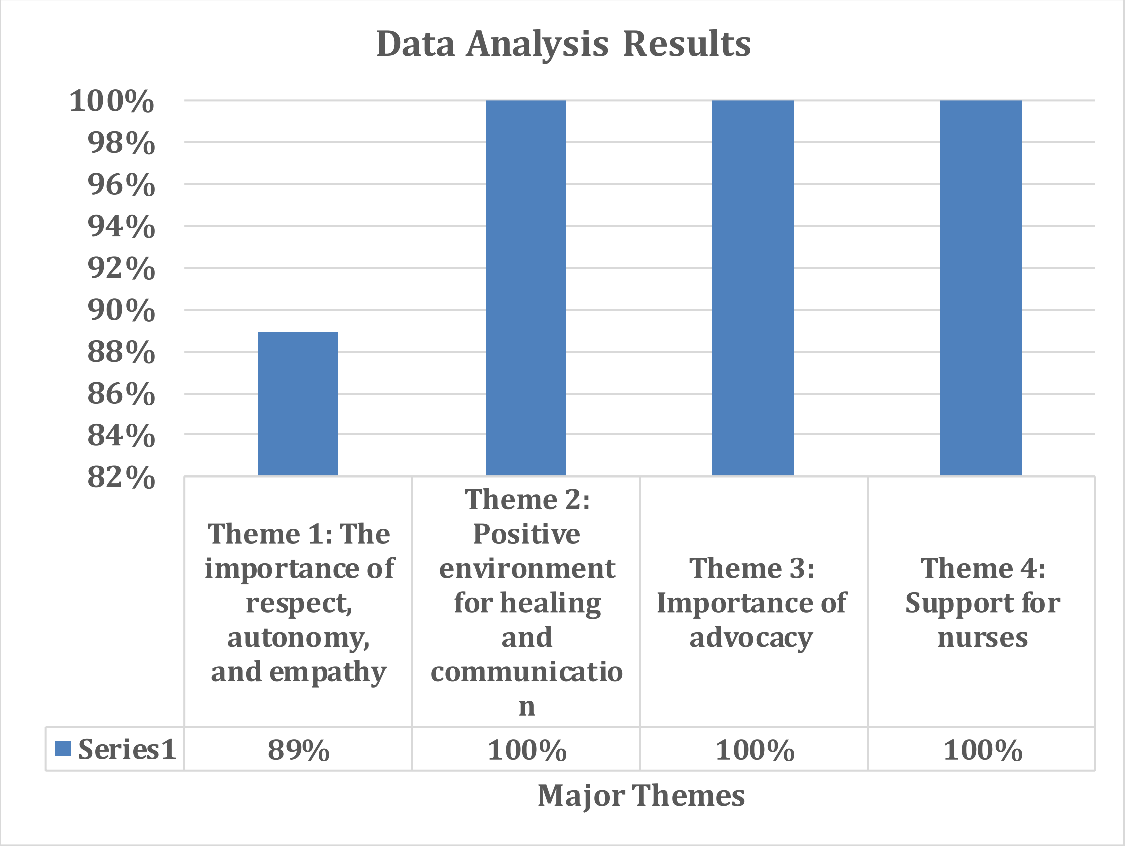
The research study was completed in a setting known to me. Therefore, I was cognizant of my positionality so that my biases did not interfere with the data collection or analysis process. There were no concerns about power balance as no subordinates were involved during the recruitment or collection of data proceedings. Therefore, biases were kept in check to minimize incidences of compromise or skew collection or data analysis proceedings (Creswell & Creswell, 2018; Rubin; Rubin, 2012).

Results

Four dominant themes were generated accompanied with the execution of manual verbatim data transcription: (a) The importance of respect, autonomy, and empathy (b) Positive environment for healing and communication (c) he Importance of advocacy (d) support for Nurses**.** Verbatim quotes were extracted through constant-comparative process to compare emerging themes against the audio recordings so that categories and themes were generated to identify the best answers for the research.

Figure 1

Major Themes



Theme 1: Importance of Respect, Autonomy, and Empathy

One of the major themes identified in the collated data was respect, autonomy, and empathy. Participants expressed their thoughts regarding the importance of respect, autonomy, and empathy deployed in nursing practices towards persons diagnosed with mental illness. Some of the participants' direct quotes, which indicated their experience regarding respect, empathy, and autonomy directed to persons diagnosed with mental illnesses, encompassed the following: P1 verbalized that patients should be able to make informed decisions and should not be dismissed but instead be honored “if the patient says no, respect the no” P2 further delineated that all patients should be treated with “respect and dignity ”. P3 statement was also aligned with P1, indicating empathy and respect to patients who are diagnosed with mental illnesses; participants stated, “It is no fault of their own why they are mentally unwell”. Furthermore, P9 posited that “regardless of patients’ beliefs, all patients should be respected”. This postulation of P9 was validated in a direct quote: “Getting to know them is getting to know their beliefs, also getting to know their fears”. P6 stated, “If they are resistant to care, maybe they are sensitive to certain situations. Probably, there is a better time to do this. Respect them when they say no, so I would follow their lead and talk to them calmly. We have to listen to what they are saying without being judgmental”. P8 posited that persons from different backgrounds have different belief practices; hence, respecting the patients' beliefs is important as the participant stated, “The ….. always prefer female assistance to help them with their bathing/ washing because ….. always prefer female; also, we ask that their family take their own cultural food they might not like the Canadian food, right?”. P7 expressed the empathy practiced by colleague’s daily are exemplary skills delivered to persons diagnosed with mental illness “Incredibly empathetic”.

Theme 2: Positive Environment for Healing and Communication

The second major theme generated from the collated data was a positive environment for healing and communication. Participants agreed that increased communication and a healing environment is important for persons diagnosed with mental illnesses. Spending time to know your patients and validating their experience helps to promote a safe and healing environment. Verbatim responses from some of the participants are as follows. P6 explained, “The patient had track marks, and she said she lost so many children to Children’s Aid. So, I think the best thing is to be nonjudgemental. I want her to be comfortable. I try not to bring even no unconscious biases into my approach. So, it is best to be equal across the board whether they are suffering from mental illness or not. One of the things that matter most is safety”. P2 also added, “Creating a healing environment for a patient diagnosed with mental illness is important”. P6 expressed that “first of all, I would start by saying that for patients with mental illness, it is important to keep a calm, quiet environment keeping a calm environment where patients can hear their own thoughts, for example, a patient who comes in with schizophrenia /has a history of schizophrenia might not be taking their meds, and now they are in relapse, hence hearing voices and other people talking, they might think that they're speaking about them.”

P8 shared the importance of keeping a calm environment for patients’ mental illness: “So we have to give them the antipsychotic medication before 4:00 pm to calm them down. So another thing that we do in this section of the unit is turn on the music so they can listen to soft music, sometimes they have to watch movies to relax them, and sometimes the personal support worker (PSW) take them for a walk”. P1 added “bedside nurse is not involved; I might hear that psychiatry just see the patient, but they're not speaking with me”. P5 expressed the importance of opening a conversation with patient a. P5 posited that “not only does communication encourage a therapeutic relationship with patient but also helps patient to understand the rationale for interventions implemented”. P5 further explained verbatim that “explaining everything or saying like why we need to do certain things or if they don't want to do something like why that is. A lot of times, it's just that they don't really understand why we're doing things”. P5 also postulated that the Transfer of Accountability is a catalyst to prevent or minimize the risk of re-traumatization of patients.P5 postulated, “I also like sometimes I’m given in the notes that had like previous, you know like bad experiences, with certain, you know healthcare situations or stuff like, that so I always try to make sure that I'm not you know like re-traumatizing someone, especially when they have mental illnesses”. P8 posited the importance of communicating with patients, for example: when the patient with mental illness has diabetes and the complications. P8 stated, “Sorry, I am not a counselor, but if I have time, I would sit down and explain to them the complications of diabetes; for example, they need to understand what is going to happen to them.” P6 stated, “It is very difficult to find a good trusting rapport when you need to rush.” P3 further delineated that there is a lack of counseling in the community given to patients with mental illness; hence they come in the hospital when they are in poor conditions as verbalized that “I think it more about complex situation because, most of these issues strike from outside of the hospital so if there is not enough counseling and support outside of the hospital by the time they get into hospital for treatment such as like a wound care, they have deteriorated so bad, that you can't treat the wound itself.”

Theme 3: Importance of Advocacy

The importance of advocating for patients with mental illness was one of the salient themes that was generated from the rich data collated. Participants provided rich information about their experiences. (a) the importance of patients continuing psychiatric medications in a timely manner to possibly prevent escalation of psychosis so that they may agree to get well-needed treatment like antibiotics. (b) Increased advocacy for harm reduction, such as nicotine patches, so that patients may not leave the units to smoke and hence miss their treatment. For example, patients missing blood sugar checks, insulin administration, and wound care therapy. Increased advocacy is noted for spiritual care as an outlet for patients' emotional needs while medical care needs are met. (c) More advocacy for interdisciplinary teams, spiritual care, social needs, and financial needs to be advocated for. P6 postulated, "So they are on anti-depressant, antipsychotic, and anti-anxiety, and all of a sudden, they are getting nothing? P3 posited, "So there's no way to provide for the physical care if somebody is actively schizophrenic in the hospital and they have diabetes and we're not treating the schizophrenia the person might just keep coming back to the hospital all the time because their blood sugars are not controlled. So you have to treat schizophrenia so that you can be able to manage their diabetes, then you get a balance". P6 expressed, "So I would encourage them to stay for treatment for those who want to go for cigarettes. I would encourage them to stay, and I would call the doctor so that I could get a nicotine patch for them to stay so that we can get treatment, for example, getting antibiotics into you".

P5 delineated the need for continued advocacy for patients " I know a lot of times we have an occupational therapist (OT) or the care transitions facilitator (CTF)/social worker come to see the patient, and sometimes you know they help them to get them stuff, like activities to do here at the hospital or like the TV stuff that helps you know to enhance their experience at the hospital which also helps them you know be more willing to like come back”. P2 expressed it is important to “collaborate with the multidisciplinary team to identify the different needs the patient have and then reported report to the doctor.” P1 stated, “Does the patient need to speak to anyone? The patient may need spiritual care, psychiatric care, and a social outlet. The patients sometimes say I haven't seen anyone for weeks. I might go call the daughter of Mrs. X daughter and say, do you live in X. I think she's lonely and just longing to see someone. I might call spiritual care and just have them just speak with the patient about how they are feeling, because it is my job as a nurse”. P8 Stated involved family as a care “We have to ask them what they like at home like playing music listening to music and writing. All those things basically, we have to involve family in their care plan**”.**

Theme 4: Support for Nurses

Support for nurses was one of the focal themes generated from participants’ data. Study participants expressed the need to have more knowledge in the area of mental illnesses. The participants expressed the needs as follows: P6, “more clarity as well, for example, there are Form 1, Form 3, and Form 42. What do these forms entail? What is the Health Care Consent Act? P9 suggested that increased insight about how to effectively care for persons with mental illness could be as follows: “Nurses should get time to spend/ to go on the psych. unit to see how things are in that unit. How the nurses care for patients on the mental health units as well.” P4 stated, “I feel limited, I don't know how to talk to them, I don't know how to pacify, I don’t know how! P7 stated, “I will be also interested in any educational opportunities that come up in the unit”.

P5 stated, “Sometimes it's a bit stressful because you don't want to say the wrong thing or do something that they don't trust you anymore. So that part I find kind of difficult or sometimes it's hard like I feel a little bit stressed out to manage”. P7 delineated that “I’m thinking about a patient that I saw two months ago who was having hallucination and was shouting and was making one of my co-workers stressed out”. P6 divulged “I feel overwhelmed at times because it takes so much of your time. You want to have therapeutic communication it is a very important part of their healing. P8 explained a near-miss situation when she had to physically jump between a patient and his wife who were having a physical encounter. P8 stated “But I know I was risking my life, I don't even think myself, I feel like I was having an…… attack”. P9 further delineated that “like if psych was able to come in and assess the patient, especially for nurses working on the night shift, I think it would be nice if you know, at times, we could have patients showing those types of behaviors like aggressive and the nurses are not able to deal with it”. P2 impressed on the need to debrief sessions. The verbatim data support this theme are as follows: “I feel good caring for them and so on, but I'm scared of the violent ones. Leaders should listen to people’s concerns regarding their problems, probably at least twice a week”.

Summary

Salient themes from data analysis were used to answer the research question. These themes highlighted experiences involving providing care for persons with mental illnesses. They indicated there is a need for interventions to improve nursing practices and health outcomes of persons with mental illnesses.

This chapter includes data results and analysis proceedings. The setting, participants, data collection, results, and evidence of trustworthiness were addressed. Chapter 5 includes a comprehensive analysis of research findings, study limitations, recommendations for further research, and implications for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this hermeneutic phenomenological qualitative study was to explore lived experiences of nurses who provide care for persons with mental illnesses because nurses provide the most hands-on treatment to patients in most healthcare organizations, which impacts patient outcomes.

This study was conducted to identify and address gaps involving lived experiences of nurses who provide care for persons with mental illnesses in an urban general hospital in Canada. Results of this study indicate potential ways to inform the practices of nurses in this setting and possibly improve health outcomes for persons with mental illnesses.

During this study, four themes were generated from rich data related to this topic: importance of respect, autonomy, and empathy, positive environment for healing and communication, importance of advocacy, and support for nurses. Chapter 5 includes interpretations of findings and limitations of the study, recommendations for future research, and potential implications for social change.

Interpretation of the Findings

Findings provided integral knowledge in addition to peer-reviewed literature in Chapter 2. Participants divulged their multifaceted experiences, which demonstrated that vulnerable populations such as persons with mental illnesses should not be treated with a judgmental approach, but instead should be listened to attentively so that their stories can be understood and treated with respect and dignity. Respect for vulnerable populations should not include care that ignores holistic care and increases health disparities, as persons needing healthcare should be treated as if they were family (Liddell, 2023; Sampaio, 2017; Santori, 2021).

Participants expressed the importance of expressing empathy to persons with mental illness as they stated it was not the fault of persons with mental illnesses why their behaviors were challenging; hence, they should be seen as mentally ill and thus should be treated empathetically. Empathetic care allows clients to gain autonomy over their care and facilitates their ability to achieve self-actualization and lead to positive outcomes.

Study findings indicate the need for nurses to be supported due to stressors they encounter while providing care for persons with mental illnesses. Martínez-Zaragoza et al. (2020) postulated nurses are exposed to daily stressors with risk factors that impact their performance and patient health outcomes.

Findings of the study were used to address positive environments for healing. Participants emphasized the importance of ensuring patients are kept comfortable in quiet and relaxing environments while fulfilling their spiritual, mental, and physical needs. Positive health outcomes can only be achieved if human biological, psychological, social, and spiritual elements are met (Kaya et al., 2022; Rogers, 1965; Watson, 2018). Furthermore, Kaya et al. (2022) suggested the absence of these components will likely promote disease or impair health outcomes. Study findings also illustrated that advocating for needs of persons with mental illnesses is crucial. Healthcare providers attending to the most vulnerable populations should bridge gaps in healthcare needs so vulnerable populations can experience improved health outcomes (Mangione et al., 2022; O’Brien et al., 2019). Participants expressed the need for support involving many aspects of nursing care due to challenges they experienced. Emotional support with debrief sessions was needed when stressful events occurred. Nurses also requested in-services and educational sessions to learn more about mental illnesses, treatment, and behavior management strategies. Shahpar et al. (2023) stated nurses with lived experiences involving providing care for persons with mental illnesses find it challenging and require support. Organizations that facilitate healing environments for their staff promote health for healthcare providers (Shahpar et al., 2023; Wei et al., 2018). Martínez-Zaragoza et al. (2020) claimed daily stressors that are experienced by nurses impact their performances and patients' health outcomes.

Limitations of the Study

Participants volunteered from a medical unit and provided care for patients with mental illnesses who also had other chronic health conditions such as diabetes and cardiovascular diseases. However, my goal was to have participants who volunteered from two medical units. However, participants only responded to recruitment emails from one of the medical units. Results may not be generalizable to all medical units in urban hospitals in Canada.

Recommendations

The purpose of this hermeneutic phenomenological qualitative study was to explore lived experiences of nurses who provide care for persons with mental illnesses in an urban hospital in Canada. As healthcare sectors continue to strategize holistic care via Person-centered care approaches, it is important for leaders to better understand how nurse practices can be better supported to enhance positive health outcomes for persons with mental illnesses. Results of this study indicated there is a need to explore barriers nurses encounter involving delivering optimal care for persons with mental illnesses effectively. Further investigations should be undertaken to understand nurses' experiences in other urban hospitals in Canada. Findings from research can be used to inform nursing practices and improve health outcomes for this population.

Implications

The findings of this study include the potential implications of promoting positive social changes to inform nursing practices and the increased health outcomes of persons who are diagnosed with mental illnesses. From a nursing level, increased advocacy for more collaborative team involvement to meet the unique needs of patients can be explored. Further research can use these collated data to identify strategies to promote nursing education to gain a greater understanding of mental illnesses. Also, identified strategies to support/address nurses' emotional and physical stressors can be further explored.

From a patient level, further research execution to gain greater insight into the patients diagnosed with mental illnesses' perceptions/perspectives of the care they receive from nurses in Canada's urban hospitals may provide insightful findings on how to inform future healthcare providers' practices. Also, strategies to achieve more timely reconciliation of antipsychotic medication for patients admitted with medical illness and mental illness.

Gaps identified in this study could also be used to conduct further research that may inform healthcare organization leaders how to implement strategies to decrease frequent readmissions of persons diagnosed with mental illnesses, reduce hospital length of stay for persons diagnosed with mental illnesses, and how to possible decrease the financial burden of the organization as care is provided for persons diagnosed with mental illnesses.

Conclusion

The magnitude of rich data collected from nurses who provide care for persons diagnosed with mental illnesses who are admitted in an urban general hospital in Canada generated meaningful, insightful, and valuable knowledge about the nurses" experiences while they provide care to persons diagnosed with mental illness.

The findings validated meaningful insights into why it is important for the discipline of nursing to model practices that demonstrate respect, autonomy, and empathy, to facilitate a positive environment for healing and communication, the importance of advocacy and the implementation of measures to optimally support nurses to provide the highest quality of care for persons diagnosed with mental illnesses. Acknowledgment of the limitation of the study was delineated, and recommendations presented uncovered suggestions for future research opportunities to identify additional findings in the discipline that may inform nursing practices and also increase the health outcomes of persons diagnosed with mental illnesses. The study’s implications included positive changes that can be achieved not only at the bedside level but also applied to the organizational level, as well as other implications for future research to be explored in other urban hospitals in Canada.

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Appendix A: Interview Guide

Parts of The Interview	Interview Questions
Introduction	Hello …… My Name is Luwieth Bolt. Thank you for taking the time to consider participating in this interview; your time is greatly appreciated. This interview aims to understand more about the lived experiences of nurses who provide care for persons diagnosed with mental illnesses who are admitted to a general hospital in urban Canada. As I mentioned in your invitation letter, all information divulged today will be kept confidential and used solely for research purposes. Hence, only those involved in this investigation can access your identifiable information. Furthermore, I would like to remind you that the interview is scheduled for 30-60 minutes. If, for any reason, you would like to discontinue this interview/participate in this interview, you are at liberty to do so with no obligations or penalties incurred. We do not want to identify your responses as belonging to you. You will not be asked to provide your name or any other piece of information that identifies you during the recording. To protect your

	identity, please do not provide your name or any other piece of information that identifies you in your responses. Do you have any questions or concerns? Do you consent to continue in the study? Before we start this interview, I would like to ask a few demographic-related questions. Do I have your permission to do this? I would like to have your consent to tape-record the conversation during the interview. Do I have your permission?	
You are eligible to participate in the study if the following demographic questions apply to you.	Do you currently work in the cardiology/General Internal Medicine unit as a RN?	
	Have you worked for more than 3 months on the cardiology/medicine unit?	
	Do you provide care to patients with both medical and mental illnesses?	
	Would you be willing to share your experiences about providing care for patients diagnosed with mental illnesses?	

	Research Questions:	
Question #1	Can you please tell me how long you have been working as a registered nurse in general internal medicine unit/cardiology unit, and can you please describe what your typical day entails as you provide care to your assigned patients?	
Question #2	Tell me about your experience providing care for persons with mental illnesses?	
Possible probing questions based on their responses: Question # 3	You shared that..xxxx tell me more about…. providing care to patients diagnosed with chronic physical and mental illnesses?	
Possible probing question: Question # 4	You mentioned….xxx please tell me more about your feelings about providing care to patients diagnosed with mental illnesses but admitted with medical illnesses?	
Question # 5	If they share this….tell me more about how you provide holistic care to your assigned patients?	
Question # 6	Can you describe how you demonstrate human care to your assigned patients?	

Question # 7 Any additional questions will be probed based on their responses; each will be unique.	Tell me, how do provide care to persons diagnosed with mental illness to support patient-centered care?
Closing Remarks	
Are there any questions or concerns you have for me at this time? If not, I want to use this opportunity to thank you for your time and for sharing this opportunity for me to learn about your experiences providing care for persons with both mental and physical illnesses. The rich information you have provided will help us gain more knowledge into the discipline of nursing and possibly inform nursing practice to improve patients' outcomes. With your permission, I will send you an electronic coffee shop card valued at $20.00 by email. Would you prefer Tim Horton's or Starbucks? Thank you again for the time you have taken to speak with me. Your willingness to assist me in conducting this interview is greatly appreciated. Please have a good day.	

Appendix B: Recruitment Email to Potential Participants

Hello *Potential Participant Name*,

My Name is Luwieth Bolt, and I am a Ph.D. student enrolled at Walden University. Firstly, I would like to extend my appreciation for your interest in participating in this qualitative research. This study is being done so that greater understanding can be achieved from the lived experiences of nurses who provide care to patients diagnosed with mental illnesses and also experience other chronic medical illnesses.

Please see attached the letter of information and consent for more information about the study.

You are eligible to participate in this study if you meet the following criteria:

- You currently work in the cardiology/medicine unit as a registered nurse.
- You have worked on the cardiology/medicine unit for at least 3 months.
- You provide care to patients with both medical and mental illnesses.
- You would be willing to share your experiences.
- You would be willing to be interviewed on the telephone or on Zoom.

If you are interested in scheduling an interview, please respond to this email with the times you are available and whether you prefer to be interviewed over the telephone or by Zoom.

At the time of the interview, the attached consent form will be reviewed with you, your verbal consent to participate will be obtained, and the above eligibility criteria will be verbally confirmed with you.

Again, thank you for your interest in participating in this study.

Sincerely,

Luwieth Bolt

PhD-Student Walden University