SITUATION AWARENESS IN MENTAL HEALTH NURSING

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In this special issue of the Shared Learning in Clinical Practice newsletter, the authors discuss the concept of situation awareness, applying it to the practice of mental health nursing.

Situation awareness is defined as a practitioner’s ‘perception of the elements in the environment in a volume of time and space, the comprehension of their meaning and the projection of their status in the near future’. Early origins of the concept were established to explain a pilot’s cognitive ability to gather, sort, and process information from their immediate environments at the time of flight and in the context of dynamic decision-making. According to Endsley¹, situation awareness forms a practitioner’s total state of knowledge of a scenario; it is a practitioner’s snap-shot or total understanding of a situation. This snap-shot is brought about by three cognitive stages of processing: Level 1 – perception of cues; Level 2 – comprehension of cues; and, Level 3 – projection of what cues mean for the future¹. And it is this mental picture that informs subsequent decisions of the practitioner.

Situation awareness is largely studied in areas where practitioners operate in environments that are dynamic, complex and challenging, and require them to identify and understand cues to make decisions. As such, the concept has increasingly been a focus of research in health practice settings. One such area is that of nursing practice and the involuntary admission decision²,³.

The involuntary admission decision is a complex health practice that occurs regularly and has potential human rights consequences, but is not yet fully understood². It is the ability of a medical practitioner or a specially trained health professional to decide whether or not a person needs to be admitted involuntarily for further mental health assessment and/or treatment.

The ability for specially qualified practitioners, including nurses, to make the involuntary admission decision remains a central component of contemporary mental health legislation worldwide⁴. How specially qualified mental health nurses make the involuntary admission decision requires careful consideration, as the decision is one of great impact – with potentially both positive and negative consequences¹,⁵.

In 2005, the World Health Organisation (WHO) stated that involuntary admission was a vital method of ensuring that a person ‘attains their right to health’³ (p. 46). However, admitting someone against their will is also recognised to adversely impact a person’s autonomy, liberty and their human rights²,⁵.

Consider the following:

You’re an advanced practice mental health nurse working in the emergency department. Sophia⁶, a 14 year old girl, attends the emergency department. She tells you her parents separated 18 months ago and they now have share access to Sophia across both households. Recently Sophia’s grades have slipped; she mentions that she was usually an ‘A’ student, but now she’s a ‘B’, ‘C’ student.

Sophia was once a keen netball player, but nowadays she is not keen to play this or any other sport. There are also noticeable changes in her sleeping. She looks tired, drawn and lethargic. Her parents will see her go to bed late in the evening (usually around 11.30pm). They also hear her getting up in the early hours of the morning (usually around 3.30am). Whenever she gets up in the early hours of the morning, Sofia sits in the lounge room, in the dark. When invited to explain this in more detail she denies having any problems. She says she is ‘just thinking’, and ‘just a bit tired’.

Sophia also has a decreased appetite. Once she was very conscientious about her diet, only eating healthy, non-processed foods. For the past three months she has ceased eating healthily. Parents note that she is now eating almost only junk food, chocolate and sweets. She does not seem to care anymore about what she is eating. When asked about this she says, “I don’t care…it doesn’t matter anymore.”

Sophia has started cutting her forearm over the past month. Her mother brings her to the emergency department in the early hours of the morning seeking help after finding her sitting in the dark at home saying, “I hate my life. I can’t cope with life, going to school, doing my assignments.” Sophia makes no eye contact. She is wearing long full body track suit. Her hair is untidy. She is withdrawn, flat and easy to tears.

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²Patterson, C., Procter, N. & Toffoli, L. 2016, ‘Situation awareness: when nurses decide to admit or not admit a person with mental illness as an involuntary patient’, Journal of Advanced Nursing, vol. 72, pp. 2042-2053
³Patterson, C., Procter, N. & Toffoli, L. (in press 2016), ‘When I say… situation awareness’, Medical Education
When approached by the student nurse on clinical placement she breaks down crying, saying in a low voice, “Life is just not worth living…it’s all too hard. You can’t do anything for me, you know”. Concerning the self-harm, Sophia says to the student nurse in a slow voice, “Cutting…it makes me feel better. I feel alive when I cut. It helps me not to think about things. I feel it’s a relief for me”. The student nurse is told by Sophia’s mother that her daughter is not wanting her legs to be seen while getting dressed and is only wearing long sleeves, even when it is warm. This is unusual. The student nurse also picks up on this as Sophia is invited to adjust her shirt sleeve for a blood pressure reading. Sophia’s mother is worried that she might be cutting herself in other parts of her body.

What cues did you identify? What are the multiple inputs you receive, what do they mean to you and why? How did your understanding of the situation described above lead to a decision about what to do next?

As the conversation between Sophia and the nurse deepened, safety planning and comfort emerged at the point of care. Sophia was admitted to hospital as a voluntary patient. Understanding how to respond to Sophia and her mother in the context of her situation was important for both therapeutic engagement as well as facilitating safety and comfort in mental health nursing practice. At a deeper level of analysis such activity can also provide greater insight into complex health practices of engaging with a person in suicide related distress in the emergency department. Defining how and where situation awareness cues are interpreted and what they mean for the future, also helps generate important insights and formulation of viewpoints; what catches our ear, our eye, and our senses really at the time of clinical assessment. Therapeutic engagement with a person in suicide and self-harm distress is a complex multi-layered activity. Situation awareness brings an additional framework to understand the decision-making process and our place in terms of what could or should happen next. By highlighting levels of information processing by the mental health nurse at the time practice, we are also deepening our understanding of what informs the decisions we make and why. Such understanding is important in its own right as well as the identification of environmental cues, their potential meaning, and related, subsequent decisions. In this way, practitioners can develop ways to become situationally aware.

The Shared Learning in Clinical Practice Philosophy

Shared Learning in Clinical Practice is a policy relevant and service delivery focussed collaboration to promote best practice in mental health and develop professional skills. The strategic purpose of the initiative is to demonstrate through research and practical example, how much consumers, clinicians, policy makers and academic faculty can achieve working together. Deep discussion, deep connectivity and diffusion of the insights are central to its philosophy. Multidisciplinary in composition, the aim of each publication, podcast, film and symposium is to capture and spread new ideas and know-how in mental health practice and challenge traditional ways of thinking.

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