

Category Status Conversations in the Psychiatric Context

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Thesis Abstract

Background

Patients with mental illness often experience stigma and marginalization, which affects the quality of their healthcare. In most settings, end-of-life decisions, including goals of care, must be discussed with all patients upon hospital admission. This includes determining cardiopulmonary resuscitation preferences, in the event of a medical emergency. Despite this requirement, category status conversations do not routinely occur in psychiatry. It is common for psychiatric inpatients, including those at high risk for cardiac or respiratory arrest, to be admitted, cared for, and discharged without their category status known or documented. By default, patients become a ‘full code status’, which mandates life-sustaining interventions, including CPR. Unwanted interventions are often unsuccessful and inappropriate. They might also cause harm through increased pain and suffering or have no medical benefit.

Aim

To explore how and why category status conversations occur, or do not occur, for patients admitted to psychiatry.

Methods

This was a descriptive qualitative study, with data collected through two semi-structured focus groups. Nine nurses working in psychiatry, representing two campuses of a larger tertiary care academic hospital in Ottawa, Ontario participated. Elo and Kyngäs’s approach to inductive content analysis was used to analyze the verbatim transcripts of the focus group discussions.

Findings

Findings reveal the shared experiences of nurses initiating and engaging in category status conversations with patients admitted to psychiatry. Four overarching categories were

identified: '*The Psychiatric Culture*', '*Being a Psychiatric Patient*', '*Physical Health Status*', and '*Suggestions and Recommendations*'. Participants spoke about important considerations for the advancement of knowledge regarding category status conversations in psychiatry, including the nurse's role in category status determination, the challenges of implementing a 'one-size fits all' approach to category status policies, and the ways in which HCPs perceptions of patients who are receiving care for depression or suicidal ideation influence these conversations in psychiatry.

Conclusion

Nurses working in psychiatry care for patients with complex medical and psychiatric comorbidities, who are also sometimes older and frail. Category status determination for these patients is complicated and often the documented status is based on clinician presumption rather than consultation with the patient. Although the importance of completing category status conversations with patients admitted to psychiatry is known, they seldomly occur, and there is ambiguity about the nursing role within the psychiatric context. Efforts are needed to improve nurses' contributions to category status determination for patients admitted to psychiatry, to ensure that patients' preferences are known and upheld. Further, there are illness-related factors that complicate typical processes used to discuss and identify patient preferences, such as suicidal ideation and minimal family support. These considerations must be accounted for in hospital policy if meaningful practice change is expected.

Co-Authorship

1. Amanda Vandyk RN, PhD, Associate Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa

As my thesis supervisor, Dr. Amanda Vandyk co-authored each chapter of the thesis and provided guidance on the overall thesis design including conceptualization of the study. Amanda provided a substantial contribution to the overall development of the final document.

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As a member of my thesis committee, Dr. Jean Daniel Jacob co-authored each chapter of the thesis, assisted in conceptualizing the qualitative study, and provided guidance and recommendations on the overall thesis design.

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As a member of my thesis committee, Dr. Mark Kaluzienski provided valuable content expertise, knowledge, and guidance, with particular contribution in facilitating the execution of the thesis study.

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Table of Contents

Thesis Abstract	ii
Co-Authorship	iv
Acknowledgements	v
List of Tables	x
Chapter One – Introduction	1
Introduction	2
Contextual Considerations and Personal Impetus	3
Research Purpose	5
Organization of the Thesis	5
References.....	7
Chapter Two – Literature Review	10
Literature Review.....	11
What is Mental Illness	11
Types of Psychiatric Disorders – An Overview	12
Psychotic disorders	12
Mood disorders	13
Neurocognitive disorders	13
Anxiety disorders	14
Personality disorders	14
Feeding and Eating disorders	15
Substance-related and Addictive disorders	15
Psychiatric Treatment	16
Recovery	16
Hospitalization	18
Community Treatment Orders	20
What Do We Know About Medical Comorbidities?.....	21
Psychotropic medications	21
Physical Disorders and Life Limiting Conditions	22
Cancer	22
Cardiovascular disease	23

Metabolic disorders	24
Immediate Medical Emergencies.....	24
Anticholinergic crisis	24
Neuroleptic malignant syndrome	25
Serotonin syndrome	26
Agranulocytosis	26
Delirium	27
Substandard Care	28
Consent and Capacity	29
End of Life Decision Making and Category Status Conversations	31
Category Status Conversations in an Acute Care Context	34
Category Status Conversations in Psychiatry	35
Theoretical Framework.....	39
References.....	43
Chapter Three – Methods	68
Methods.....	69
Qualitative Research	69
Paradigmatic Stance.....	70
Research Design	70
Research Setting	71
Sampling Strategy.....	72
Sample Size	73
Eligibility Criteria.....	73
Recruitment.....	74
Ethics	75
Data Collection	76
Data Analysis.....	77
Trustworthiness.....	78
References.....	80
Chapter Four – Findings.....	83

Findings.....	84
Participants Characteristics	84
Categories and Subcategories	84
Category 1: The Psychiatric Culture.....	85
Nurses role.....	87
Category 2: Being a Psychiatric Patient	90
Fluctuating competency.....	92
Suicidal ideation/Depression	95
Category 3: Physical Health Status.....	96
Category 4: Suggestions and Recommendations.....	100
Chapter Five – Discussion	103
Discussion	104
Attribution Theory	105
The Nurses Role in Category Status Determination	106
No One Size Fits All Approach to Category Status Conversations in Psychiatry.....	111
Suicidal Ideation/Depression and the Completion of Category Status Conversations .	116
Nursing Implications.....	118
Implications for Practice	118
Implications for Policy	120
Implications for Education	121
Implications for Research	122
Strengths and Limitations of the Thesis Study	123
Conclusion	125
References.....	127
 Appendix A – Recruitment Script	 137
Appendix B – Recruitment Poster	138
Appendix C – Minimal Risk Informed Consent.....	139
Appendix D – Interview Guide.....	144

List of Tables

Chapter Four, Findings

Table 1: Categories and Subcategories	145
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Chapter One

Introduction

Introduction

All patients admitted to hospital have a right to express their end-of-life (EOL) choices, including their goals of care and cardiopulmonary resuscitation (CPR) preferences (i.e. category status) in the event of a medical emergency (McKean et al., 2015). These informed decisions are made through discussion with their providers; and they are imperative to ensure wishes regarding life-sustaining measures are known by the healthcare team and substitute decision maker(s) (SDMs) (Dunlay & Strand, 2016; You et al., 2014). According to the College of Physicians and Surgeons of Ontario (CPSO) policy ‘Planning for and Providing Quality End-of-Life Care’, physicians *must* endeavour to understand what is important to their patient regarding treatment decisions, in order to ensure that their goals of care are understood, and quality care is provided (CPSO, 2019). Thorough discussions regarding what is important to the patient while hospitalized promotes sound decision-making and patient-centered care (Dunlay & Strand, 2016), while empowering patients to play a role in the decision-making process (Elwyn et al., 2012). Locally, our hospital policy stipulates that all persons admitted to hospital have a documented category status within 72 hours of admission (The Ottawa Hospital [TOH], 2019a).

With respect to goals of care and patients’ wishes, category status discussions refer to the level of medical interventions and measures taken in emergency situations (Szmuiłowicz et al., 2012). The typical category statuses used in hospitals include: ‘Full Code’, ‘Do Not Intubate’, ‘Do Not Attempt Resuscitation (‘Do Not Resuscitate’), and ‘Comfort Measures Only’. Full Code is when all life-sustaining measures, including resuscitative treatment, are provided. Do Not Intubate is full treatment, but with no insertion of an advanced airway. Do Not Attempt Resuscitation (DNAR) or Do Not Resuscitate (DNR) means that resuscitation (chest compressions) will not be attempted; however, all other desired treatment is provided as

appropriate. Lastly, Comfort Measures Only entails providing treatment to promote comfort, without any life-sustaining and/or prolonging measures (Mittal et al., 2014). While these determinations are mostly standardized, it is important to note that they are nuanced and context-specific depending on the healthcare setting. Further, a category status is designed to be part of a holistic plan of care and not utilized as ‘*all or nothing*’ criteria against which all medical decisions are made. A DNAR/DNR does not imply that healthcare professionals will *do nothing* in the event of a patient deterioration or change in status (Heitkemper, 2014). Equally, Full Code does not imply that healthcare professionals will continue life-sustaining interventions on a patient for whom they determine they are nonbeneficial (Downar et al., 2019).

Despite the obligation to determine and document a patient’s category status, in psychiatry, these conversations do not routinely occur. As such, patients requiring psychiatric inpatient care are often admitted to hospital without a record of their desired life-sustaining measures (Warren et al., 2015). HCPs working in psychiatry care for patients with complex medical and psychiatric comorbidities, who are also sometimes older and frail (Mental Health Commission of Canada, 2012). This is problematic because the medical instability of persons with mental illness is often overlooked, and their respective rights to refuse life-sustaining treatments are omitted. Clear documentation of category status discussions, including identification of patient goals and values prior to any sudden deterioration is thus very important (Ahmed et al., 2011). Additionally, understanding patient’s EOL decisions allows HCPs to inform all care delivered in a holistic way, while avoiding unwanted interventions and promoting patient autonomy and dignity (Chittenden et al., 2006).

Contextual Considerations and Personal Impetus

The local tertiary care hospital's policy stipulates that a category status should be discussed as part of the overall treatment plan for patients admitted to hospital. The discussion should take place at the earliest convenience upon admission and be clearly documented in the patient's medical record (TOH, 2019a). After a critical incident involving a patient admitted to psychiatry at this hospital, a brief scan of the remaining inpatient's charts revealed that conversations regarding category status and subsequent documentation was not complete for most patients. Interestingly, many of these patients were diagnosed with complex medical comorbidities, including heart disease, diabetes, cancer, Parkinson's, and dementia. These observations shed light on an important local practice gap.

As a Registered Nurse (RN), I have worked in a variety of clinical areas including psychiatry. While I have some experience working in psychiatry, my primary area of focus is vascular surgery, which is an environment offering healthcare to high acuity patients who have complex critical illnesses. I have provided care to a population of patients prone to complications, specifically stroke, amputations, and unstable chronic conditions like diabetes, heart failure, and peripheral artery disease. This clinical perspective provides me with an interesting lens when thinking about category status determination in psychiatry, because I have lived this phenomenon in another context where the presumption and views of physical health and illness differ. I have noted when working on the inpatient psychiatric unit that most patients do not have a documented category status and thus, by default, are assumed to be 'full code'. Yet, these patients are often diagnosed with multiple comorbidities and taking psychotropic medications, many of which are known to have serious side effects (Khasawneh & Shankar, 2014; Marano et al., 2011). As an RN, not knowing the patient's wishes or their category status increases my level of discomfort when providing patient care. Thus, I developed a particular

interest in category status conversations within the psychiatric context. Upon reviewing the literature, I found that there was scant amount of research completed on the topic of category status discussions for psychiatric inpatients, and therefore, I sought to explore this phenomenon further.

Research Purpose

The purpose of the proposed study was to explore how and why category status conversations occur, or do not occur, for patients admitted to psychiatry. The research question of interest was: “What are the experiences of HCPs initiating and engaging in category status conversations with patients admitted to psychiatry?”

Organization of the Thesis

This thesis is composed of five chapters and is presented in a traditional style. Chapter One provides a brief introduction to the thesis, including contextual considerations as well as my personal impetus for the study, the research purpose, and the organization of the thesis. Chapter Two describes a review of the literature on the current issues surrounding mental illness and category status conversations. The theoretical framework used to guide and inform the research study is also outlined. Chapter Three describes the methods used in the study, including the research design, paradigmatic stance, research setting, sampling strategy, sample size, eligibility criteria, recruitment strategies, ethics approval, data collection, and data analysis procedures. In addition, strategies to ensure rigour and trustworthiness of the study are described. Chapter Four presents the main findings of the qualitative study exploring the experiences of HCPs initiating and engaging in category status conversations with patients admitted to psychiatry. Chapter Five summarizes the thesis and includes a discussion of the study findings as well as the study’s

strengths, limitations, implications for practice, policy, education, and future research directions.

Chapter Five is followed by a conclusion, references, and appendices.

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Chapter Two

Literature Review

Literature Review

In this chapter, I present the literature relating to the issues surrounding mental illness and category status conversations. An overview of mental illness, along with the types and prevalence of psychiatric disorders are discussed. This is followed by a discussion of general psychiatric treatment, of which is dependent on the type and severity of the mental illness. The prevalence of medical comorbidities among people with mental illness is described, highlighting the importance of category status conversations in psychiatry. Lastly, the concepts of consent, capacity, and category status conversations in psychiatry are explored, including the attitudes of healthcare providers (HCPs) towards initiating these conversations.

The topics addressed and expanded upon provide a landscape of what we generally see within psychiatry.

What is Mental Illness

Mental illness, also referred to as psychiatric disorders, are health conditions involving changes in an individual's emotions, thinking, and behaviour (or all three). Mental illnesses are often associated with distress and may interfere with an individual's social, work, or relational functional abilities (American Psychiatric Association [APA], 2019; Canadian Mental Health Association ([CMHA], 2020a). According to the World Health Organization (WHO) (2018a), one in four people are affected by psychiatric disorders in the world, making these disorders the leading cause of disability worldwide. There are a variety of different mental illnesses, including psychotic disorders, mood disorders, cognitive disorders, anxiety disorders, personality disorders, eating disorders, and substance-related and addictive disorders. Each mental illness presents its own characteristics of symptoms; however, symptoms in general and across disorders may include loss of motivation and energy, marked changes in sleeping and eating

patterns, extreme mood swings, disturbances in thought or perception, or overwhelming obsessions or fears (CMHA, 2020a). Mental health professionals (i.e. nurses and physicians, among other HCPs) utilize their clinical judgement and the information provided in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to diagnosis psychiatric disorders and provide appropriate care to individuals with mental illness (APA, 2013). The DSM-5 is used to categorize mental illnesses and for each illness, it provides a general description and a list of typical symptoms (Regier et al., 2013).

Types of Psychiatric Disorders – An Overview

Psychotic disorders. Psychotic disorders are severe and complex psychiatric disorders that cause abnormal thinking and perceptions. Examples of psychotic disorders include schizophrenia and schizoaffective disorder (Clarke, 2015). Approximately 360,000 Canadians have some form of schizophrenia and three percent of the population will experience psychosis at any given time (Schizophrenia Society of Canada, 2018). These disorders are characterized by distortions in thinking, perception, emotions, sense of self, and behaviour (WHO, 2019). The classic signs and symptoms of psychosis include hallucinations, delusions, disorganized speech, thoughts, or behaviour, social withdrawal, incoherent speech, restricted emotional and facial expression (flat affect), and difficulties with concentration and reasoning (Centre for Addiction and Mental Health [CAMH], 2015; Clarke, 2015). There is no typical clinical presentation or course of illness for psychotic disorders. For some individuals, the illness onset is slow and insidious; for others, it is sudden and unpredictable (Clarke, 2015). Symptoms are also highly variable from one individual to another, and may vary from episode to episode (CAMH, 2015; Clarke, 2015). Acute psychosis is often considered a psychiatric emergency due to a higher risk

of self-harm and suicide. Individuals with psychotic disorders may have significant problems functioning in society, at work or school, and in relationships (Clarke, 2015).

Mood disorders. Mood (or affective) disorders are characterized by the presence of sad, empty, or irritable moods, accompanied by somatic and cognitive changes that disrupt an individual's capacity to function (Hayne, 2015). Examples of mood disorders include major depression and bipolar disorder. Affecting approximately 3.5 million Canadians (Statistics Canada, 2015a), individuals with mood disorders often live with severe, long lasting symptoms. Symptoms include feelings of hopelessness, psychomotor agitation, mania, suicidal thoughts, and disruptions in sleep, appetite, concentration, and energy (CMHA, 2020b), which cycle through periods of remission and exacerbation. Additionally, mood disorders rarely occur independent of other psychological disorders, including anxiety disorders and substance abuse. The presence of comorbid disorders exacerbates the clinical and social consequences of mood disorders and makes treatment more challenging. These disorders can cause changes in an individual's behaviour and affect a person's ability to deal with routine daily activities such as work or school (APA, 2013; Hayne, 2015).

Psychotic disorders and mood disorders, which are typically labelled as serious mental illnesses (SMIs) are mental, behavioural, or emotional disorders resulting in significant functional impairment and limitation in one's ability to perform major life activities (National Institute of Mental Health [NIMH], 2019).

Neurocognitive disorders. Neurocognitive disorders are characterized by deficits in cognition or memory that represent a decline from a previously attained level of mental functioning (APA, 2013; Forbes & Austin, 2015). Examples of neurocognitive disorders include delirium and dementia, which most commonly occur in adults ages 65 years or older (Gangull et

al., 2011; Sachdev et al., 2014). There are approximately 76,000 new cases of dementia diagnosed in Canada annually (Government of Canada, 2017a). The signs and symptoms of these disorders typically include a disturbance in baseline cognition (i.e. attention, awareness, memory deficit, disorientation, visuospatial ability, language, or perception). Some neurocognitive disorders are short-term and reversible (ex. Delirium) where others are long-term and progressive (ex. Alzheimer's disease), the latter leading to a gradual cognitive decline that interferes with an individual's functional abilities and daily life (Forbes & Austin, 2015).

Anxiety disorders. Anxiety disorders are characterized by intense, excessive, and persistent feelings of anxiety or fear. Examples of anxiety disorders include generalized anxiety disorder and obsessive-compulsive disorder (CMHA, 2016). These disorders are some of the most prevalent among all mental illnesses and affect approximately one in ten Canadians (Government of Canada, 2009). Common symptoms include irrational and excessive worrying that disrupts daily functioning, apprehensive and tense feelings, irritability, and restlessness (APA, 2013; CMHA, 2016). The symptoms can interfere with daily activities such as job performance, socializing, and are difficult to control. These disorders are often chronic and without good management can significantly impair an individuals' ability to function socially, occupationally, and personally (Hegadoren & Lasiuk, 2015).

Personality disorders. Personality disorders are characterized by maladaptive and inflexible patterns of thinking, functioning, and behaving. Personality disorders affect between six to 15 percent of the Canadian population (Statistics Canada, 2015b). Currently, there are ten personality disorders recognized in psychiatry, which are organized into three clusters according to similar characteristics and symptoms. Cluster A includes paranoid, schizoid, and schizotypal personality disorders. These are characterized by paranoid, distrustful, odd, and suspicious

thinking or behaviour. Cluster B includes impulsive personality disorders, such as antisocial, borderline, histrionic and narcissistic personality disorders. These are characterized by having difficulty controlling emotions, desires, fears, and anger. Cluster C includes obsessive-compulsive, avoidant and dependent personality disorders and are characterized by anxious, fearful thinking or behaviour (Austin, 2015; CMHA, 2020c). Generally, individuals with personality disorder have difficulties with interpersonal relationships, which can lead to social isolation, alcohol or drug misuse (Tyrer et al., 2015).

Feeding and Eating disorders. Feeding and Eating disorders involve a preoccupation with food, weight, and appearance. Examples of feeding and eating disorders include anorexia nervosa, bulimia nervosa, and binge-eating disorder (NIMH, 2016a; Weaver, 2015). Individuals with these disorders often experience severe disturbances in their eating behaviours, as well as disturbances in related thoughts and emotions. Approximately one percent of Canadians are affected by anorexia nervosa (Statistics Canada, 2015c), while binge-eating disorder affects about two percent (CMHA, 2020d), and bulimia nervosa affects one to three percent of women (Statistics Canada, 2015c). Common signs and symptoms include a fixation with weight, food, calories, dieting, interference with psychosocial functioning, and extreme mood swings (APA, 2013; Weaver, 2015). These disorders often manifest from a need to cope with distress or regain a sense of control in one's life. Specifically, an unconscious attempt is made to numb out intense emotions through inadequate or excessive food intake (CMHA, 2020d). Feeding and eating disorder behaviours are associated with significant morbidity and mortality (CMHA, 2020d; Weaver, 2015).

Substance-related and Addictive disorders. Substance-related and Addictive disorders, for example, include substance use disorders (SUDs) and nonsubstance behavioural addiction

disorders. Addiction is a complex process where problematic patterns of substance use or behaviours can interfere with an individual's life. To understand and describe addiction, the 4Cs approach is used to evaluate craving, loss of control of amount or frequency of use, compulsion to use, and continued use despite consequences (CAMH, 2020). SUDs are classified by ten drug classes including alcohol, cannabis, phencyclidine, hallucinogens, opioids, inhalants, sedatives, tobacco, stimulants, and other/unknown substances. Diagnosis is substance specific, (i.e. alcohol use disorder) (APA, 2013), and individuals diagnosed with a SUD exhibit maladaptive patterns of behaviour related to substance use (Kunyk & Els, 2015). Substance use often results in serious, enduring, and costly consequences, including compromised physical and mental health, reduced quality of life, abuse, increased motor vehicle accidents, suicide attempts and fatalities, or overdose deaths (McLellan, 2017). In Canada, more than 12,800 opioid-related deaths occurred between the years of 2016 to 2019, (Government of Canada, 2019) highlighting the prevalence of SUDs. Nonsubstance behavioural addictions disorders include for example, pathological gambling or internet addiction (Pinna et al., 2015; Yau & Potenza, 2015). Individuals with behavioural addictions and those with SUDs both share core features such as repetitive engagements and emotional dysregulation leading to impaired functioning and adverse psychosocial consequences (Grant et al., 2010).

Psychiatric Treatment

As seen in the aforementioned text, mental illnesses can take many forms. Due to this variability, treatment is usually individualized and dependent on the type and severity of the mental illness.

Recovery. Healthcare providers use a strengths-based approach to underpin mental health recovery (Mental Health Commission of Canada, 2015). The Recovery Model, also

known as recovery-oriented practice, is a holistic, person-centered approach to psychiatric care, which places emphasis on shifting focus away from a person's deficits and disabilities (an illness perspective) and concentrates upon their strengths, abilities, capacities, and aspirations (recovery perspective) (Snow & Davis, 2015; Thornicroft et al., 2016). Specifically, recovery-oriented practice is tailored towards symptom management and generally targets a person's goals while considering their social and life circumstances (Dixon et al., 2016). For example, the therapeutic goal for people with severe and persistent mental illnesses, such as schizophrenia or bipolar disorder, may be to help them engage in and regain functioning in their life (Snow & Davis, 2015), rather than 'cure' their illness (Grant et al., 2017). The individual is encouraged to take personal responsibility for their part in recovery and is empowered in a process that focuses on strengths, peer support, and respect (Dixon et al., 2016; Mental Health Commission of Canada, 2015). The hallmark principle of this model is the belief that people can recover, regain functioning, and lead meaningful and satisfactory lives despite experiencing ongoing symptoms of their mental illness (Snow & Davis, 2015; Waldemar et al., 2016).

Recovery-oriented practice is predominately based in outpatient and community mental health settings (Waldemar et al., 2016). Due to the complex and chronic nature of psychiatric disorders, the majority of individuals with mental illness require on-going care (Dixon et al., 2016). According to the WHO (2018b), community mental health services are associated with continuity of care, are more accessible and effective in comparison to hospital settings, provide better protection of human rights, and increase adherence to treatment. These services enable individuals with mental illness to develop, maintain and/or regain their social and life skills while still having the ability to remain in their community and receive ongoing treatment.

There is no one-size-fits-all approach to psychiatric treatment; however, clinical management generally takes place in the community setting rather than in a hospital. Care often consists of a combination of psychotropic medications (antipsychotics, antidepressants and mood stabilizers), and behavioural therapy (Snow & Davis, 2015). Although most mental illnesses cannot be cured, symptoms can be managed with effective care in order to provide the individual with the ability to function in work, school, or social environments (Biological Sciences Curriculum & National Institutes of Health, 2007). Access to outpatient treatment, rehabilitation, and support services is imperative to reduce inpatient hospitalization (WHO, 2009).

Hospitalization. Individuals experiencing severe symptoms of a mental illness may require hospitalization, which is a critical component for the restoration of their functional and independent living (Health Canada, 2002). Hospitalization for the treatment of psychiatric disorders is often a critical treatment decision involving intensive intervention and is considered the most restrictive setting for the provision of mental health care (Pollard, 2015). Regardless, individuals suffering from acute psychiatric symptoms are often admitted to hospital (Byrne, 2007; Harvey et al., 2008). The various purposes of hospitalization include stabilizing the patient, adjusting medications, and ensuring safety of self and others (Loch, 2014; National Alliance on Mental Illness, 2019). Generally, inpatient treatment is reserved for acutely ill patients (Pollard, 2015). The most prevalent mental diagnoses among hospitalized inpatients are psychotic disorders, mood disorders, and neurocognitive disorders (Statistics Canada, 2015d). In 2017 to 2018, hospital stays due to neurocognitive disorders made up the largest proportion of days spent in psychiatric hospitals; accounted for 147.99 days, followed by schizophrenia and psychotic disorders at 99.71 days, and mood disorders at 35.92 days (Canadian Institute for Health Information, 2019).

Individuals with mental illness may be voluntarily or involuntarily hospitalized. Involuntary hospitalization refers to when the patient is detained in a psychiatric facility due to a perceived risk of danger towards self or others (CAMH, 2018; Ministry of Health and Long-Term Care, 2016a). A study completed by Lebenbaum et al. (2018) found that the prevalence of involuntary psychiatric admissions to hospitals have increased. Specifically, nearly three-quarters of all psychiatric hospital admissions in Ontario are involuntary. Involuntary patients are often brought into the hospital without consent under the Mental Health Act (MHA) and ‘formed’ (i.e. a physician order to safely manage mental health illnesses) (Ontario Hospital Association [OHA], 2016). In Ontario, a Form 1 allows a physician to hold an individual in a psychiatric facility for up to 72 hours in order for them to undergo a psychiatric assessment. The physician must then determine whether the person needs to be admitted for further care and supervision in a general hospital psychiatric unit, as an involuntary or voluntary patient, or if they should be released and discharged (Ministry of Health and Long-Term Care, 2016b). An involuntary patient will be detained and placed on a Form 3 (Certificate of Involuntary Admission) for up to two weeks; however, treatment cannot be forced without a patient’s consent. At the time of admission, involuntary patients who are found incapable of consenting to treatment will also be given a Form 33 (a written notice to the patient of a finding of incapacity). After a Form 33 is issued to a patient, a Form 50 can be filled out by a Rights Advisor to confirm the patient was given rights advice (Ministry of Health and Long-Term Care, 2016b; OHA, 2016). Incapacity to consent is often associated with psychosis, treatment refusal, severity of symptoms, involuntary status, and older age (Okai et al., 2007).

Voluntary hospitalization refers to when a patient decides, in partnership with a physician, to receive psychiatric care and treatment. Voluntary patients are presumed to have the

capacity to make decisions about their treatment options and personal health information on the basis of informed consent (Ministry of Health and Long-Term Care, 2016c). Patients can either be admitted voluntarily for observation and treatment, or a physician may change a patient's involuntary status to voluntary, under a Form 5 when their condition improves (OHA, 2016). Whether on an involuntary or voluntary basis, hospitalization for the treatment of mental illness can greatly contribute to an individual's sense of safety and provides the environment required to cope with their illness (Loch, 2014; OHA, 2016).

Community Treatment Orders. A Community Treatment Order (CTO) under the MHA, is a physician's order for a person to receive continuing care or treatment, support, and supervision in the community (Kent-Wilkinson, 2015; OHA, 2016). CTOs serve individuals with serious mental illness (SMI) who have a history of repeated hospitalizations, and who would otherwise decompensate in the community, or be likely to cause harm to themselves or others (Kent-Wilkinson, 2015; Ministry of Health and Long-Term Care, 2016d). A CTO is based on a comprehensive community treatment plan that is developed by the doctor and agreed to by the person who is subject to the plan (and/or their substitute decision maker [SDM]). The plan outlines the medications, medical appointments, and other aspects of care that are necessary to allow the person to live in the community, rather than remain in the hospital (Ministry of Health and Long-Term Care, 2016d). Failure to comply with the community treatment plan can result in the physician issuing an Order for Examination (Form 47), which authorizes the police to apprehend the person to the hospital for an assessment (OHA, 2016). This treatment option may reduce multiple readmissions and involuntary hospitalizations by providing individuals with access to the community, while living under medical supervision to ensure a better quality of life (OHA, 2016; O'Reilly et al., 2019).

What Do We Know About Medical Comorbidities?

Comorbidity is often the rule rather than the exception for individuals with psychiatric disorders (Sartorius, 2007). Approximately 25 percent of the adult population are diagnosed with a mental illness, of which, 68 percent also have a medical comorbidity (Šprah et al., 2017); highlighting the prevalence of physical health problems among people with mental illness. According to the CMHA (2020e), mental and physical health are fundamentally linked. Individuals living with SMIs are at higher risk of developing a wide range of chronic physical conditions. Conversely, individuals with chronic physical health conditions are more likely to develop mental health concerns. Co-existing mental and physical health conditions can diminish quality of life, leading to longer illness duration and worse health outcomes (CMHA, 2020e). Individuals afflicted with SMIs have a higher incidence of poor physical health, which may include a wide range of serious and chronic medical comorbidities. Compared to the general population, the life expectancy of individuals with SMI is shorter by approximately 15 to 25 years. High morbidity and premature mortality are mainly due to physical illness, specifically comorbid medical conditions such as cancer, cardiovascular disease, and metabolic disorders. It is estimated that 50 to 80 percent of individuals with SMI have one or more comorbidities that may worsen prognosis and lead to mortality (Bahorik et al., 2017; De Hert et al., 2011). Contributing factors that influence the development of poor physical health are due to a combination of psychotropic medications, socioeconomic disadvantages, as well as disparities in healthcare (Bahorik et al., 2017; De Hert et al., 2011; Lawrence & Kisely, 2010).

Psychotropic medications. The most common psychiatric medications used to treat mental illness include antidepressants, antipsychotics, anti-anxiolytics/sedatives, and mood stabilizers (NIMH, 2016b). Antidepressants are generally categorized according to the

mechanism of action (ex. selective serotonin reuptake inhibitors or monoamine oxidase inhibitors) (Hegadoren & Lasiuk, 2015; Hillhouse & Porter, 2015). Antipsychotic medications are grouped as typical or first-generation antipsychotics (ex. chlorpromazine or haloperidol) and atypical or second-generation antipsychotics (ex. olanzapine or clozapine) (Honkola et al., 2012). The most common sedative medications are called benzodiazepines, which include alprazolam, lorazepam, and clonazepam. Lastly, mood stabilizing medications include lithium and anticonvulsants (valproic acid, carbamazepine) among others (Hegadoren & Lasiuk, 2015). While these medications are useful for minimizing psychiatric symptoms, they are also associated with (sometimes serious) adverse effects and can further increase the risk of physical disorders or life-limiting conditions such as cancer, cardiovascular disease, and metabolic disorders (Correll et al., 2015). In addition, some psychiatric medications may be associated with potentially life-threatening complications that lead to immediate medical emergencies such as anticholinergic crisis, neuroleptic malignant syndrome, serotonin syndrome, agranulocytosis, and delirium (Forbes & Austin, 2015; Kim, 2016; Tse et al., 2015; Wilson, 2015).

Physical Disorders and Life Limiting Conditions

Cancer. Individuals with SMI have higher cancer mortality than those of the general population (Weinstein et al., 2016). Specifically, people with mental illnesses suffer a disproportionate burden associated with physical comorbidities, leading to worse outcomes once cancer is diagnosed (Lawrence et al., 2015). The incidence of mortality in persons with schizophrenia who develop cancer is reported to be three times higher than those in the general population with cancer (Barley et al., 2013). In addition, the use of psychotropic medications, specifically antipsychotics, may contribute to the risk of hormone-related cancers in psychiatric patients. Most first-generation antipsychotics significantly elevate serum prolactin levels, which

promote breast cancer and endometrial cancer risk. Patients with elevated prolactin levels typically have quicker disease progression and lower survival rates (Weinstein et al., 2016). Furthermore, a study completed by Hippisley-Cox et al. (2007) found a marked increased risk of colon cancer in individual's with schizophrenia prescribed antipsychotic medications. Overall, cancer represents a major cause of excess mortality for people with mental illness (Lawrence et al., 2015).

Cardiovascular disease. There is an increased risk of cardiovascular disease (CVD) associated with psychotropic medication (Mackin et al., 2008; Marano et al., 2011). CVD includes conditions such as atherosclerosis, aneurysm, cerebrovascular disease, angina, heart attack, myocarditis, peripheral vascular disease and stroke (Marano et al., 2011). Many psychotropic medications have undesirable side effects such as weight gain, dyslipidemia, hypertension, and diabetes, which substantially affect cardiovascular health; leading to a risk of cardiovascular mortality (Khasawneh & Shankar, 2014). In persons with schizophrenia, CVD is the leading cause of death (Olfson et al., 2015). The use of psychotropic medications, particularly antipsychotics and antidepressants, are also strongly associated with an increased risk of sudden cardiac death (Honkola et al., 2012; Marano et al., 2011). Certain antipsychotics such as haloperidol and thioridazine can induce prolongation of the QT interval and can predispose a patient to develop a life-threatening ventricular arrhythmia (Marano et al., 2011; Nachimuthu et al., 2012). Moreover, the prescribing of antipsychotics in the elderly with dementia is associated with adverse events such as acute cardiac events and greater mortality (Ralph & Espinet, 2018). Psychotropic medications have several serious cardiac side effects that can contribute to a reduced quality of life and a worse illness course (Khasawneh & Shankar, 2014; Marano et al., 2011).

Metabolic disorders. The majority of psychotropic medications contribute to the high prevalence of medical comorbidity in individuals with SMI. Medications such as antipsychotics, antidepressants, and mood stabilizers increase a person's risk of weight gain. Approximately 60 to 80 percent of people taking antipsychotics experience medication-induced weight gain (Correll et al., 2015), leading to increased obesity rates and cardiovascular events in patients with schizophrenia and other SMI patient groups (Bahorik et al., 2017; De Hert et al., 2011). In addition to weight gain, antipsychotics are also associated with a higher risk of developing metabolic complications (impaired glucose metabolism, increased cholesterol, and triglyceride levels) subsequently leading to the development of diabetes mellitus (DM) (Correll et al., 2015). Evidence suggests that the prevalence of DM in individuals with schizophrenia and bipolar disorder is two to three times higher compared with the general population (Bradshaw & Mairs, 2014; De Hert et al., 2011). Of the antipsychotics, clozapine and olanzapine are specifically associated with an increased risk of developing DM. Complications associated with DM include risk of blindness, renal failure, amputation, and cardiovascular disease, which are significant causes of increased morbidity and mortality among people with SMI. Equally, antidepressants increase the risk of DM due to hindering side effects such as sedation, increased appetite, and weight gain (Correll et al., 2015; De Hert et al., 2011). Individuals suffering from depression are noted to have an approximately 40 to 60 percent increased risk of developing type two DM (Robinson et al., 2018).

Immediate Medical Emergencies

Anticholinergic crisis. Anticholinergic crisis is a potentially life-threatening medical emergency caused by an overdose or sensitivity to drugs with anticholinergic properties, including tricyclic antidepressants and some atypical antipsychotics. The syndrome may occur in

psychiatric patients who are receiving therapeutic doses of anticholinergic drugs in combination with other psychotropic drugs that produce anticholinergic side effects (Tueth, 1994; Wilson, 2015). Clinical manifestations are caused by central and peripheral nervous systems effects, which can lead to physical and mental impairment. The signs and symptoms of anticholinergic crisis include increased heart rate, widely dilated eyes, blurred vision, warm and dry skin, fever, confusion, agitation, hallucinations, delirium, and seizures (Lieberman, 2004; Wilson, 2015). Older persons are especially vulnerable because they are oftentimes prescribed multiple medications with anticholinergic effects. If left untreated, the associated fever and delirium may progress to cause serious medical complications such as coma or cardiac and respiratory depression (Wilson, 2015).

Neuroleptic Malignant Syndrome. Neuroleptic malignant syndrome (NMS) is a rare but life-threatening reaction associated with the use of antipsychotic medications. The syndrome is characterized by distinctive clinical symptoms, which include high fever, altered mental status (confusion to coma), muscle rigidity, sweating, and fast heart rate (Tueth, 1994; Wilson, 2015). The medications most often associated with NMS are typical antipsychotics (ex. haloperidol, chlorpromazine, and fluphenazine) and atypical antipsychotics (ex. clozapine, risperidone, and quetiapine) (Tse et al., 2015). NMS may occur at any time during antipsychotic drug treatment, even after recent discontinuation of the drug. However, onset is often within a few weeks of starting the medication (Strawn et al., 2007). Although NMS can affect all age groups, most cases occur in young and middle-aged men (Kwei & Frucht, 2017). Tse et al. (2015) found that 63 percent of male patients with a mean age of 45.1 years were affected by NMS associated with typical antipsychotics. Among patients receiving antipsychotics, NMS remains a significant source of morbidity and mortality. Failure to recognize and promptly diagnose the syndrome can

be fatal, with mortality estimated to be approximately 20 percent (Kwei & Frucht, 2017; Strawn et al., 2007).

Serotonin syndrome. Serotonin syndrome is a potentially fatal condition resulting from an accumulation of medications in the body that impact serotonin levels (Volpi-Abadie et al., 2013). Common medications associated with serotonin syndrome include antidepressants and mood stabilizers (Kim, 2016). Clinical presentation is extremely variable, ranging from mild to severe life-threatening symptoms. The symptoms are described as the triad of altered mental status (agitation, anxiety, disorientation), neuromuscular excitation (tremors, muscle rigidity, hyperreflexia) and autonomic dysfunction (hypertension, tachycardia, diaphoresis, vomiting). The wide range of symptoms reflects the degree of serotonin toxicity; however, due to the variable and nonspecific nature of its presentation, serotonin syndrome can be difficult to diagnose and easily overlooked (Kim, 2016; Wang et al., 2016). Older patients who have multiple comorbidities and a higher rate of polypharmacy are at an increased risk for the development of serotonin syndrome (Wang et al., 2016).

Agranulocytosis. Agranulocytosis is an acute condition involving a severe reduction in the number of granulocytes (white blood cells, most commonly neutrophils) required to fight infection in the body. It is the most dangerous hematological side effect of psychiatric medication, putting individuals at risk for serious fatal infections (Andrès et al., 2011; Tueth, 1994). Patients with agranulocytosis may present with a sudden fever, chills, weakness, sore throat, or mouth ulcers. A lack of prompt treatment can lead to death, most commonly through septicemia (bacterial infection of the blood) or septic shock (Nazer et al., 2012). Agranulocytosis is most commonly experienced with the antipsychotic medication clozapine (Wilson, 2015). Clozapine-induced agranulocytosis is estimated to occur in one to two percent of treated patients

(Kar et al., 2016; Ojong & Allen, 2013). Patients with SMI receiving clozapine therapy require more frequent monitoring of white blood cell and absolute neutrophil counts for reducing mortality (Kar et al., 2016).

Delirium. Delirium is an acute complex disorder, also known as a psychiatric emergency, that requires immediate evaluation and treatment to prevent permanent brain damage and death (Forbes & Austin, 2015). It is characterized by fluctuating disturbance in attention, cognition, and consciousness level and is usually accompanied by disordered speech and perceptual abnormalities (hallucinations and illusions) (Fong et al., 2009; Forbes & Austin, 2015). If treated promptly, delirium can be reversed; however, it is a serious disorder associated with increased morbidity and mortality with mortality rates of approximately 25 to 33 percent. Although delirium may occur at any age, it is most frequent among the older adults (Forbes & Austin, 2015; Tosun Tasar et al., 2018). Individuals 65 years and older represent nearly 40 percent of hospitalized adults with delirium (Ahmed et al., 2014). The etiology of delirium is usually multifaceted, with drug intoxication being one of the most commonly identified risk factors (Alagiakrishnan & Wiens, 2004; Forbes & Austin, 2015). There are many psychotropic medications that are associated with delirium, but certain medications are more commonly viewed as causative agents for delirium, such as tricyclic antidepressants and lithium (Alagiakrishnan & Wiens, 2004). In addition, lithium is associated with neurotoxicity and can cause delirium even at therapeutic serum levels (Alagiakrishnan & Wiens, 2004; Clough et al., 2014). Overall, this condition is often underrecognized and underdiagnosed, contributing to poor patient outcomes (Fong et al., 2009).

Correspondingly, older patients diagnosed with neurocognitive disorders have the highest risk for medical comorbidities. A study completed by Proctor et al. (2003) studied 195 older

adults hospitalized for depression on a geropsychiatric unit and found a high prevalence of medical comorbidities. Approximately 75 percent of patients had a least one comorbid condition requiring treatment, 46 percent had two or more, and 25 percent had three or more conditions. The most common medical comorbidities among older adults with depression were hypertension, coronary artery disease, congestive heart failure, neurologic disorders, diabetes, urinary tract infections, and chronic obstructive pulmonary disease. Furthermore, numerous older patients with schizophrenia present with co-occurring depression, which negatively impacts their quality of life, functioning, and the severity of comorbid medical conditions (Felmet et al., 2011). Clearly, individual's with psychiatric disorders represent a medically vulnerable group with immense healthcare needs.

Substandard Care

Individuals with SMI, especially those with complex needs (ex. medical comorbidities, chronic treatment, and continuity of care), often receive substandard quality of care due to disparities in healthcare access and provision, which contribute to poorer health outcomes (CAMH, 2016; Lawrence & Kisely, 2010). Challenges with accessing routine healthcare services and community supports are associated with socioeconomic disadvantage (Lawrence & Kisely, 2010). Individuals with SMI face higher rates of poverty, unemployment, lack of stable housing, and social isolation (CMHA, 2007). Socioeconomic disadvantage in the form of poverty can diminish access to essential services such as transportation, making it difficult for people to attend primary care appointments (CAMH, 2016). Furthermore, insufficient income and unstable housing may serve as a hinderance for people with SMI, as it relates to their access to primary care (Ross et al., 2015).

A combination of healthcare provision factors often contributes to the poor physical health of people with SMI. For example, systemic issues such as the separation of mental healthcare services from physical healthcare services, combined with HCP tendencies to stigmatize people with mental illness are prime examples of barriers to healthcare provision (Lawrence & Kisely, 2010). Some reports suggest that psychiatrists have a tendency to overemphasize and distinctly focus upon mental health and are reluctant to diagnose and treat physical health conditions (Lawrence & Kisely, 2010; Lawrence et al., 2015). The unequal quality of healthcare provision and the misattribution of physical symptoms to mental illness result in infrequent screening for metabolic abnormalities and the omission of medical examinations or treatments (Jones et al., 2008; Lawrence & Kisely, 2010). Patients with both diabetes and a mental illness, for example, are less likely to receive standardized diabetes care, and people with SMI are less likely to receive routine screening for cancer (Lawrence & Kisely, 2010). Additionally, negative attitudes and behaviours of HCPs can be stigmatizing to people with SMI, which contributes to under-treatment of physical illnesses and lack of continuity of care (Rodgers et al., 2018; Lawrence & Kisely, 2010).

Consent and Capacity

Consent and capacity are two central principles in mental healthcare and critical to patient autonomy. Physicians facilitate the decision-making process to ensure the competent patient, or their SDM can give consent (OHA, 2016). Competence is the degree of mental soundness legally required to make decisions about consenting to treatment and care, or to carry out a specific task (Neilson & Chaimowitz, 2015). Determining whether a person is legally competent to make decisions regarding their own treatment and care requires an assessment of their mental capacity (Buchanan, 2004). A capable person has the ability to understand

information that is relevant to making a decision about a proposed intervention or treatment and is able to appreciate the consequences of their decision or lack of decision (Neilson & Chaimowitz, 2015; Van Staden & Krüger, 2003). An individual's capacity is never fixed and can fluctuate (Kent-Wilkinson, 2015) depending on the proposed treatment, such as a person may be capable of giving consent to one treatment or intervention, but incapable of giving consent to another. For example, a patient who has schizophrenia may be capable of consenting to their diabetic treatment, but not to the treatment for their mental illness (Van Staden & Krüger, 2003). Nevertheless, it is essential to note that people with mental illness *are presumed to be capable* of deciding to accept or reject treatment until assessed by a physician and deemed otherwise (Neilson & Chaimowitz, 2015).

Healthcare providers (HCPs) often have negative views towards the competency of persons with SMI. Unfortunately, the assumption by many HCPs is that psychiatric patients do not have the capacity to make decisions regarding treatments (Hamm et al., 2017; Munjal, 2016). A study completed by Ganzini et al. (2003) found that 22 percent of psychiatrists believed that patients with mental illness such as schizophrenia, lacked the capacity to make medical decisions. In addition, Hamm et al. (2017) noted that patients with SMI are viewed by HCPs as incompetent to follow up or adhere to medical recommendations such as, psychiatric medications or diabetes treatments. However, studies have shown that the majority of psychiatric patients decision-making capacity is preserved (Okai et al., 2007) and clinical diagnosis alone (ex. psychotic disorders, mood disorders, and neurocognitive disorders) does not equate with decisional incapacity (Baruth & Lapid, 2017). It is important to take into consideration the complex relationship between psychopathological features (psychiatric symptoms) and decisional capacity of the mental illness (Candia & Barba, 2011; Sugawara et al., 2019). For

example, in schizophrenia, capacity is more largely associated with cognitive dysfunction (difficulty understanding, and poor memory or concentration), than the severity of positive (delusions and hallucinations) and negative (restricted affect and drive) symptoms of psychosis (Carpenter et al., 2000; Sugawara et al., 2019). Moreover, mood disorders, such as bipolar disorder, may impair decision-making capacity when a person is in a manic state and experiencing a lack of insight (Candia & Barba, 2011). However, HCPs must take into consideration that manic states are often brief and effective treatments can prevent acute exacerbations of mania, leading to periods of remission and full capacity (Candia & Barba, 2011; Gergel & Owen, 2015; Misra et al., 2010). Lastly, for neurocognitive disorders, age-related cognitive decline is an important consideration when assessing capacity (Murman, 2015; Tannou et al., 2019). A person with a diagnosis of dementia cannot be assumed to have impaired decision-making capacity as many patients can still articulate their values, needs, and preferences (Wilkins, 2017).

End of Life Decision Making and Category Status Conversations

End-of-life (EOL) decision making is the process that HCPs, patients, and patients' family members undergo when considering treatment options in the event of a medical emergency (Government of Canada, 2017b; Stone, 2001). In order to develop a plan of care, assessment of goals and priorities are of great importance to ensure that the individual, family, and healthcare team are collaborating to maximize the individual's quality of life (Stone, 2001). Several forms of decision making are possible, which include advance directives and resuscitative efforts/wishes in the event of life-limiting illness or emergency (category status discussions).

Advance directives are written, legal documents regarding an individual's preferences for medical care and are utilized in the event that the individual is unable to make decisions for themselves in the future. Advance directives are a way to ensure that a person's wishes and values are respected and serve to guide HCPs and caregivers in their decisions with regards to treatment for a critical illness. There are two major types of advance directives: instructional and proxy. Instructional directives include living wills, which detail an individual's preferences in relation to life-sustaining treatments and comfort care (Heitkemper, 2014; Shapiro, 2014). Treatments may include but are not limited to cardiopulmonary resuscitation (CPR), mechanical ventilation, medications, feeding tubes, intravenous fluids, artificial nutrition, and dialysis (Thompson, 2015). A proxy directive, also referred to as a power of attorney for personal care (i.e. housing, food, hygiene, healthcare), explains who is to make healthcare decisions if the individual becomes incompetent (ex. a depressed and suicidal psychiatric patient). Advanced directives are important to support individuals in making decisions on their behalf, thereby promoting self-determination (Heitkemper, 2014; Shapiro, 2014).

In mental health, there are psychiatric advanced directives (PADs). PADs are written legal documents that are created at a time when individuals are competent with their decision-making capacity and document their prospective treatment choices regarding future mental healthcare (Elbogen et al., 2007; Shapiro, 2014). PADs differ from 'medical advance directives', whereby individuals completing these directives are often making decisions in regard to future EOL treatments (i.e. to increase comfort and dignity). In contrast, the goal of PADs is often to maximize the chances of recovery, while minimizing unwanted interventions based on past treatment experiences (i.e. ineffective antipsychotics) (Olsen, 2016; Swanson et al., 2006). These directives can be used in the event that an individual is deemed incompetent to make informed

choices on their own, such as during an acute episode of psychiatric illness (Shapiro, 2014; Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). In addition, during a medical crisis, a PAD protects an individual from ineffective, unwanted, or possibly harmful treatment or actions by having pre-described treatment preferences and identifying a proxy decision maker to act on the individual's behalf (Zelle et al., 2015). Swanson et al. (2008) noted that PADs are utilized to provide greater autonomy and self-determination for individuals with SMI. Specifically, PADs can give psychiatric patients more control over their own treatment during a mental health crisis by reducing the use of coercive interventions, such as physical restraints, involuntary medications, police transport, and involuntary commitment to a hospital for psychiatric treatment. Moreover, Elbogen et al. (2007) demonstrated an increased sense of autonomy and empowerment among individuals with mental illness who understand and complete PADs. These elements of autonomy and empowerment are essential for recovery and rehabilitation.

Category status discussions serve to identify a patient's wishes, values, and goals regarding life-sustaining interventions, and help in the development of a treatment plan that incorporates these preferences (Balaban, 2000). At The Ottawa Hospital (TOH), a category status is commonly referred to as a 'code status', which includes four levels that are specific to the research site: Category 1 is full treatment (i.e. any and all interventions including CPR) plus admission to intensive care unit (ICU)/critical care unit (CCU). Category 2 is full treatment plus ICU/CCU, but with no CPR; and category 3 is full treatment, but no ICU/CCU or CPR. Category 4 is the same as category 1, but the allocation of this designation is based on clinician presumption rather than discussion with the patient and/or family (TOH, 2019b).

CPR is an emergency lifesaving measure, which includes a collection of interventions performed to provide oxygenation and circulation to the body during cardiac arrest. Interventions may include chest compressions, defibrillation, artificial ventilation, endotracheal intubation, and advanced resuscitation drugs. Individuals requiring CPR are unconscious and unresponsive with absent pulses (Archer, 2014). Moreover, a DNR or DNAR is an advance medical directive that instructs HCPs not to perform life-saving CPR interventions. It is important to note that DNR/DNAR orders do not remove all care or treatment options, just active CPR interventions to save an individual's life (Heitkemper, 2014).

Category Status Conversations in an Acute Care Context

Discussions between HCPs and patients, or their SDMs regarding patients' preferences for life-sustaining treatments and goals of care are completed in hospital (i.e. an acute care context) to promote patient autonomy and improve EOL care (Dunlay & Strand, 2016; El-Jawahri et al., 2017; Kim et al., 2016). Sasaki et al. (2017) noted that category status discussions completed within 48 hours of admission are associated with a decrease in invasive procedures (i.e. central venous catheter placement, intubation with mechanical ventilation) and, CPR among both cancerous and noncancer patients. HCPs are required to discuss and document a category status for *all* patients admitted to hospital (McKean et al., 2015; TOH, 2019a); however, the incidence of these discussions varies depending on age, illness severity, and comorbidity burden (Kim et al., 2016).

In an acute care context, these discussions are more prominent for patients in hospital with a serious illness, or near EOL (Dunlay & Strand, 2016; You et al., 2014). For example, patient's receiving high-risk surgery, or diagnosed with a life-threatening illness, and/or disease (ex. heart failure) (Dunlay & Strand, 2016). Furthermore, Binder et al. (2016) noted that

decisions to complete a category status conversation are highly dependent on factors such as older age, admitting diagnosis, and comorbidities. Although inconsistent documentation of category status conversations occurs in hospitalized patients (i.e. medicine, oncology, and surgery) (Binder et al., 2016; El-Jawahri et al., 2017; Thurston et al., 2014; Weinerman et al., 2015), institutional policy, as well as existing guidelines, recommend that determination of category status occurs during hospital admission (TOH, 2019a; McKean et al., 2015).

Category Status Conversations in Psychiatry

Discussion and documentation of a patient's category status is an essential aspect of any hospital admission. According to our local hospital's policy (TOH, 2019a), EOL decisions, which encompass goals of care, must be discussed with all patients upon hospital admission – including their CPR preferences (i.e. category status) in the event of a medical emergency (McKean et al., 2015). Category status discussions are an inherent part of hospital care; however, they are seldom completed in psychiatry (Balaban, 2000; Warren et al., 2015). It is common for psychiatric inpatients, including those at high risk for cardiac or respiratory arrest, to be admitted, cared for, and discharged without their category status being known or documented. As such, by default, these patients become a category 4 or 'full category status' (Harari & Macauley, 2018; Warren et al., 2015), which mandates life-sustaining interventions, including admission to the ICU and CPR. Unwanted interventions where there is no medical benefit are often unsuccessful, inappropriate, and may potentially cause harm through increased pain and suffering (Canadian Medical Association, 2013).

Engaging in category status conversations with psychiatric inpatients can be challenging and clinicians may avoid these interactions for various reasons (McKean et al., 2015). For example, at the time of admission, the relative medical stability of the patient and their

expectation of surviving until discharge may undermine the relevance of these conversations (Warren et al., 2015). The effects of psychiatric disorders such as anxiety, psychosis, or depression may also affect the patient's decision-making capacity, impeding a discussion regarding their category status. Alternatively, patients admitted to psychiatry for attempting suicide may instinctively request a no-category status, as their current state of mind is strongly associated with rejecting CPR (McKean et al., 2015).

Nurses play an important role in category status discussions by being an information broker, supporter, and advocate. They provide information about patients' emotional and psychological status, while advocating for patients by informing physicians of their expressed wishes (Adams et al., 2011). Nurses may be hesitant to initiate such conversations because of a lack of experience, fear of saying the wrong thing, or disagreement with the patient's decisions (Peereboom & Coyle, 2012), yet a paucity of evidence exists on the topic.

Despite the complexities of discussing a category status with psychiatric patients upon admission, these discussions must occur at some point during their hospitalization. Unless acutely unwell, patients with mental disorders have similar capacity to make treatment decisions compared to persons with medical illnesses (Amer, 2013). Therefore, a person who is mentally ill should not be presumed incompetent to consent to treatment and psychiatric inpatients deserve the same respect and autonomy as other admitted patients during these discussions (McKean et al., 2015). From an ethical standpoint, if a patient's category status is not clearly documented, HCPs may opt to engage in life-sustaining treatments against the patient's will (Karnik & Kanekar, 2016).

Strategies are required to improve category status discussions and documentation for psychiatric inpatients; however, there is limited existing literature on the topic and specific

practice recommendations do not appear to exist. McKean et al. (2015) conducted an anonymous, electronic, web-based survey consisting of a 25-item questionnaire to examine the range of opinions of trainees (residents and fellows) and faculty psychiatrists regarding the assessment of category status in psychiatric patients. Although there was a substantial consensus that category status assessments were important, a quarter of the respondents reported that initiating these discussions was difficult. In addition, McKean et al. (2015) noted that approaches to category status discussions used in other hospital units have unknown efficacy in psychiatry, given the cognitive issues involved in providing consent. Ahmed et al. (2011) completed an audit of category status decisions for inpatients in psychiatry and noted that conversations about resuscitation preferences with subsequent documentation in health records occurred for only nine percent of patients. Furthermore, Warren et al. (2015) completed a retrospective chart review of hospitalized patients in a psychiatric unit and found that when category status was documented, psychiatrists tended to default to a 'full category, not discussed' decision.

After a comprehensive search of the literature, it was noted that HCPs in general struggle to initiate category status conversations in psychiatry. Researchers have examined the completion of category status conversations upon hospital admissions in other settings. For example, in a retrospective chart review Warren et al. (2015) noted that 96 percent of medical inpatients had a category status documented on admission. Furthermore, Binder et al. (2015) completed a survey with internal medicine residents and noted that the majority of residents discussed category status with more than 40 percent of patients admitted to hospital, and 66 percent of all residents had the conversation with at least four out of five admitted patients. Despite these conversations occurring more frequently in other inpatient settings, the overall consensus within the literature notes that HCPs face challenges when initiating category status

conversations (Binder et al., 2015; Chittenden et al., 2006; Dunlay & Strand, 2016; El-Jawahri et al., 2017; Warren et al., 2015). Specifically, HCPs (i.e. predominantly physicians) encounter barriers when conducting these discussions such as, lack of adequate training and skills, lack of time, personal discomfort, lack of rapport, and difficulty managing family dynamics (Binder et al., 2015; Calam et al., 2000; Chittenden et al., 2006; Dunlay & Strand, 2016).

Although the literature may offer important insights regarding the completion of category status discussions in other settings, no published qualitative studies exploring HCP's experiences in initiating category status conversations in the psychiatric setting were found. In addition, no research studies exploring this phenomenon within the Canadian context were found. The available articles focus solely on quantitative research methods, specifically a retrospective chart review, a web-based survey, and a chart audit. These study designs are descriptive in nature and less suited to providing insights into the opinions, practices, and experiences of the HCPs regarding the phenomenon (Jones et al., 2013; Safdar et al., 2016). Although the literature alludes to some possible explanations for why HCPs omit category status discussions in psychiatry, there are no clear conclusions and further research is needed to improve practice in this area. Furthermore, I was unable to locate any studies exploring the nurses' perspectives on the importance of these conversations. As such, the purpose of the proposed study is to explore how and why category status conversations occur, or do not occur, for patients admitted to psychiatry. It is hoped that the findings will influence future research and guide in the development of improved practice strategies specific to psychiatric patients in order to discuss and document their goals of care successfully.

In summary, individuals with mental illness may require emergency interventions, including CPR, while hospitalized due to the complex and unstable nature of psychiatric

disorders (Dixon et al., 2016). The harmful effects and life-threatening complications associated with treatment options (i.e. psychotropic medications) such as, anticholinergic crisis and neuroleptic malignant syndrome (Tse et al., 2015; Wilson, 2015), in addition to, the high prevalence of medical comorbidities, including heart disease, diabetes, and cancer, increases the medical instability of psychiatric patients (Correll et al., 2015). Thus, it is clearly articulated the various ways in which psychiatric patients have conditions that require category status conversations to be completed or clarified. Although HCPs may separate mental healthcare services from physical healthcare services (Lawrence & Kisely, 2010) and undermine the relevance of these conversations (Warren et al., 2015); it should be recognized that poorer physical care for persons with mental illnesses is another consequence of stigmatization and may significantly worsen morbidity and mortality (Knaak et al., 2017; Lawrence & Kisely, 2010).

Theoretical Framework

Weiner's attribution theory is a theoretical framework which attempts to conceptualize stigma and discriminatory behaviour in relation to mental illness (Corrigan et al., 2003).

Weiner's theory creates the link between attributions, emotions, and behaviour. The term 'attribution' refers to explanations of behaviour and inferences or ascriptions of blame (Malle, 2011). Attribution theory holds that behaviour is determined by a cognitive-emotional process, where individuals correctly or incorrectly attribute the causes of a mental illness leading to inferences about the person's responsibility for their behaviour. Consequently, these inferences lead to emotional reactions, such as anger or pity, that affect the likelihood of an individual engaging in helping or punishing behaviours (Corrigan et al., 2003).

Attribution theory is a middle range theory that provides a potential explanation for how an individual perceives, analyzes, and responds to the behaviours of others (Ruybal & Siegel,

2019). The theory includes three dimensions of causal attributions: *locus of causality*, *stability*, and *controllability* (Weiner, 1985). First, *locus of causality* consists of whether the cause of a person's behaviour is influenced by internal or external factors. Second, *stability* is whether the attribute cause will change over time, and third, *controllability* is whether a person has control over the causes of their behaviours, actions, or situation (Corrigan et al., 2003). Through the application of this framework we come to understand that individuals may attribute the cause (*locus of causality*) of the mental illness to the person, which in turn leads to the belief and opinions that the person with the mental illness is to blame (*controllability*) for their problems (Corrigan, 2006).

To exemplify the above process, if a patient's mental illness is attributed to substance use (an internal locus of causality), they will likely be considered responsible for their illness by others. This may lead to negative affective responses, such as anger from HCPs, potentially resulting in punishing or discriminatory behaviour. Alternatively, if the mental illness is attributed to genetic factors and therefore having an external locus of control, such as with bipolar disorder, the patient is perceived to not be in control of their situation (Read et al., 2013) and HCPs are more likely to believe that the patient is not responsible for their mental illness. This results in emotional responses such as pity or sympathy and helping behaviours (Corrigan et al., 2003). In terms of the dimension of stability, when stability of a mental illness is perceived to be low (meaning the person is likely to recover), feelings of optimism for change will be generated thus leading to helping behaviour. Conversely, if attributions of high stability are made regarding the mental illness, the options for change will be low, leading to stigmatizing and discriminatory behaviours (Corrigan, 2006).

Attribution theory stipulates that individuals develop their own explanations/views about

the world around them (Hashemi & Zabihi, 2011). Nurses and/or physicians may form their own attributes and construct reasoning as to why discussions of category status are not completed in the psychiatric setting. These ideas correlate with a relativist ontology in that understanding and reality are socially constructed, unique to each person, and based on experiences and interactions within a specific context (Kivunja & Kuyini, 2017). The focus of attribution research is to identify constructs that affect causal attributions (Malle, 2011). Clear theoretical constructs that form the path in which stigma is formed and maintained among HCPs is created through the social interaction with psychiatric patients, portrayal of psychiatric patients in popular culture, and institutional laws and policies (Ahmedani, 2011; Stangl et al., 2019). These ideas mirror the epistemology of constructivism in that knowledge is created by individuals through their experiences and social interactions (Ahmedani, 2011).

The attribution framework allows the researcher to think about the ways in which stigma is formed and maintained among HCPs and, as a result, serves as a useful initial theoretical foundation to explore the reasons why discussions regarding category status are seldom completed in psychiatry. Further this theory provides an explanation for how stigma can facilitate discriminatory behaviours, such as nurses who hold blame and hostile attitudes towards suicidal patients while treating them in a demeaning manner (Ross & Goldner, 2009). In a psychiatric inpatient unit, HCPs may incur negative attributes about the patient's mental illness, thus influencing behaviours that contribute to lower quality of care and failure to adhere to standards of care (i.e. the requirement to discuss and document a category status) (Corrigan & Watson, 2002). With this theoretical perspective in mind, the researcher can consider the socially constructed realities of nurses and physicians about category status discussions, which will help to identify patterns within these realities. Currently, there are no clear conclusions as to why

HCPs omit category status discussions in psychiatry and further research is needed to understand this phenomenon within a context where stigma influences ones perceived capacity (or right) to engage in their care. The attribution framework provides a conceptual foundation through which I base my understanding of this topic; however, it is not being used to explicitly guide the data analysis as an analytical tool. In the discussion, Chapter 5, the utility of this theoretical lens is explored in relation to the findings of this study.

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Chapter Three

Methods

Methods

In this chapter, I outline the research methodology that I followed in the study and present a comprehensive description of qualitative research followed by my ontological and epistemological stance. The study's research design is based upon qualitative description (QD) and an overview of this design is provided. Additionally, I present the study's setting, sample, recruitment strategies, and methods for data collection and analysis. Lastly, the strategies I employed to ensure methodological rigour are reviewed in detail.

Qualitative Research

Qualitative research is a process of naturalistic inquiry that seeks in-depth understanding of phenomena (i.e. human behaviour, cultural or social organization) (Austin & Sutton, 2014). This type of research is used to examine subjective human experiences by understanding people's attitudes, behaviour, interactions, perceptions, and experiences (Austin & Sutton, 2014; Pathak et al., 2013). According to Polit and Beck (2017), qualitative research involves the use of exploratory methods in order to gain insight into underlying reasons, opinions, decisions, and motivations. Qualitative studies are often used by researchers to develop a rich, comprehensive, and context-bound understanding of a poorly understood phenomena. Collection of information is often obtained in narrative form through open-ended and conversational communication, which enables participants to express themselves freely without constraint (Austin & Sutton, 2014; Polit & Beck, 2017). Qualitative research is best suited for "why", "how" and "what" questions to obtain data. With its mainly inductive approach, qualitative research is used for problem identification, theory formation and concept development (Neergaard et al., 2009).

This study aimed to obtain and understand the healthcare professionals (nurses and physicians) subjective experiences on the complexity of category status discussions in psychiatry. My goal as the primary investigator was to rely on the participants' views in the context of psychiatry, in order to gain an understanding of the problem and fill this knowledge gap. In turn, the knowledge created from understanding the participants' views can guide the development of acceptable strategies specific to psychiatric patients in order to successfully discuss and document their goals of care.

Paradigmatic Stance

Approaching this research study through a constructivist lens allowed for a holistic understanding of the subjective realities of nurses, as it relates to their experiences in addressing the complexity of category status discussions. The constructivist paradigm assumes a relativist ontology; the view that there are multiple realities constructed by individuals that are relative to a situation (Guba & Lincoln, 1994). Thus, there is no single objective truth, as people interpret and make their own meaning of events. A constructivist researcher maintains that knowledge is socially constructed, and reality is ultimately subjective (Guba & Lincoln, 1994; Kivunja & Kuyini, 2017). In linking this lens to the proposed study, from a constructivist perspective, there is no single reality or truth, and therefore multiple constructed realities are possible when considering why category status conversations occur, or do not occur, for patients admitted to psychiatry. Applying a constructivist lens allowed me to develop new insight related to the problem by maintaining an active role to construct meaning from the data gathered through qualitative methods.

Research Design

This study implemented QD as the chosen methodology. QD follows the tradition of qualitative research and is a useful method for studies which are descriptive in nature for examining healthcare and nursing-related phenomena (Kim et al., 2017). Sandelowski (2000) describes QD as a method that provides a comprehensive summary of phenomena in everyday terms known as events. This method allowed me to describe and attribute the meaning of the events from the perspectives and worldviews of the participants involved, while staying close to the data. A QD method is particularly relevant where there is a need to gather rich descriptions about a phenomenon for which limited information may be known (Bradshaw et al., 2017). Data are in the form of words, phrases, stories, and experiences that are analyzed into a formal structure (Sandelowski 2000, 2010). QD is consistent with the naturalistic approach and the principles of a constructivist paradigm, where the central aim is to understand the subjective world of human experience (Guba & Lincoln, 1994; Sandelowski, 2000). The study of phenomena in the natural setting is a central requirement and includes a unique opportunity to gain inside or emic knowledge (Bradshaw et al., 2017; Sandelowski, 2000). The rationale for choosing a QD method was due to the paucity of research on psychiatric HCPs' experiences and practices surrounding category status discussions. This method offers some insight into the phenomenon of interest and potentially leads to further problem identification and future research questions (Neergaard et al., 2009).

Research Setting

This study took place at The Ottawa Hospital (TOH), Inpatient Psychiatry, which is offered at two campuses (Civic and General) of this tertiary care academic hospital. TOH has a total of 87 inpatient psychiatry beds at the two campuses including six beds funded for the treatment of eating disorders. The two units do not differ in regard to patient population and

areas of expertise. The vast majority of patients are admitted through Psychiatric Emergency Services (PES), and approximately 80 to 85 percent of patients are admitted on an involuntary basis. PES ensures unnecessary admissions to inpatient psychiatry are avoided by using available and appropriate community resources such as, providing an educational service and referring patients to community clinics, mental health clinics, and consumer groups. Patient care on these units is provided by multidisciplinary teams, which consist of psychiatrists, mental health residents/fellows, registered nurses (RNs), and social workers. Despite different locales (i.e. inpatient psychiatric units), there are two distinct cultures, whereby members of the multidisciplinary teams (i.e. RNs) work at a designated campus (Civic or General). The average length of stay is between 11 and 13 days for non-complex patients (i.e. stable psychiatric/medical conditions who do not require frequent adjustments of medications). For patients with highly complex psychiatric/medical conditions, including Parkinson's or dementia, the length of stay can be up to two years. Furthermore, TOH has multiple psychiatric services including outpatient units and urgent consultation clinics that provide follow-up treatment for patients following discharge, where ongoing support and treatment is required (TOH, 2018).

Sampling Strategy

A convenience approach to sampling was used to obtain participants representing various levels of expertise and viewpoints about category status discussions. Convenience sampling is widely used in qualitative research to seek participants with certain characteristics who need to be recruited from a particular clinical setting. For this research study, convenience sampling was an economical and straightforward way to begin the sampling process (Polit & Beck, 2017). It allowed me to select participants (nurses) who were readily available or accessible to participate in a focus group discussion (Bradshaw et al., 2017). In addition, snowball sampling is a variant

of convenience sampling and was also utilized. With this approach, early research participants were asked to spread the word to other participants, among their acquaintances on the inpatient psychiatric unit at TOH Civic and General campus who met the eligibility criteria.

Sample Size

In the absence of fixed recommendations regarding qualitative research sample sizes; a guiding principle is that sample sizes should be based on informational needs and stop when patterns are repeated, and data becomes redundant (Polit & Beck, 2017). Sandelowski (1995) emphasizes that qualitative studies should focus on the quality of the data collected rather than the sample size. Thus, as the primary investigator I am required to interview an adequate quantity of participants in order to collect sufficient data, and to gain a rich understanding of the phenomenon under study. However, I must strive to avoid over or under sampling in order to support an in-depth analysis (ONyumba et al., 2018; Polit & Beck, 2017). The sample of this study consisted of nine RNs from two inpatient psychiatric units at TOH. There is a total of 84 RNs employed between the two campuses (Civic and General). For this research study I completed two focus groups. The recommended sample size for focus group discussions varies from four to twelve participants (Doody et al., 2013; Polit & Beck, 2017). Focus group interviews are frequently used as a qualitative approach to gain an in-depth understanding of health problems (Polit & Beck, 2017).

Eligibility Criteria

The eligibility criteria selected were broad enough to allow the majority of the nurses and physicians working in inpatient psychiatry to participate in the study. Participants were eligible to participate in the study if they were psychiatric HCPs (i.e. nurses and physicians) that worked in the identified inpatient psychiatric units. The participants were required to have provided

direct patient care within the last six months. Additionally, the participants were required to communicate in either English or French. Individuals not meeting these inclusion criteria were excluded from the study.

Recruitment

To recruit participants, I met with the department head and managers of the two Inpatient Psychiatry units at TOH to explain the research study's purpose, aims, and methods. Verbal permission to conduct the study was provided by the managers of both units and guidance was provided to ensure the effective recruitment of participants without disrupting and/or impeding unit workflow. Once ethics approval was received by the Ottawa Health Science Network Research Ethics Board and the Health Sciences and Science Research Ethics Board of the University of Ottawa, a key informant (gatekeeper) working at the study hospital was utilized to facilitate participant recruitment. As explained by Polit and Beck (2017), establishing trust with participants is a central issue in qualitative research. To best support the research process, a gatekeeper can be utilized to initiate and establish rapport with potential participants. The gatekeeper advertised the study through email (Appendix A) and word-of-mouth. Participants who were interested in the study were encouraged to contact myself, the primary investigator, by email or phone. I initiated recruitment by posting information posters within the units on bulletin boards and in staff lunchrooms. The poster (Appendix B), described the study's purpose, data collection methods, inclusion criteria, and included a request for interested nurses and physicians to contact me via email or phone. Furthermore, I advertised the study to unit nurses during unit rounds and I posted a sign-up sheet on the unit for interested participants, which indicated the time and date of the focus group discussions. A focus group was then scheduled at a convenient time and within a private room at TOH (Civic or General campus). A subsequent email

confirming the location, date and time of the focus group was sent to the participants, which also served as a friendly reminder for those who had signed up. Due to the challenges encountered in recruitment of physicians (i.e. lack of availability, time, and capacity to participate) the physicians focus group was omitted. A decision was made to focus on the RN's valuable perspectives at this time and explore the physicians' perspectives at a future date.

Ethics

Ethical approval was obtained from the Health Sciences and Science Research Ethics Board of the University of Ottawa and the Ottawa Health Science Network Research Ethics Board. Prior to each focus group, participants were given the Minimal Risk Informed Consent Form (Appendix C) and I explained the research study's purpose, methods for data collection, and associated risks or harms. The informed consent form also described the nature of participation and the measures taken by the research team to protect the confidentiality of the participants. I reviewed the informed consent form with all the participants and answered any questions that arose. Participants were asked to sign the consent form prior to data collection, and an informed verbal consent was obtained by the moderator and captured on the encrypted audio file.

As the primary investigator, I emphasized that participation in the study was voluntary and that participants had the right to withdraw from the study at any point in time and the right to refuse to answer any particular questions. To maintain confidentiality and anonymity, the audio recorded interviews and transcripts were stored on an encrypted and password protected USB key. The signed consent forms were securely locked in a cabinet at The University of Ottawa. Authorization access of the interview material were limited to the research team. A member of the research team is employed as a psychiatrist at TOH and acted as the Responsible Site

Investigator during the research study. Ethical considerations such as the existence and closeness of working relationships with potential participants were considered for their influence upon collected data. Measures were taken to ensure that confidentiality was respected for all nurses choosing to participate. The interview data were de-identified prior to the research team having access. This consisted of removing participants' identifiers including names, email addresses, and phone numbers from all transcripts and research data; information was coded. Further, I assured participants that their involvement in the study had no bearing on their employment status within TOH. In order to protect their anonymity during focus group discussions, all participants were given a number (i.e. Participant 1) to ensure no real names or other directly identifying information were reported. All study-related material would be kept in a locked cabinet, in a locked office, for a period of at least five years and then destroyed appropriately as per the University of Ottawa ethics guidelines (University of Ottawa, 2018).

Data Collection

Data were collected through semi-structured focus groups designed to guide discussion around the participants' experiences regarding category status discussions. I conducted two focus group discussions (two separate focus groups for RNs). One focus group took place at TOH General Campus with four RNs and the other at TOH Civic campus with five RNs. The focus group discussions consisted of a moderator and an assistant (ONyumba et al., 2018). I acted as the moderator and in this role, I discussed ground rules with the participants such as advising the participants to speak one at a time, being respectful towards one another, and maintaining confidentiality of what was discussed in the focus groups. The ground rules and focus group process were explained to participants in writing and once again prior to commencing the interview. As the moderator, I was responsible for soliciting input from all participants by

enabling input from both very vocal and minimally vocal people. This encouraged all group members to participate, and prevented a single person dominating the discussion) (Doody et al., 2013; Krueger, 1994; Polit & Beck, 2017). Similarly, the assistant (my supervisor) was responsible for observing group dynamics in discussions (i.e. participants questioning each other's responses, eliciting clarification, and exploring caveats to their statements) (Doody et al., 2013; Freeman, 2006).

Participants were asked experientially based open-ended questions (see Appendix D for complete interview guide) such as: 'Tell me about the current practices for determining a patients code (category) status?', 'To what extent should we discuss code status with patients admitted to psychiatry?', and 'When is it appropriate - or not appropriate - to engage in code status conversations with patients?' RNs were encouraged to speak freely about their experiences regarding category status discussions and to share their stories, anecdotes, and reflections. Both focus group discussions were approximately one hour in length and were audio-recorded and transcribed verbatim.

Data Analysis

Data were analyzed using iterative inductive content analysis, according to the process described by Elo and Kyngäs' (2008), which is consistent with a QD study. Iterative inductive content analysis is a minimally interpretative approach and focuses upon low-inference description (i.e. minimizing generalizations/interpretations made in order to stay close to the data), resulting in easier consensus of the data among researchers (Neergaard et al., 2009; Sandelowski, 2000). This approach to data analysis provides a systematic organization method to code, categorize, and utilize abstracted data to produce main categories or themes to describe a phenomenon. As per the method, data analysis occurred independently after data collection (Elo

& Kyngäs, 2008). Specifically, I listened to the audio-recording and completed verbatim transcription within 24 hours of each focus group discussion. Upon completion, I verified the transcript with the audio-recorded focus group interviews to ensure accuracy.

Once transcription was complete, I immersed myself in the data by re-reading the transcripts several times. I became familiar with the data, by formulating an understanding of the main points requiring consideration. I then organized the qualitative data by completing open coding, creating categories, and completing the abstraction process. During the open coding process, I reviewed the material, while making notes and preliminary headings in the margins of the text to describe all aspects of the content. The preliminary headings were then grouped on to coding sheets; the initial categories were generated at this stage. The purpose of creating categories is to provide a means of describing the phenomenon of interest, to increase understanding of the participants experiences, and to generate knowledge (Elo & Kyngäs, 2008). I then completed the abstraction process by determining which categories were related to one another and grouped and organized them into subcategories and main categories. Codes were allocated for key categories following discussion and agreement between the researchers. Utilizing such an inductive approach led to the emergence of new insights and a richer understanding of this category status discussion phenomenon (Elo & Kyngäs, 2008; Vaismoradi et al., 2013). The coding of transcripts commenced after the focus groups were completed and abstraction continued until no further categories were identified.

Trustworthiness

Lincoln and Guba's (1985) trustworthiness criteria were employed to ensure the rigour of this study. The criterion of trustworthiness includes the dimensions of credibility, dependability, confirmability, and transferability.

Credibility refers to confidence in the truth and interpretations of the data. Credibility was enhanced through investigator triangulation, as differing understanding of the data were discussed with members of the research team during the data analysis process to make coding and analysis decisions together (Polit & Beck, 2017). Members of the research team were experts in qualitative methods and psychiatric nursing. To enhance credibility, I also replayed each audio-recorded interview while reviewing the verbatim transcript for accuracy. Dependability refers to the stability and consistency of data over time, which implies that the findings would be reproducible if the study was replicated (Polit & Beck, 2017). Sandelowski (1993) indicates that a study and its findings are dependable when it is possible for other researchers to clearly follow the decision trail used in the study and obtain comparable results. Thus, a detailed audit trail was constructed to account for all the methodological considerations and analytic decisions relating to the research study (Polit & Beck, 2017). Confirmability refers to the extent that the study's results and conclusions represent the information provided by the participants rather than the researcher's biases or interpretations of the data. To support confirmability, the inclusion of verbatim anonymous quotations were reported to ensure that the findings remained grounded to the participants' experiences and to present a faithful range of participants' realities (Bradshaw et al., 2017; Lincoln & Guba, 1985; Polit & Beck, 2017). Furthermore, transferability alludes to the extent that a study's findings can be applied to other similar settings or groups. As the primary investigator, I provided rich descriptions of the setting and participant characteristics (Lincoln & Guba, 1985).

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Chapter Four

Findings

Findings

In this chapter, I present the participant characteristics and the shared experiences of nurses initiating and engaging in category status conversations with patients admitted to psychiatry. The major categories used to describe these findings are consistent with the purpose of the study, which was to explore how and why category status conversations occur, or do not occur, for patients admitted to psychiatry. To support the identified categories and subcategories, direct quotes are used from the participants.

Participants Characteristics

Nine nurses participated in the study (two men and seven women), all of whom were Registered Nurses (RNs) working in psychiatry at The Ottawa Hospital (TOH). All participants spoke English during the focus groups. Five of the participants were recruited from TOH Civic campus and four from the General campus. The participants' years of nursing experience ranged from less than one year to 18 years. The focus group that took place at the General campus consisted of a younger group of nurses (mid to late twenties), whereas at the Civic campus the nurses were older, with more years of nursing experience. All of the participants possessed a degree in nursing.

Categories and Subcategories

The participants' experiences of initiating and engaging in category status conversations with patients admitted to psychiatry are described with the help of the following four categories: '*The Psychiatric Culture*' which represents the current practices and prioritization of completing category status discussions in psychiatry, as well as the participants views of the nursing role; '*Being a Psychiatric Patient*' which describes how competence, capacity, and suicidality influence these conversations; '*Physical Health Status*' which details how differences in physical

health status affect the ways in which healthcare providers (HCPs) engage in category status determination; and '*Suggestions and Recommendations*' which provides ways to improve practice in this area according to the participants (see Table 1).

Category 1: The Psychiatric Culture

All of the participants articulated the importance of completing category status conversations with patients admitted to psychiatry. However, when asked about the current practices for determining a patient's category status, the participants admitted: "Well we find a lot, it's not discussed." (P5B, P2, L81). In fact, they noted that in most cases: "There is no discussion with the patient about their category status" (P2A, P2, L86), with some participants reporting: "Working here I've never, I've never actually seen or heard any talk about these discussions happening" (P4A, P3, L89-90). Despite the absence of these conversations, the participants emphasized: "It is a discussion that should be had, and more likely than not it will be category 1 for the majority of the patients, but that doesn't mean you should just avoid the conversation all together which is what happens" (P2A, P3, L130-132).

From their perspectives, the participants felt that the physicians did not prioritize these conversations: "I find it's not a very high priority for a lot of doctors. Not every doctor, but it's often common that it's left kind of, for sure" (P5B, P3, L116-118). Instead, many patients are assigned a category status by default and without the patient's input. For example: "In an ideal world it would be a discussion with every patient but a lot of patients are presumed category 1, rather than having an actual discussion about it" (P2A, P2, L37-38) and "It's also by default if it's not brought up then they're automatically a category 1" (P2B, P4, L155-156). According to the participants, this lack of prioritization also extends to *knowing* the category status of patients admitted to psychiatry:

There's only been one code blue, and I was a part of it, and I don't think we even looked to see whether she had a category status. We just initiated CPR, she was very young so. Again, so what if she was a category 3? We didn't even look, for sure we didn't look, we just initiated CPR. (P3A, P10, L412-415)

Interestingly, the participants recounted how, in the psychiatric context, patients are commonly considered and assumed to be healthy, and thus: "it's not really the first thing the doctor is thinking about when they're admitting a young healthy patient, like physically healthy patient" (P2A, P8, L338-342). This perception of health appears to be deeply ingrained in the psychiatric culture: "I also think it's just part of the culture, like for years everybody who's on mental health has been generally physically healthy, walking around young, so they almost like, they don't need to discuss it because they are healthy" (P3A, P4, L142-144). Furthering this idea, one participant explained:

Like we have this expectation, I guess kind of, just this immediate thought that they're not going to die while they're on this unit, they're not going to come close to it. The intent is to treat, they are here for treatment and they are here to get better. And we're not even supposed to get near death or code situation. (P4A, P10, L436-439)

While other participants spoke about how older age of the patient reprioritizes category status conversations to an extent:

And I think going back to age, it's just more publicly, culturally, and socially discussed in elderly [patients], like if they're above 65 and retirement, it's just always discussed. And I think doctors know that, so when we get a patient who comes in and is over 65, it almost reminds them 'oh yeah, we'll we need to have this conversation because they're elderly. (P3A, P18, L771-774)

They also described several situations where, in hindsight, a category status conversation was prudent, but omitted:

I remember a patient stuck with me, he was middle aged and... he had many admissions for bipolar disorder, depressed and manic throughout the years... I am thinking he would have been an example of somebody maybe that should have been addressed and asked.

(P2B, P12, L488-493)

The participants readily acknowledged that: “Anyone can have a heart attack, or a stroke, so doesn’t matter if you’re young or old” (P1A, P22, L947). Yet, even with older patients, category statuses were not always discussed and documented: “But especially with having more and more elderly patients coming in and do have a lot of comorbidities, ... and it’s regularly not discussed, which it should be as it is on any other unit” (P3A, P3, L120-122). Finally, the participants explained how current practices are problematic given a recent shift in psychiatry: “Like it’s becoming half the floor is housing, the rest is all geriatrics, it’s all total care, they don’t need to be on our floor, mental health wise. Some of them they don’t have a mental illness at all” (P1B, P5, L203-205).

Nurse’s role. As part of their description of the psychiatric context and the current practices regarding the determination of category status for patients, the participants elaborated upon their views of the nursing role. Their perceptions of how nurses contribute to category status determination were varied. Some participants reported that it was not something nurses should do: “I’ve not advocated for a patient’s code status on psych” (P2A, P20, L873-874). These participants explained how responsibility laid primarily with the physicians working in psychiatry:

I don't think it's a nurse's role to be the one that's having these discussions with the patients. I think it should be the doctors, so I think our role is mostly being aware of what a patient's code status is and knowing what to do if an emergency situation arose. (P2A, P9, L366-368)

Others spoke about how nurses can contribute through specific actions, such as facilitating discussions:

I think it's our role to elicit the patient's wishes and end of life needs/desires, that kind of thing. I think we have a role in kind of maybe inserting ourselves in these conversations like cueing the doctors for example or advocating for the patients that they do have these conversations. (P4A, P9, L361-364)

In addition to cueing physicians:

I definitely have advocated for, I guess not as overly as I could be, but I put sticky notes and I've mentioned it to the doctor because it does concern me. I don't know why but when I'm on a night shift I almost get more concerned about when their sleeping. The other day my last night shift I had this little 90 year old lady, very frail and in my head I'm just like what if her heart stops? And so, I've put a sticky note saying please clarify category status because it was presumed category 1. (P3A, P21, L883-888)

Engaging in category status conversations was not always top of mind for the participants:

I login and the code is not the first thing that I check and I should. So, I feel like it's one of those things that in different units it's more, like you said in medical floors it's more important to talk and hear. I feel like we don't do it as much. (P1A, P12, L500-503)

They also described how the 'nursing role' in 'knowing' a patient's category status differed in psychiatry, when compared to medical units due to the 'culture of the unit':

I worked on a medical unit recently for a while, and I just think... it should be part of the nursing culture as well. When you are on a medical unit and you go on break the first thing you say about a patient is ‘this is what their diagnosis is and this is their category status’, so I feel like, just us on break in psych, we should be putting that into our report cause its super important. (P4A, P10, L398-405)

Additionally, at times, they worried about how to invite physicians into these efforts:

I think though if, as the nurse, if I was to go to the doctor and ask them to address the code status of my 20 year old patient, I think they would probably like not (laugh), but I’m pretty sure they wouldn’t take it seriously which is unfortunate... I don’t know how seriously they would take it. But I think it’s something that needs to happen, but it also needs to involve a face to face meeting with the patient and not just deciding. (P4B, P18, L760-762)

Generally, the participants expressed their discomfort with category status conversations: “I always kind of shy away like personally from having these conversations with the patients because I feel like the psychiatrists will do it better, I feel like they know how to talk about these kinds of things” (P4A, P9, L364-366), indicating that lack of practice and opportunity contributed to their unease:

Again, we don’t see it very often, we don’t have codes very often, so lack of practice.

Potentially, after that scenario actually our educator, I pushed for more education and we did more education around code blues and how to run them and stuff. We were supposed to do sims, like acting it out and stuff but that never happened, so maybe more of that to get in the routine of, cause even when we do our CPR training in the hospital it’s not like

the first thing to say check their category status it's assumed that everybody knows.

(P3A, P10, L421-426)

An overwhelming concern for the participants was what might happen in response to an unexpected medical crisis on the psychiatric unit. One participant provided a real example of the chaos that ensued when a patient's category status was unknown:

I actually have an example that happened ... probably three to four years ago. We had a patient who was in stage 3 or 4 lung cancer, anyways was doing okay and just all of the sudden hemorrhaged in the hallway, coughing and we yelled a code blue. This doctor was unable to get a hold of her family doctor to find a code status and as we were yelling code blue and starting compressions he called one last time and her doctor happened to pick up and then he yelled out 30 seconds later, stop the code it's DNR. (P5B, P22, L935-940)

This fear resonated with the participants, with several sharing their own concerns: "Even I was thinking the other day, oh if there was a code on my buddy's patient and I needed to know what category status there was, I wouldn't even know where to find that" (P4A, P10, L399-401).

Category 2: Being a Psychiatric Patient

Being a psychiatric patient related to assumptions where 'young' and 'physically healthy' is typical in psychiatry. The participants often inferred people who were 'young' and 'physically healthy' as the standard psychiatric patient; however, solely for symptoms related to their mental illness. According to the participants, being a psychiatric patient meant that you had 'less right' to an appropriate conversation about your category status compared to patients with medical problems:

...it's just the general demographic of these patients is a bit different. ... you're not going to see a lot of your middle class, upper class patients that are educated and really

advocating for themselves or have even thought about this ahead of time. We have to keep in mind that some of these patients haven't thought of this ahead of time, they don't want to have families to help trigger these conversations or support people. They don't have, some don't have big jobs to lose or that kind of thing when they become ill. So, it's just like, it seems because they are mental health patients or the lower kind of hierarchy of power, unfortunately that's not how we should treat them, but that's kind of how they are treated. That 'oh these conversations are not important'. (P4A, P19, L800-809)

The importance of family involvement in category status conversations, and what this looks like in psychiatry, was also discussed: "They need to contact the family, or SDM [substitute decision maker]... we have trouble with that because sometimes patients they barely have no family or you know..." (P1B, P3, L107-109), and: "They're not capable to make other decisions as well which then, as participant 1 said, you have to start involving family members which could be difficult for our patient population at least" (P3B, P5, L211-212).

The participants spoke about how 'being a psychiatric patient' sometimes overshadowed the reality of a patient's health situation and HCP common sense. They described how DNR requests were common among psychiatric patients with advanced life-limiting disease, but that sometimes these requests were viewed through a psychiatric lens rather than a holistic perspective of their health:

That patient that we had, like this was a couple summer's ago, she had stage 4 cancer. They admitted her [to psychiatry] because she wanted to die. And I remember, all the staff were like 'oh that's so bizarre, she has stage 4 cancer. She's really suffering, like of course she wants to die'. Why would you form her? That is so awful. So, I remember we all had that visceral reaction, like 'what? This is so unfair!' And I thought 'what's going

on? Maybe there's something more to it that I don't know but this just seems wrong'.

(P4A, P17, L710-716)

This example sparked a lot of discussion among the participants about how having a mental illness is the defining attribute of most psychiatric patients' lives:

I agree it feels wrong because the patient was so close to end of life, so it's like where's the line when a patient is so close to end of life... that them [patients] wanting to die is a mental illness? Or them wanting to die is because their life is going to be over soon and that's part of nature. (P3A, P17, L723-726)

Fluctuating competency. One of the key ideas' participants discussed was the importance of assessing patient's capacity and their competence to engage in category status conversations. According to the participants, a multitude of factors affect a patient's capacity to engage in their treatment decisions, such as the type and severity of mental illness, suicidality, and stability of the patient. This reality, where many persons with mental illness have fluctuating competence or capacity to make decisions regarding their life and health, confused the typical process for these conversations. The participants' discussions centered primarily around patients who are competent to make an informed decision regarding their category status, patients who are in a psychiatric crisis and clearly not competent, and patients who fall somewhere in between.

There was little variability in the participants views of category status determination for patients who they viewed to be logical, coherent, and having sound judgement: "A patient, if he is all there, what do you want? You know because we had a 93-year-old gentleman not too long ago and he said no, I had a good life, I just want to go" (P1B, P11, L451-453). For these patients, the participants endorsed having conversations about their category status: "Yeah I agree, if a

patient is logical and coherent you can have the discussion” (P2A, P11, L457) or maintaining pre-determined orders from long-term care facilities:

I think the only exception would be if somebody’s coming from a long-term care home or they’re over the age of 65, they’ve already had a previous discussion, then that does sometimes get followed through PES [psychiatric emergency services]. (P3B, P3, L90-91)

Equally as clear for the participants, was the inappropriateness of having category status conversations with patients upon admission who were clearly not competent due to the symptoms of their mental illness:

I think the times it’s not appropriate is when they’re experiencing a crisis, I guess that would be my main thing... I would think it’s more appropriate when they’re maybe in the later parts of their treatment. (P3B, P14, L596-598)

They readily acknowledged that: “If a patient is actively psychotic, if they have been deemed not capable, if they can’t have an organized conversation, I don’t think it’s appropriate” (P2A, P12, L519-520).

Patients on psychiatric forms were also included into the participants’ dialogue about incompetent patients: “On a form 1 but that’s usually when the patients are most acute so I wouldn’t for many patients” (P4A, P14, L560-570). However, there was ambiguity in relation to patient’s competency and being admitted to hospital on a psychiatric form:

I think it depends on... why they are on a Form 1. Whether it’s because they’re psychotic or suicidal or just because they can’t, sometimes patients come in because they’re not taking care of themselves in the community. Their schizophrenia, like the negative symptoms of schizophrenia where lack of motivation, they can have a coherent

conversation, they're just not functioning well. Like maybe it would be more appropriate in that case because they are speaking more coherently and logical. (P3A, P13, L561-566)

The participants voiced how confusion can stem from the fact that patients placed on psychiatric forms are not globally incompetent: "Sometimes they are competent to make certain decisions but not others" (P3B, P10, L398-399). Regardless, being on a psychiatric Form was considered a barrier to engaging in category status conversations:

Barriers I think is because if somebody's coming in and say they're on a Form 33, they're not even able to make or consent to treatment decisions on their own. In regard to psychiatric treatment, then I think the doctors might assume then that they're not capable to make other decisions as well. (P3B, P5, L208-212)

The issue with these forms, from the participants perspectives, was that patients may be incapable of consenting to psychiatric treatment, but competent to provide consent for medical care:

But there is also a difference, capacity to consent to psychiatric treatment and capacity to consent to medical treatment, and our doctors rarely ever fill out forms for medical treatment only in cases when they need a surgery and we have to force it. So, it's like a whole other door that they almost don't, I don't know if they don't want to open because it's a lot more work and paperwork for them to justify why they're not capable to consent to medical treatment, which I would think would be the case with category status. (P3A, P5, L197-202)

Finally, the participants spoke to "*grey areas*" in regard to fluctuating decisional capacity, and how this confuses category status conversations further:

A lot of our patients, they're incapacity fluctuates so often especially the young patients depending on treatment or what stage they are in their illness, and even day to day their decisions on certain things like medications it changes, every single day. (P4B, P16, L672-675)

For patients with fluctuating capacity who are unable to participate in category status conversations upon admission, the participants stressed the importance of revisiting them routinely: "The cases that it's not appropriate right on admission that it actually gets revisited and revisited until it is an appropriate conversation so that it's never just left indefinitely" (P3A, P23, L965-967).

Suicidal Ideation/Depression. While the participants acknowledged that category status conversations are appropriate to engage in with patients who are competent to make their treatment decisions, they described their reluctance and unease about having these conversations with competent patients who are receiving care for depression or suicidal ideation:

If it's someone who's depressed, who's actively suicidal but they're still deemed capable, like they've been assessed or deemed capable, and then they decide 'I want category 3' even know they're like 25 years old and physically healthy it's a tricky situation. (P2A, P4, L175-177)

Compared to patients with psychosis or mania, the participants were much less confident in how to proceed with category status determination:

With a depressed patient who is suicidal I guess it's more of a grey area because they're coherent you can have a logical conversation, so then I don't know if it would go more into the doctors doing a full capacity assessment about whether their capable or not... (P3A, P11, L449-453)

Participants highlighted how past and present suicidal ideation must always be considered when caring for patients with depression: “A lot of the patients are comorbid with depression and suicidal thoughts, even if it’s not active... but they do seem to have those thoughts” (P2A, P22, L919-920). Furthering this idea, another participant shared their clinical examples:

I can think of two or three different patients where their diagnosis was depression and they were actively suicidal, one patient was blatantly asking multiple times for a DNR category 3 because she would say ‘I want to die’, but asking for it, and she asked for MAiD, was assessed by MAiD, so that type of thing. And then another patient again was asking for category 3 because they actively wanted to die. So... it’s the same issue that we were talking about earlier. (P3A, P17, L700-705)

Thus, despite the importance of completing these conversations, the participants all described how category status discussions may be less appropriate with suicidal patients:

I agree with the other participants that it should be a discussion with every patient, but then the same thing, it is hard if you have a patient who’s actively suicidal. Like how are they able to consent to that kind of discussion and how are they able to decide what’s going to be best for their long term health? (...) (P2A, P3, L126-129)

Lastly, some of the participants reported how it never crossed their minds to address category status with suicidal patients: “... Honestly, I’ve never thought of it, addressing a code status with a young suicidal, initially suicidal patient that comes in who could have other comorbidities” (P2B, P9, L375-376).

Category 3: Physical Health Status

According to the participants, being ‘young’ and ‘physically healthy’ is the expectation and norm in psychiatry, as seen in the *‘Being a Psychiatric Patient’* category. However, the

participants described how patients in psychiatry are changing and category status is dependent on other factors, such as, physical health status. This category clarifies what it means being outside a ‘typical’ psychiatric patient.

The participants described the completion of category status discussions was highly dependent on the overall physical health status of the psychiatric patient. Oftentimes the medical stability of a patient (i.e. physically healthy or near EOL) would play a role in category status determination:

...It’s almost like physicians will naturally assess the risk of them going into cardiac arrest and having that conversation with somebody who’s blatantly ill, physically so they’ll have that conversation, as supposed to somebody who like Participant 4 was saying where your plan is discharge, you’re hoping that they’re not going to be here long enough that they, whatever happens and they have a code, so it’s not discussed. (P3A, P15, L645-650)

Despite the more common occurrence of these discussions when there was a known *medical issue*, the participants expressed concern that many patients who are medically unwell admitted to psychiatry, have no documented category status: “But especially with having more and more elderly patients coming in and they have a lot of comorbidities, ...and it’s regularly not discussed which it should be as it is on any other unit” (P3A, P3, L120-122).

Inpatient psychiatric units, according to the participants, are housing more patients with medical comorbidities such as diabetes, seizure disorders, and cardiac conditions: “We have a lot of people with cardiac history, even things like seizure disorders” (P4B, P9, L357). This reality contributes to a heightened perception of risk: “When you have a patient with all those comorbidities the chance of them going into cardiac arrest is way higher” (P3A, P8, L345-346).

Even for relatively young patients, when a physical illness is present, participants perceived notable risk for cardiac events:

...we do get patients that are ill for example, we've had one patient who comes in quite frequently who had very untreated diabetes and she's having a kidney transplant, she's quite young, but kidney transplant, has multiple comorbidities, even though she's relatively young but the risk of cardiac arrest for a physical illness is there. (P3A, P18, L744-748)

The participants also explained how some conditions, like addiction and eating disorders, are primarily treated in psychiatry, despite having significant effects on physical health. For substance use, the participants shared the unpredictable nature of the patient's physical health status and how this contributes to risk:

Quickly, what we're also seeing more of is the substance abuse and the drug use on the streets and patients coming in with that, so how scary is that? A lot of patients are using drugs lethal doses and coming onto our unit. So, we're seeing the effects, they are high, they are this... (P5B, P12, L495-498)

For eating disorders, the participants recounted how unpredictable metabolic changes can have negative health outcomes sometimes resulting in death: "But you think if they're purging and vomiting a lot, they can have hypokalemia, they can go into cardiac arrest, that is a possibility." (P2A, P19, L790-791), and "That is a good point that we didn't even discuss is the eating disorder patients because they're so young and they're so frail and so malnourished that there is a higher risk of their heart stopping" (P3A, P19, L802-804).

The participants noted an increase in the number of patients admitted to psychiatry who are terminally ill or near the EOL and stressed the importance of: "A lot of people with terminal

illness that we've been seeing coming to the unit as well" (P4B, P4, L135-136), with some participants reporting: "We are seeing uh, there's higher incidence of terminal patients and patients with dementia...than in the past" (P2B, P5, L194-195). While it seemed intuitive to them that category status conversations would occur for these patients, they seldom do: "They keep them category 1 (presumed), when they should be category 3 or even 4, and what, where are we going with that? And most of the time, the doctor, they just wait and wait and wait" (P1B, P3, L110-111). However, when patients are imminently dying while admitted to psychiatry, involvement of the palliative care team sparks category status determination: "The only good news lately is palliative is getting involved. So, there's a lot, I think we got two or three patients that actually went palliative to die" (P1B, P7, L289-291). The same participant explained the impact of palliative care on patient's category status determination near EOL:

I've seen palliative often involved, and then they will call the family or the SDM or whoever you know who's in charge of the patient and we have two in the last three to four months, maybe three. And they were at the end, 92-year-old, you know 89... (P1B, P7, L299-301)

As a final thought within the physical health status category, the participants discussed the role of psychotropic medications and their adverse effects on physical health: "Some of the classic psychiatric patients that we have are on pretty harsh antipsychotics that can have direct impact on cardiovascular effects" (P3B, P9, L361-362). The participants provided an example of an experience that occurred with a patient admitted to psychiatry who had a medication complication, which they said emphasizes why category status is required, even in psychiatry: "We had someone go into cardiac arrest from a medication" (P5B, P9, L379-383). Another participant continued to explain:

Basically, was a fellow in his, I would say early thirties, and he was on clozapine therapy, basically in the dining room he was fine, ate breakfast and everything. Going back to his room he kind of fell on the floor but was still kind of okay. Brought him to his room and what happened, that's when everything got loose. So basically, all the nurses got involved and we had to call a RACE [rapid assessment of critical events] code and after that they declared him dead. So, we did, I would say for maybe five to ten minutes trying to resuscitate him, he came back everybody was happy and then suddenly he went back down. (1B, P10, L421-427)

This highlights the importance of completing category status conversations among psychiatric inpatients, as physical health status can fluctuate, and thus, the assumption of medical stability should not affect the ways in which healthcare professionals engage in category status determination.

Category 4: Suggestions and Recommendations

All of the participants provided suggestions and recommendations about how to improve category status determination in psychiatry. Many of the participants discussed creating a separate policy or guideline specific to psychiatry, because existing practices do not account for mental illness:

So even if there was... like Participant 1 said, there is no policy around a timeline, and everybody is different. So even if there was a policy saying that you have to revisit it in let's say a week, or revisit it in two weeks and then they can be re-assessed and if they are capable at that time great, and if not then okay we'll re-assess in another week or two weeks or however long. Something that makes it more forcible. (P3A, P7, L281-284)

The participants also recommended explicit efforts to clearly answer the question: What to do if a patient with a documented category 3 status attempts suicide in hospital?:

The only thing I can think about is separating it from whether they were to go into cardiac arrest naturally and they were deemed category 3 then we don't resuscitate or if they actively attempt, do something to try to end their life, and it's not medically natural so we could potentially intervene but there is no policy. So again, maybe there could be more research about should there be a policy that if it's an active attempt that we do have the right to intervene and resuscitate or prevent it. (P3A, P11, L481-486)

All participants spoke about ways to better enforce the completion of category status conversations in psychiatry, such as normalizing these conversations during hospital admissions, if possible, by embedding category status documentation within existing processes:

I think it would be useful... the same way that doctors have to go through their home medications and reconcile the medications' match up. I think code status should almost be like a checkbox they have to check off during their admission that it's been reviewed. (P4B, P24, L1033-1035)

Furthermore, education and the use of external supports (ex. consulting services within the hospital or involving ethics) to increase nurse's skills to conduct effective category status discussions was recommended by participants:

I think it is great if we were to have ethics or have a team that could help us through those conversations you know even if you just start the conversation and say well, I don't really know. I'm not fully equipped to discuss the terms of every category with you ... but let me put in a referral and we can plan a meeting for it. (P4B, P13, L553-556)

Finally, the participants discussed improving family involvement in category status conversations with patients admitted to psychiatry: “Having families involved whether it be a substitute decision maker or even just support people for the patients to make that decision. Yeah, I think it would be important to involve family, if they are around” (P3B, P17, L710-712).

Chapter Five

Discussion

“Mental health and physical health are intertwined; both types of care should be provided and linked together within healthcare delivery systems.”

Craig W. Colton, PhD and Ronald W. Manderscheid, PhD.
Johns Hopkins, 2015.

Discussion

In this chapter, I provide a summary of the findings and how they relate to Attribution Theory, which was the theoretical lens through which I approached the study. I also discuss the findings in relation to the extant literature, provide implications for nursing practice, policy, education, and research, comment on the strengths and limitations of the study, and draw conclusions.

In this study, I explored how and why category status conversations occur, or do not occur, for patients admitted to psychiatry. The research question was: “What are the experiences of healthcare professionals initiating and engaging in category status conversations with patients admitted to psychiatry?” Using a Qualitative Description (Sandelowski, 2000) study design, I collected data through two semi-structured focus groups with nine Registered Nurses working in psychiatry at The Ottawa Hospital (TOH). Although most participants were reluctant to initiate or engage in category status conversations in psychiatry, they nonetheless described the importance of completing these discussions and having a documented category status in their patient’s health records. The overarching categories derived from the focus group interviews included: *‘The Psychiatric Culture’*, *‘Being a Psychiatric Patient’*, *‘Physical Health Status’*, and *‘Suggestions and Recommendations’*. The findings suggest that while the majority of the nurses described the importance of completing category status discussions in psychiatry, in general, nurses require further education, training, and support in order to adequately initiate and engage in these conversations. While the final documentation of a formal category status is ultimately a physician’s responsibility, there is a need to include other HCPs in these discussions, to ensure their timely completion. Ultimately, there is a lack of discussion or action on the issue, despite

there being widespread acknowledgement that omitting category status determination is problematic in psychiatry.

Attribution Theory

My theoretical thinking for this topic was informed by Weiner's attribution theory, which offers a conceptual explanation of stigma related to mental illness (Corrigan et al., 2003; Weiner, 1985). The theory includes three dimensions of causal attributions: locus of causality, stability, and controllability (Weiner, 1985), which affect the ways in which a person with mental illness is perceived and responded to by HCPs. When considering the results of the study through this theoretical lens, we see that the participants' stories reflected the dimensions of stability and controllability.

Based on this theory, when stability of a mental illness is perceived to be high, feelings of optimism for change will be low, leading to stigmatizing and discriminatory behaviours by others (Corrigan, 2006; Weiner, 1985). Participants described how being a 'chronic psychiatric patient' meant that they were less likely to have an appropriate conversation regarding their category status. Often, the decision to *choose for the patient* was based on a presumption of incompetence to participate in decision-making, rather than an assessment of their actual capacity. These assumptions were most prevalent when discussing patients with past and present depressive or suicidal symptoms. For these patients, the participants recounted how, because of their diagnosis, it is difficult to trust that their preference against life-saving intervention in the event of medical emergency is not simply a manifestation of their illness. Similar to the explanation offered by Weiner (1985), patients with long-standing depressive or suicidal symptoms appear to lose their right to participate in decision-making regarding their category status even when they are competent to consent to treatment.

As per the attribution theory, the dimension of controllability is about whether a person has control over their behaviours, actions, or situation (Weiner, 1985; Corrigan et al., 2003). The participants described how having a mental illness was the defining attribute of most psychiatric patients' lives. Being labeled a 'psychiatric patient' created a perception that they were incapable of engaging productively in their healthcare, thus rendering them unable to exert control. This lack of ownership over their own healthcare (and their lives) was most notable when discussing category status for patients with severe and persistent mental illness combined with life-limiting physical disease (e.g. end-stage cancer). Examples were shared in which these patients would request Do Not Resuscitate orders and yet, because of concerns over their competency, formal discussion and documentation of this status would not occur.

Although some aspects of attribution theory resonate with the findings of this study, other elements, such as locus of causality, were not apparent. Stigma is always important to consider when exploring the lived experiences of persons with mental illness, but based on the stories shared by our participants, preconceived ideas about the person only partially contributed to the omission of category status discussion in the study context. Ambiguity about how to engage in these conversations and a culture where physical health concerns are less prioritized were also important considerations for this phenomenon.

The Nurses Role in Category Status Determination

There was ambiguity regarding the nursing role in category status determination. The participants frequently noted being hesitant to initiate or engage in category status discussions because of a lack of experience, training, education, and knowledge. While category status

determination and nurses working in psychiatry is largely unexplored, the existing literature speaks to the topic more broadly, including the expectations of nurses generally, as well as the important role they have in category status determination overall and in areas other than psychiatry.

Nurses are information brokers, supporters, and advocates for patients who are considering their goals of care options (Adams et al., 2011). They provide information about patients' emotional and psychological status and advocate for patients by informing physicians of their expressed wishes (Adams et al., 2011; Strachan et al., 2018). In addition, nurses spend more time at the bedside in comparison to other HCPs, thus are in an ideal position to foster a safe environment for patients to voice their care needs (Adams et al., 2014; Hohenleitner, 2002).

The Canadian Nurses Association [CNA] (2016) provides guidance on the nursing role in advance care planning (i.e. goals of care), which involves reflecting on future healthcare preferences and treatments in case of incapacity (Shaw, 2018). Category status determination fits within advance care planning and, according to the CNA (2016), nurses play a key role by initiating related conversations, honouring patient's values and healthcare wishes, and advocating for and supporting patients and their families. Nurses also encourage patients to reflect on, and engage in, advance care planning by providing clear, empathetic communication, which helps people express their wishes for future care, including end-of-life (EOL) considerations (CNA, 2016; Miller et al., 2019). Lastly, nurses ensure that the patient's family or substitute decision maker(s) (SDMs) know their wishes (CNA, 2016).

When considering the findings of this study and what is published in the extant literature, we see that nurses' actions and perceptions about EOL decision-making for patients admitted to psychiatry differ from what is expected or completed elsewhere (i.e. other inpatient units). For

example, nurses are more actively involved in advance care planning in critical care, where discussions regarding EOL occur frequently (Adams et al., 2011). As *information brokers*, nurses working in critical care provide data about the patients and families to the physicians or health care team, such as the patient's clinical status, patient's and family's emotional and psychological states, and their expressed wishes. Nurses help increase understanding for the patient and family regarding the patient's condition by translating medical terminology into common language, as well as educating, explaining, and clarifying diagnosis, interventions, or plans of care. Moreover, critical care nurses enact the role of information broker by coordinating EOL discussions and facilitating communication between family members and the healthcare team (Adams et al., 2011; McMillen, 2008; Silen et al., 2008). As patient *supporters*, nurses working in this setting build trusting relationships with family members by establishing rapport (Espinosa et al., 2010) and demonstrating empathy by taking the time to listen and acknowledge feelings about EOL (Adams et al., 2011). Critical care nurses also act as *advocates* during decision-making with both physicians and family members by critically evaluating and questioning the plan of care, as well as directly reporting patients and families expressed wishes to other members of the healthcare team (Adams et al., 2011). More specific to decision-making concerning resuscitation, EOL situations, and category status determination, nurses in critical care are shown to initiate early discussions about treatment choices and reduce unwanted interventions, including cardiopulmonary resuscitation (CPR) (Hohenleitner, 2002).

While nursing care is different in psychiatry compared to critical care, there are certain aspects of nursing practice that cross-cut many domains. Developing a therapeutic relationship, for example, is both pivotal to category status determination, but also patient-centered psychiatric care. Nurses working in psychiatry spend time talking with and fostering meaningful

engagement with patients. In fact, the nurse-patient relationship is the foundation upon which psychiatric nursing was established (Thibeault, 2016). Nurses working in psychiatry practice therapeutic use of self as a primary intervention, which requires forming a trusting relationship that provides comfort, compassion, safety, and non-judgmental acceptance of patients. To successfully deliver this intervention, nurses must be self-aware and able to communicate effectively to help improve their patient's mental health status (Jones, 2012). The nurse-patient relationship has the capacity to transform and enrich patient experiences (Kornhaber et al., 2016), thus contributing to positive outcomes for psychiatric patients. Additionally, psychiatric patients, specifically individuals with serious and persistent mental illnesses, tend to be repeatedly admitted or have prolonged hospitalizations (Jayatilleke et al., 2018; Schmutte et al., 2009), therefore patients and nurses get to 'know' each other, further solidifying the trust and rapport needed to discuss category status. Yet, as evidenced by the findings of this study, nurses are hesitant and unclear about how to enter into these discussions within the psychiatric context.

Given the professional and ethical responsibility nurses have to ensure that their patients' wishes are known and upheld, nurses in psychiatry need to be confident and capable of engaging in category status conversations. Clearly, much change is needed to current psychiatric care to create a culture in which nurses fully enact their role in category status determination. Hospital leaders, for example, should recognize, support, and optimize nurses' involvement and contribution in goals of care discussions, by clearly articulating the nurse's roles in initiating and leading these formal conversations. This would help to ensure the contribution of nurses in these discussions, because ambiguity regarding their role, which includes facilitating goals of care discussions and supporting the decision-making process, would be lessened for all HCPs (Strachan et al., 2018).

Providing continuing education for nurses to initiate and facilitate these discussions in psychiatry is also essential. Some strategies exist to improve practice in this area, such as the structured goals of care communication guide developed by Bekelman and colleagues (2017). The intent of their tool is to provide guidance to nurses about how to initiate and facilitate goals of care discussions with patients, families, and HCPs in the outpatient or home settings, though the tool is transferable to other areas. Bekelman and colleagues recommend that nurses use the communication guide during stand-alone visits to prepare patients and family members for further conversations about goals of care and treatment decisions. The guide includes questions to elicit patient understanding of and attitudes towards the future of illness, identify EOL preferences, clarify values and goals, and develop a follow-up plan. One example question is: ‘If you were to get sicker, what would be most important to you?’. Similar to the mini-mental state examination, which is a screening tool used extensively in psychiatry to measure cognitive impairment and document a patient’s course of cognitive changes over time (Norris et al., 2016); this communication guide could be integrated into psychiatry as a standard tool to facilitate category status discussions.

To improve knowledge and comfort of having category status discussions, Schoonover and colleagues (2019) utilized a short case-based PowerPoint presentation as an educational intervention to train physician assistant and nurse practitioner students. The PowerPoint presentation reviewed the different category status choices and the likelihood of survival to hospital discharge for inpatient cardiac arrest. After training, there was a significant increase in knowledge ($P = .01$) and comfort level ($P = .02$) in having these discussions. Educational interventions, such as these, should be offered to nurses working in psychiatry and tested to determine their effectiveness to improve knowledge and comfort within the psychiatric context.

Ultimately, nurses working in psychiatry need to enhance their capacity to enact their roles of information broker, supporter, and advocate so they can alleviate unwanted medical interventions and ensure goals of care wishes for their patients and families are met.

No One Size Fits All Approach to Category Status Conversations in Psychiatry

All of the participants expressed how category status conversations are not prioritized in psychiatry and how they are deferred or avoided upon admission and throughout hospitalization. Currently, there are protocols for category status determination that do not adequately address the complex challenges of mental illness. At the hospital from which the sample of nurses was drawn, the policy indicates that category status be determined as soon as possible (but no later than 72 hours) after admission (TOH, 2019a). Further, the CPSO policy states that physicians *must* endeavour to understand what is important to the patient regarding treatment decisions, in order to ensure that the patient's goals of care are understood and quality care is provided (CPSO, 2019). The participants of this study described the complex challenges related to category status determination, which include decisional capacity concerns, psychosis, and different thought processes (i.e. logical and coherent versus altered and pathologic). It is well-known that each mental illness affects cognition, behaviour, and mood in different ways, and sometimes differently in persons with the same diagnosis (Biological Sciences Curriculum & National Institutes of Health, 2007). This variability creates ambiguity about how and when patients are competent to have these conversations, which contributes to nurses and other HCPs' uneasiness to complete category status discussions in the standard way. To this end, the participants of this study highlighted the importance of implementing a different approach to category status determination in psychiatry that accounts for the illness and life-circumstance characteristics that alter the process and are commonplace in psychiatry. Typically, when a

patient comes to hospital for a medical emergency, such as a stroke, and they are unable to actively engage in their care due to an altered level of consciousness, a surrogate (i.e. the patient's family member) is contacted and consulted in their place (Mamo, 2014). However, the participants of this study explained that family support is minimal or non-existent in psychiatry. The impact of severe mental illnesses on family members can be detrimental, leading to poor physical health, psychological distress, and difficulties in social relationships (Fekadu et al., 2019). Thus, many patients do not have a SDM identified or willing to act on their behalf.

According to the participants of this study, to circumvent the requirement to have a category status conversation with patients admitted to psychiatry, a presumed status is frequently used by physicians. A presumed category status (also known as a category 4) is the same as category 1, which is full treatment (i.e. any and all interventions including CPR) plus admission to intensive care unit (ICU)/critical care unit (CCU), but the allocation of this designation is based on clinician presumption rather than discussion with the patient and/or family (TOH, 2019b). Similar to the findings of this study, the literature provides insight into the struggles of HCPs in other domains as well. A recent mixed methods study by El-Jawahri and colleagues (2017) looked prospectively at a cohort of hospitalized patients with cancer. The authors found that physicians working in oncology most often document a presumed category status at admission, rather than complete a discussion with their patients. This leads to a high proportion of patients for whom full life-saving measures are required, without the patient's direct consent. Their results revealed that approximately one-third of patients who were presumed to want full-measures would have preferred a DNR category status if adequately informed about the associated risks of CPR (El-Jawahri et al., 2017). Furthermore, Warren and colleagues (2015) noted HCPs discomfort regarding category status discussions and how using the determination

“full code, not discussed” (i.e. presumed category status) provides HCPs the option of opting out of these conversations.

Although this study explored nurse’s experiences with category status determination, the participants surmised about possible reasons for why physicians may opt to blanketly assign ‘full measures’ to patients, as the duty and responsibility to document a patient’s category status lies with the physicians. Most predominantly, the participants believed that physicians omit these discussions with patients in order to avoid litigation and malpractice lawsuits. This hypothesis is similar to what is discussed in the extant literature, which reveals that physicians tend to over-treat, thereby disregarding a person’s category status, due to the fear of litigation (Boyle et al., 2005; Vento et al., 2018) or concerns regarding the threat of litigation for not writing a DNR category status order (Yuen et al., 2011). A presumed category status is problematic because it places patients at high risk for receiving aggressive medical interventions, including CPR, to sustain life against their wishes (El-Jawahri et al., 2017), while compromising their autonomy and dignity (American Heart Association, 2000; Chittenden et al., 2006). Given the challenges relayed by the participants of this study, it is unsurprising that HCPs in psychiatry choose to omit these discussions and document instead a presumed category status. This option facilitates the avoidance of navigating difficult conversations with patients who have symptoms such as indecisiveness, rumination, or passive suicidal ideation, which do not offer a clear barrier to category status determination, but which may cast doubt on the credibility or authenticity of their choice (Michaelis et al., 2017).

Regardless of the existing barriers to involving patients in their category status determination, patients admitted to psychiatry have a right to have their wishes known and upheld. Although I was unable to find any published research exploring the use of Psychiatric

Advance Directives (PADs) as a tool to facilitate category status determination, it is an area worthy of exploration. PADs are written legal documents that are created at a time when individuals are competent with their decision-making capacity and document their prospective treatment choices regarding future mental healthcare (Elbogen et al., 2007; Shapiro, 2014). PADs include instructional directives (detailed instructions outlined in advance), proxy directives (legal authority provided to another individual to make decisions on the patient's behalf), or hybrid directives (incorporating both instructional and proxy directives) (Ambrosini & Crocker, 2007). These directives help offset the reality that mental illness can cause temporary periods when patients lack decision-making capacity and are unable to engage in collaborative partnerships with their HCPs (Elbogen et al., 2007; Shapiro, 2014). They provide a venue for people with mental illness to express their psychiatric treatment preferences and wishes so HCP's can better assist and provide treatment appropriately when the individual is deemed not competent to make decisions regarding their health and care (Elbogen et al., 2007).

Additionally, the use of PADs provides greater patient autonomy and can lead to better clinical outcomes (Ambrosini & Crocker, 2007). A good PAD will outline all treatments options and care, for example, an individual's hospitalization preferences and medications given for their mental illness. It can provide emergency contact numbers or healthcare proxies who can consent to treatment on the patient's behalf, and while hospitalized, the PAD can outline how to manage a person's affairs at home (Ambrosini & Crocker, 2007; Elbogen et al., 2007). PADs honor the rights of persons with mental illness to have their voices heard, while respecting the patient's rights to make autonomous treatment choices. For patients who often feel a lack of control over their lives because of mental illness or suffer from a mental health crisis and become incompetent, a PAD can empower them to dictate their own healthcare (Ambrosini & Crocker,

2007). Research has shown that persons who complete a PAD tend to experience greater therapeutic alliance with their HCPs, fewer coercive crisis interventions, better correspondence between preferred medications and treatment modalities, and increased perceptions that their preferences for psychiatric care are being met (Elbogen et al., 2007; SAMHSA, 2020; Wilder et al., 2013).

With their goal of specifying patient wishes regarding their healthcare, PAD's could be used to identify category status preferences as well. In the event of a medical emergency, a PAD could be a tool that clearly outlines patient's wishes in regard to life-sustaining interventions and category status, thus ensuring patients are not getting unwanted CPR or other heroic measures. Despite the above benefits of PADs, there is a lack of recent evidence supporting their use and effectiveness. What literature does exist is over 10 years old and study results are less than promising. A study completed by Swanson and colleagues in 2006 noted that out of 1011 psychiatric outpatients, only four to 13 percent of patients had completed a PAD; however, between 66 and 77 percent reported the desire to create a PAD if given the opportunity and assistance. Further, several studies have reported on healthcare provider hesitancy with PADs, such as a lack of awareness or familiarity with how to create and use them, concerns about legal liability, and discomfort with the notion of shared decision-making for persons with severe mental illness due to capacity concerns (Ambrosini et al., 2008; Elbogen et al., 2007; Swanson et al., 2006). In fact, Ambrosini and colleagues (2008) completed a survey exploring the perceptions of PADs among legal and mental health professionals and found that 50 percent of the participants were not willing to use PADs within their professional practice. More research is needed in regard to the completion and implementation of PADs generally, as well as how to meaningfully embed category status conversations within PADs.

Suicidal Ideation/Depression and the Completion of Category Status Conversations

The participants spoke of grey areas, which they described as situations when they were conflicted about how (or if) to engage in category status conversations. Specifically, the participants spoke about patients who were depressed or expressing suicidal thoughts. Their ambiguity about how to act in these circumstances was fueled by the common perception that patients expressing suicidality are blanketly incompetent to make decisions about their category status and goals of care (Szanto, 2015). They discussed the uncertainty resulting from patients who are both capable of having a logical conversation and lacking decisional capacity due to their suicidality, and echoed concerns noted in the literature about what to do if patients with underlying depression request DNR orders (Henman, 2016; McKean et al., 2015). Through their stories, it was clear that the participants believed that in some instances, their (or the physician's) judgement was more sound than the patient's, even when deemed competent to make treatment choices.

Similar to what is discussed in the extant literature, HCPs may make treatment and care decisions based on what they discern to be best, regardless of the patient's wishes or consent; a phenomenon known as paternalism (i.e. patriarchal thinking) (Pelto-Piri et al., 2013). Paternalism in healthcare is defined as the interference with a person's autonomy, justified by the intent of promoting good or preventing harm (Buchanan, 2008). Although HCPs aim to promote their patients' best interests in everyday care and treatment, at times, they inadvertently (or intentionally) limit individual autonomy and acquire an authoritative approach when making treatment decisions (Murgic et al., 2015).

Unfortunately, paternalistic views, decisions, and actions are prevalent across all healthcare domains (Bailoor et al., 2018; Clark & Preto, 2018; Hestevik et al., 2019; Murgic et

al., 2015; Rustad et al., 2016). A study conducted by Bailoor and colleagues (2018), for example, explored clinicians (residents, fellows, nurses, nurse practitioners, and physician assistants) and non-clinician's opinions on the acceptability of paternalistic decision-making with patients who present with intracerebral hemorrhage or critical illness. Overall, clinicians considered their decision to withhold life-saving interventions acceptable when prognostic certainty was poor, irrespective of their patient's wishes. Further, Hestevik and colleagues (2019) found that older patients in acute care hospitals are often subject to paternalistic practices because HCPs do not always consider their need to understand and actively engage in decision-making regarding their healthcare. Paternalistic healthcare occurs when patients are expected to comply with decisions despite not having their individual needs, values, goals, and preferences considered (Bridges et al. 2010; Hestevik et al., 2019). It can lead to patients experiencing feelings of powerlessness, fearfulness, and ignorance, and results in lost control over decision-making, especially in patients with impaired cognition, physical disabilities, or communication difficulties (Bridges et al. 2010; Hestevik et al., 2019; Rustad et al., 2016).

Most of the participants of this study believed that engaging patients with suicidal ideation in their category status determination was inappropriate and that their healthcare decision-making would be influenced by their desire to die, regardless of their competency. Patriarchal thinking in psychiatry is common, and it is shown to negatively impact patient's autonomy and health outcomes (Hem et al., 2016; Pelto-Piri et al., 2013). Pelto-Piri and colleagues (2013) completed a study with psychiatric staff members who described real situations and ethical reflections about patients in psychiatry by keeping a diary over the course of one week. The authors found that paternalism appeared to be the dominant perspective among the psychiatric staff members statements. Many of the paternalistic statements conveyed in the

diaries revealed psychiatric staff acting in ways that they believed were beneficial for their patients, however corresponding actions included taking and implementing difficult decisions against their patients' wills, such as using coercive measures. While this provides one example of patriarchal thinking in psychiatry, the literature on this topic is abundant and beyond the scope of this thesis.

Based on the findings of this study, it appears as though efforts to improve category status determination in psychiatry must be coupled with efforts to reduce stigmatizing attitudes towards patients with past and present depressive or suicidal symptoms. Not all patients who attempt suicide are necessarily incapable of making decisions about their healthcare (Henman, 2016). Creating a culture that allows for patients admitted to psychiatry to have a say in all aspects of their care (i.e. physical and mental) can help to build trusting nurse-patient relationships and enhance treatment engagement (Dixon et al., 2016). Category status discussions may, in fact, be therapeutic for patients experiencing depression and/or suicidal ideation and present an opportunity for nurses to reframe, assess acuity, and communicate further information about overall decision-making capacity to the healthcare team (Warren et al., 2015). Nursing management in psychiatry can aid in the delivery of ethical education and training focused on paternalism in order for nurses to successfully promote the principle of autonomy in medical decision-making without impinging on patients' feelings, experiences, and thoughts in the planning process.

Nursing Implications

The research presented in this thesis study supports specific nursing implications for practice, policy, education, and research.

Implications for Practice

The participants of this study were unclear regarding their nursing role in category status determination in psychiatry and frequently expressed their discomfort with initiating or engaging in these discussions due to a lack of experience, training, and knowledge. The participants explained how role ambiguity was compounded by ‘the psychiatric culture’, where category status conversations are not prioritized nor routinely completed as intended. Nurses play a key role in category status conversations by encouraging patients or SDMs to reflect on and engage in these discussions, while honouring patient’s healthcare wishes and advocating for patients and their families (CNA, 2016; Miller et al., 2019). Improving nurse’s comfort with their role, and engagement in category status determination can be completed through communication skills training, including practice-based learning through role play. These interventions can help nurses learn skills and increase confidence with their role in having challenging conversations about EOL care (Coyle et al., 2015). Enhancing communication skills also reduces stigmatizing attitudes by improving the quality of interpersonal contact between HCPs and patients (Ungar et al., 2016).

Evidence-informed strategies should also be adopted to improve effective facilitation of category status discussions in psychiatry, so that knowledge can be translated and provided consistently across psychiatric settings and HCPs. Practice through simulations, such as the one described by Gottheil and colleagues (2016), may be useful. These authors found that simulation-based interventions, which consisted of two standardized simulated ‘code status discussion’ scenarios (i.e. a 68 year old patient on chronic dialysis presenting with pneumonia), followed by an educational session in a teaching hospital, improved internal medicine resident’s performance and comfort in leading and documenting category status discussions. Similar

interventions can be completed with nurses to increase their comfort and confidence in category status determination in psychiatry.

Finally, clinical ethicists (i.e. ethics committee) may work collaboratively with nurses to facilitate these difficult conversations, while building capacity (Rasoal et al., 2017). As highlighted in the aforementioned text, nurses are ideally positioned to advocate for and facilitate discussions in regard to advance care planning (CNA, 2016). Consulting other allied health professionals such as ethicists, who are experts in the decision-making process might alleviate some of the uncertainty and uneasiness felt by nurses when engaging in category status determination with patients admitted to psychiatry. Further, hospital ethics committees can provide ongoing support to HCPs during the decision-making process (Bruun et al., 2018).

Implications for Policy

There was consensus among the participants of this study and other reported findings (ex. McKean et al., 2015; Warren et al., 2015) about the challenges faced when engaging in category status conversations with patients admitted to psychiatry. Conversations about goals of care differ with these patients because of symptom and illness-related factors. Currently, there are local hospital policies directing goals of care conversations, which are not adapted for the psychiatric context. At the hospital from which the sample of nurses was drawn, the local policy indicates that category status be determined within 72 hours of admission (TOH, 2019a). Initiating a conversation about goals of care preferences warrants thoughtfulness and preparation to ensure patients have a full understanding of all their treatment options, including the potential risks and benefits of CPR (You et al., 2014). However, in psychiatry, these conversations are often omitted due to capacity and competency concerns, and conflicting clinical data (i.e. being

admitted for suicidality and engaging in category status determination), thus potentially leading to unwanted life-saving interventions.

To address the challenges with category status determination and improve communication during the documentation of EOL treatment decisions, a more inclusive policy or framework appropriate to psychiatry is needed. Having a policy that outlines an appropriate timeline to have conversations about category status with patients admitted to psychiatry would ensure nurses and other HCPs respect the dignity and autonomy of persons with mental illness. Nurses should be able to assess a psychiatric patient (based on their complex needs) upon hospital admission and have flexibility and guidance about how to re-engage in or reassess the status determination based on the patient's presentation. This would ensure that the discussion is not left indefinitely and that a presumed category status is not blanketly assigned to patients simply to meet existing policy expectations. As advocates, nurses have the capacity and responsibility to influence current and future practice standards and policies to assure the delivery of quality healthcare in psychiatry. Nurses can shape policy changes through their involvement in professional organizations and collaboration with other members of the healthcare team, and advocate for policies and practices around category status determination in psychiatry (i.e. reviewing the current policy to be more inclusive or creating a separate policy for psychiatry).

Implications for Education

Education about category status and goals of care communication is essential to equip nurses with the necessary knowledge, skills, and guidance to engage in category status discussions in psychiatry. Furthermore, education is necessary for nurses to appropriately enact the roles of information broker, supporter, and advocate to support and facilitate the completion

of these discussions. The participants described feeling underprepared and underconfident to initiate or engage in these discussions due to a lack of formal education and training regarding goals of care. Education and exposure to goals of care communication in the psychiatric context should begin during entry-to-practice education (i.e. undergraduate education). According to Furnes and colleagues (2018) Bachelor of Nursing students can improve their knowledge and communication skills through blended learning (i.e. video lectures and role play simulation) in preparation for mental health nursing practice. These authors found that a communication skills course based on a blended learning method improved student's mental health nursing competence and prepared them for practice.

However, given the complexities of discussing category status with patients with mental illness, nursing students should receive both didactic and skills-based training about goals of care. For example, they could learn the necessary skills during nursing labs and be exposed to these conversations during clinical rotations, in order to develop the confidence and knowledge needed to competently engage in these discussions. Furthermore, ensuring that physical and mental health are equally prioritized in all nursing courses will help normalize the medical needs of psychiatric patients, and also the mental health needs of patient's receiving medical care.

Implications for Research

To build the evidence base about category status conversations in psychiatry, future research is needed to explore physician's experiences of initiating and engaging in these discussions with patients admitted to psychiatry. While the nurses in this study hypothesized about the views of their colleagues, they were not privy to the thoughts and decisions underpinning the existing practices of the physicians in psychiatry or the reasonings of hospital administrators creating policy. In order to have a global understanding of category status

determination in psychiatry, researchers should take into consideration the physician's perceptions as well, as their voice is an essential narrative that is lacking.

Furthermore, research is needed to explore the psychiatric patients' perspectives and preferences around the process of category status determination and conducting goals of care conversations in hospital. Researchers can evaluate the patients' needs, while taking into account differing medical backgrounds, personal values, and level of awareness. Exploring the needs of patients admitted to psychiatry would provide insight and understanding into their particular preferences during the process of category status discussions (i.e. the timing of when to complete category status determination based on patient capacity and appropriateness) and thus, reduce stigmatizing attitudes and paternalistic views HCPs may have towards these patients. Lastly, future research is also needed to determine what resources can be instituted within hospital organizations to help nurses and physicians facilitate category status discussions in the psychiatric setting. This would allow HCPs to be better supported in a consistent, evidence-informed manner when engaging in category status determination in psychiatry.

Strengths and Limitations of the Thesis Study

This study sought to explore how and why category status conversations occur, or do not occur, for patients admitted to psychiatry through two semi-structured focus groups with nurses working in psychiatry. This appears to be the first study to explore category status discussions from a nursing-specific lens and the only study to explore the phenomenon within the Canadian context. Despite the limited research in this area, this study is clinically meaningful and was created based on an identified practice issue at the participating hospital.

The participants represented both campuses of a large tertiary care hospital that provides psychiatric services to a city with a population of approximately 1.25 million. By using focus

groups, I obtained detailed information about the nurses personal and group experiences, feelings, perceptions, and opinions towards the completion of category status conversations in psychiatry (ONyumba et al., 2018). Further, when engaging in moderate interaction with the nurses during the focus groups, I garnered an in-depth understanding of category status conversations in the psychiatric context from the nursing lens. By facilitating the focus group discussions in this study, new thinking and ideas among the participants were produced, which resulted in an in-depth discussion.

As with all studies using focus groups, there are limitations to consider. First, focus groups do not allow as much time for individual perspectives and experiences, compared to interviews. This is partly because the primary intention of a focus group is to gain insight into how people in a particular group perceive a phenomenon of interest, rather than the perceptions of specific individuals (Sim & Waterfield, 2019). Further, because of the group setting, some participants may have been hesitant to express their thoughts, due to the fear of being criticized if their point of view differed from other participants in the group (Krueger, 2014). In order to mitigate this, the participants were reassured that all opinions were important, valued, and not to be ridiculed or dismissed and the participants were reminded that there were no right or wrong answers. I listened to all ideas and ensured respectful conduct by providing ground rules at the beginning of each session.

Second, the lack of anonymity during a focus group discussion means that the participants' gender, age, and other demographics are known to the other participants, which could lead to the attribution of information, where participants can be identified from the information they provide (Sim & Waterfield, 2019). The participants may have been more reluctant to share their experiences and opinions, because their contributions were not

anonymous. In order to protect their anonymity, participants signed a confidentiality agreement prior to the study and were provided with instructions on the importance of respecting group privacy and keeping group discussion confidential.

Third, as part of the focus group process, my supervisor was present to safeguard against moderator bias, which is a known limitation of focus group research (ONyumba et al., 2018; Stewart et al., 2007). Moderators can greatly impact the outcome of a focus group discussion because they may inadvertently inject their personal biases and opinions into the participants' exchange of ideas (Stewart et al., 2007), which can influence group participants into reaching certain assumptions and conclusions about a phenomenon of interest and thus, lead to inaccurate results (ONyumba et al., 2018).

Finally, this study was originally designed to include a physician focus group as well as a nursing focus group. However, due to their lack of availability and unwillingness to participate, the physicians focus group was omitted and a second focus group was conducted with a new group of nurses instead. While I was able to explore the phenomenon from the perspective of nurses working in psychiatry, the documentation of a formal category status is ultimately a physician's responsibility. Including their perspectives would have provided a global understanding of the struggles HCPs face when facilitating category status discussions in the psychiatric setting, including how physicians view their role in category status determination.

Conclusion

Nurses working in psychiatry care for patients with complex medical and psychiatric needs, who are also sometimes older and frail, yet many do not have a documented category status. Although the importance of completing category status conversations with patients admitted to psychiatry is known, they seldomly occur. Often, a presumed status is documented

without input from the patient and/or their support persons. The current practices regarding the determination of category status for patients admitted to psychiatry are problematic and there appears to be ambiguity about how to appropriately enact the nursing roles needed to support and facilitate their completion. While it appears to be simpler to initiate category status conversations with some patients, such as those who are older and with complex medical comorbidities, competency, capacity, and suicidality complicate the typical process for category status determination.

Findings from this study help improve understanding about how nurses view their role in category status determination within the psychiatric context and captures the barriers experienced by nurses in regard to facilitating or engaging in category status conversations with patients admitted to psychiatry. These barriers include working in a culture where physical health is not prioritized, discomfort engaging in challenging conversations with physicians, and uncertainty about the process and nursing role related to category status determination. Research is needed to explore physician and patient views and preferences related to category status determination in psychiatry. Healthcare leaders should reconsider the current standard approach in favour of a process that acknowledges the illness characteristics and personal factors that make category status determination different in psychiatry.

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Appendix A Recruitment Script

Recruitment Email

Subject Line: Invitation to participate in research

Hello,

You are being asked to participate in a research study that we are conducting. Participation is voluntary.

Briefly, the study involves reflecting upon your experiences through answering open-ended questions. There will be one focus group interview that will last for approximately 60-90 minutes on your experience and beliefs about initiating code status conversations with patients admitted to psychiatry. The session will be scheduled to take place at The Ottawa Hospital or other predetermined location in a private room. The nature of the questions you will be asked would include: "When is it appropriate - or not appropriate - to engage in code status conversations with patients?" You may ignore or skip any question that you do not want to answer. The focus group will be audiotaped and later transcribed by the researcher.

The Informed Consent Form is attached for your review.

If you have any questions or if you are interested in participating, please contact the Research Coordinator at _____.

*One reminder email will be sent two weeks after the initial email.

Thank you,

Researcher's name: Olivia Provencal Levesque

Researcher's institution: The University of Ottawa

Researcher's email address: _____

Researcher's telephone number: _____



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Appendix B Recruitment Poster

PARTICIPANTS NEEDED FOR RESEARCH IN PSYCHIATRY

We are looking for psychiatric nurses and physicians to volunteer to take part in a study of exploring how and why code status conversations occur, or do not occur, for patients admitted to psychiatry who meet the following criteria:

Registered nurses or physicians who work full-time or part-time on the inpatient psychiatric unit, have provided direct patient care within the last six months, and are fluent in English or French

If you are interested and choose to participate you would be asked to: Participate in a 60-90 minute focus group discussion focused on the conversation about code (category) status and patients admitted to psychiatry

Your participation would involve 1 study visits;
each visit will be about 60-90 minute long.

In appreciation for your time and participation in the study, you will receive a five dollar gift card. In addition, coffee and light snacks will be provided during focus groups.

For more information about this study, please contact
the Research Coordinator.

Phone: _____

Email: _____



Appendix C

Minimal Risk Informed Consent

Minimal Risk Informed Consent Form for Participation in a Research Study

Study Title: Category Status Conversations in the Psychiatric Context

OHSN-REB Number: 20190539

Principal Investigator Olivia Provencal Levesque, RN, BScN
Master of Science in Nursing Student
School of Nursing, Faculty of Health Sciences

INTRODUCTION

You are being invited to participate in a research study. You are invited to participate in this study because of your experience with psychiatric inpatients.

This consent form provides you with information to help you make an informed choice. Please read this document carefully and ask any questions you may have. All your questions should be answered to your satisfaction before you decide whether to participate in this research study.

Taking part in this study is voluntary. You have the option to not participate at all or you may choose to leave the study at any time. Whatever you choose, the decision will not affect your employment.

IS THERE A CONFLICT OF INTEREST?

There are no conflicts of interest to declare related to this study.

WHY IS THIS STUDY BEING DONE?

The purpose of the study is to explore how and why code status conversations occur, or do not occur, for patients admitted to psychiatry. We hope to gain an understanding of the perspectives and experiences of healthcare professionals in initiating code status conversations with patients admitted to psychiatry.

HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

It is anticipated that about twelve people will take part in this study, from The Ottawa Hospital.

This study should take five months to complete and the results should be known in about ten months' time.

WHAT WILL HAPPEN DURING THIS STUDY?

You will be asked to participate in a focus group. A focus group is a small group of representative people who are asked to speak about their opinions as part of the research. A moderator will organize the focus group. The focus group discussion will be about 60-90 minutes and will take place at The Ottawa Hospital. The focus group discussion will not occur during working hours. You will be asked to speak about your experience and beliefs about initiating code status conversations with patients admitted to psychiatry. The session will be scheduled to take place at The Ottawa Hospital in a private room.

The information you provide is for research purposes only. Some of the questions are personal. You can choose not to answer questions if you wish. Your participation in this study will entail that you discuss personal experiences, which may cause you to feel emotional discomfort or psychological distress related to the possible reminder of stressful events. You have received assurance from the researcher that every effort will be made to minimize these risks, including debriefing and you may contact researchers by phone or email should they have questions or concerns.

You will be audio recorded during the focus group.

WHAT ARE THE RESPONSIBILITIES OF STUDY PARTICIPANTS?

If you choose to participate in this study, you will be expected to:

- Not discuss any information you learn in the focus group with others. This includes information about and opinions from other members.
- Tell the study doctor if you are thinking about participating in another research study

HOW LONG WILL PARTICIPANTS BE IN THE STUDY?

Your participation on this study will last for about 60-90 minutes

CAN PARTICIPANTS CHOOSE TO LEAVE THE STUDY?

You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences or having to provide a reason. If you choose to withdraw from the study, you are encouraged to contact the research team.

You can decide whether or not your previously collected data can be used for the purposes of the study. You may withdraw your permission to use information that was collected about you for this study at any time by letting the research team know.

WHAT ARE THE RISKS OR HARMS OF PARTICIPATING IN THIS STUDY?

The risks incurred during your participation in this study are minimal. However, you understand that your participation in this study will entail that you discuss personal experiences, which may cause you to feel emotional discomfort or psychological distress related to the possible reminder of stressful events. You have received assurance from the researcher that every effort will be made to minimize these risks, including debriefing and being offered a card containing the Crisis Line phone number. You may contact researchers by phone or email should you have questions or concerns. You may become uncomfortable while discussing your experiences. You may choose not to answer questions or leave the interview at any time if you experience any discomfort. While the study team will take precautions to protect your confidentiality, we cannot guarantee that other members of the focus group will respect your privacy or keep the discussions of the group confidential.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

Your participation in this study will allow you to share your experiences and opinions regarding the advanced care planning of psychiatric inpatients. This process will help to contribute to the current understanding of the experiences of healthcare professionals in initiating code status conversations with patients admitted to psychiatry. The knowledge gained has the potential to influence future research and interventions for psychiatric inpatients in regard to advanced care planning.

HOW WILL PARTICIPANT INFORMATION BE KEPT CONFIDENTIAL?

If you decide to participate in this study, the research team will only collect the information they need for this study.

Records identifying you at The Ottawa Hospital will be kept confidential and, to the extent permitted by the applicable laws, will not be disclosed or made publicly available, except as described in this consent document.

Authorized representatives of the following organizations may look at your original (identifiable) records are held, to check that the information collected for the study is correct and follows proper laws and guidelines.

- The Ottawa Health Science Network Research Ethics Board who oversees the ethical conduct of this study.
- The Ottawa Hospital Research Institute, to oversee the conduct of research at this location.

Information that is collected about you for the study (called study data) may also be sent to the organizations listed above. Your name, address, email, or other information that may directly identify you will not be used.

The audio recordings will be stored in a secure location and viewed only by members of the research team. The recordings will be kept until they have been transcribed (turned into written records), and then they will be destroyed.

Measures to protect confidentiality include encryption of the tape recorder used in focus group interviews. A code number will be assigned to your information, and this information will be stored in a locked cabinet at the University of Ottawa that only the researcher team will have access to it. During the discussions, participants will be encouraged to refrain from using names. If names or other identifying information is shared during the discussion, it will not be included in the written records.

If the results of this study are published, your identity will remain confidential. It is expected that the information collected during this study analyzed and published. All information collected as part of the study will be coded. Participants names or other identifying information will be excluded from any publications. Direct quotes from participant interviews may be used in publications or reports from this study; however, they will be modified so as not to reveal any identifying information.

Your de-identified data from this study may be used for other research purposes. If your study data is shared with other researchers, information that links your study data directly to you will not be shared.

Even though the likelihood that someone may identify you from the study data is very small, it can never be completely eliminated.

WHAT IS THE COST TO PARTICIPANTS?

Participation in this study will not involve any additional costs to you or your private health care insurance.

ARE STUDY PARTICIPANTS PAID TO BE IN THIS STUDY?

You will be given a five dollar gift card for your time and participation in the study.

WHAT ARE THE RIGHTS OF PARTICIPANTS IN A RESEARCH STUDY?

You will be told, in a timely manner, about new information that may be relevant to your willingness to stay in this study.

You have the right to be informed of the results of this study once the entire study is complete. If you would like to be informed of the results of this study, please contact the research team.

Your rights to privacy are legally protected by federal and provincial laws that require safeguards to ensure that your privacy is respected.

By signing this form, you do not give up any of your legal rights against the researcher or involved institutions for compensation, nor does this form relieve the researcher of their legal and professional responsibilities.

You will be given a copy of this signed and dated consent form prior to participating in this study.

WHOM DO PARTICIPANTS CONTACT FOR QUESTIONS?

If you have questions about taking part in this study, or if you suffer a research-related injury, you can talk to your study researcher, or the doctor who oversees the study at this institution. That person is:

Principal Investigator Name

Telephone

If you have questions about your rights as a participant or about ethical issues related to this study, you can talk to someone who is not involved in the study at all. Please contact The Ottawa Health Science Network Research Ethics Board, Chairperson at 613-798-5555 extension 16719.

Study Title: Category Status Conversations in the Psychiatric Context

SIGNATURES

- All my questions have been answered,
- I understand the information within this informed consent form,
- I allow access to personal health information as explained in this consent form,
- I do not give up any of my legal rights by signing this consent form,
- I agree to take part in this study.

Signature of Participant /
Substitute Decision Maker

Printed Name

Date

Signature of Person Conducting
the Consent Discussion

Printed Name and Role

Date

Appendix D

Interview Guide

Sample Research Questions Interview Guide

- The interview guide will include questions such as:
 1. Tell me about the current practices for determining a patient's code (category) status?
 2. To what extent should we discuss code status with patients admitted to psychiatry?
 - a. How should/can/do we engage in these conversations?
 3. Tell me about (what is) your role in this process?
 4. When is it appropriate - or not appropriate - to engage in code status conversations with patients?
 5. How should patients and families be included in the code status determination?
 6. Reflecting on your experiences, what made the process easier or harder?

Table 1

Categories and Subcategories

Category	Subcategory
The Psychiatric Culture	Nurses role
Being a Psychiatric Patient	Fluctuating competence Suicidal ideation/ Depression
Physical Health Status	_____
Suggestions and Recommendations	_____