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ABSTRACT

Working with medication is an important role of the mental health nurse. However, little research has focused on staff nurses' perspectives on where the responsibility lies for preparing student nurses for safe, competent medication management. This study investigated mental health nurses' perspectives of medication education. An interpretive descriptive approach was used. Two focus groups were conducted, and data were analysed using inductive content analysis. It was found that participants embraced a medical approach to servicer user care, with less positive attitudes demonstrated toward psychosocial approaches. There were also tensions expressed between clinical practice and the university, with uncertainty voiced about whose responsibility it was to educate students about medication management. It is important that both environments complement each other in order to enhance the student nurse educational experience. While mental health nurses should be educated in this area to practice in a safe and competent manner, it is also key that a holistic approach to care is considered.

KEYWORDS

Clinical competence; Health Education; Models, Nursing; Pharmacology; Students, Nursing

INTRODUCTION

Pharmacology, or medication education, is a key aspect of student nurse education. This includes assessment, prescribing, transcribing, dispensing, administration, provision of medication information, monitoring concordance/side effects, and evaluating effectiveness (Dilles et al. 2011; Sulosaari et al. 2012). Medication administration is an important role of the mental health nurse (Duxbury et al. 2010; White et al. 2018) and the newly qualified nurse is expected to be adequately prepared for autonomous administration of medication soon after qualifying (Wright, 2005). However, there is evidence to suggest that newly graduated mental health nurses do not know enough basic principles of pharmacology (Dilles et al., 2011; Goodwin et al. 2019). Although nursing education is built on a close relationship between theory and clinical experience (Esmaeili et al. 2014), there is a lack of consensus as to how best to integrate pharmacology content into nursing programmes to bridge the theory-practice gap (Preston et al. 2019).

BACKGROUND

Globally, the provision of clinical education for nursing students is described as a challenge for health service organisations (Grealish et al. 2018). It is vital that education programmes prepare students for working in professional environments (Esmaeili et al. 2014). This education also needs to be sufficiently focused and relevant so that students can become competent practitioners quickly and safely (Didion et al. 2013). Student nurses undertake education in various environments: as part of the undergraduate nursing curriculum, and as part of their clinical experience. The dual nature of education often creates tensions, with the co-existing reality of being both trainee and learner within university and practice environments reported as problematic (Jack et al. 2017). One such problem is related to the

delivery of medication education, with students identifying theory–practice gaps in this area (Devi et al. 2010; Ewertsson et al. 2017).

The clinical workplace is a highly complex social environment that provides invaluable experiences for student learning. Nurses are required to facilitate and supervise student learning, in addition to playing a role in assessing competency (Phillips et al. 2017). However, clinical education is context dependant; the experience of learning in clinical practice differs widely from area to area. This variability in workplace culture means that the clinical learning environment influences student nurses positively or negatively (Smedley & Morey, 2009). Furthermore, the nature of nurse education means that students rotate frequently across various settings, and students can miss out on certain medication learning opportunities (Jack et al. 2017; Goodwin et al. 2019).

Before students enter the clinical environment, they should be theoretically prepared; this occurs in the university setting (Jamshidi et al. 2016). Nurse educators are tasked with identifying comprehensive pedagogical programmes that see students transition safely into practice. Part of this process involves equipping students with the skills to transfer knowledge from one setting to another (Benner 2015; Ewertsson et al. 2017). However, research has identified that university settings sometimes facilitate only a narrow focus on medication calculation skills, overlooking other competency areas, such as medication administration and service user education skills (Sulosaari et al. 2012). However, there is a lack of consensus as to how best to integrate pharmacology content into nursing programs (Preston et al. 2019). Furthermore, students have reported medication education to be lacking in varied teaching-learning methods, and found it to be monotonous, with no active learning component (Devi et al. 2010).

Examining ways to improve the landscape of learning and teaching in clinical and academic settings is timely and of vital consideration (Jack et al. 2017). Failure to recognise the limitations that students experience is a major barrier to learning and skill acquisition (Jamshidi et al. 2016), and may hold service user safety implications. Previous research in this area has explored students' perceptions of the theory-practice gap in relation to medication education (Dilles et al. 2011; Esmaeili et al. 2014; Ewertsson et al. 2017), and staff nurses' perspectives on their role in medication administration (Duxbury et al. 2010). However, little research has been conducted on mental health staff nurses' perspectives on responsibilities around medication education.

METHODS

Design

This research aimed to explore mental health nurses' perspectives on undergraduate mental health nursing medication education in university and clinical practice using an interpretive descriptive design (Thorne 1997; 2016). Interpretive description moves away from more traditional descriptive approaches, and from conventional structured methodologies, towards an investigation of the deeper, contextual meaning within phenomena. It is concerned with providing in-depth, nuanced understandings using a flexible inductive approach. This flexibility encourages researchers to embrace techniques of data collection and analysis from various qualitative approaches (Thorne 1997; 2004; 2016).

Setting and Sample

A convenience sample of 10 qualified mental health nurses working in two separate acute inpatient settings (7 female, 3 male) participated in the study. Five were at clinical nurse manager grade; the remaining five were staff nurses. Permission to undertake the study was

granted by the Director of Nursing. An email advertising the study was sent to nurse managers for distribution amongst all qualified mental health nurses in two hospitals in the centre of a medium-sized city. Those interested in partaking contacted the researcher directly. Based on the number of volunteers, two focus group interviews were arranged.

Ethics

Ethical approval to undertake the study was gained from the University's Social Research Ethics Committee (Log 2017 – 117). Participation was voluntary and all data was anonymised. Informed written consent was obtained from each participant. Data is stored in line with University policy.

Data Collection

The first focus group was conducted by two male interviewers, the second by one male and one female; all interviewers were experienced researchers in mental health nursing. Participants were provided with written details outlining the purpose of the study who was conducting the research. At the beginning of the focus groups, the researchers outlined their personal interest in the area and why the study was important to them; an opportunity was provided for participants to ask any initial questions. Focus groups took place at the participants' place of work. Interviews were audio recorded and, other than noting the gender and grade of the participants, field notes were not taken. Focus groups lasted one hour each and were guided by a piloted semi-structured interview guide.

Data analysis

Data were analysed using inductive content analysis at both manifest and latent levels. All analysis was completed using MS Word. In line with Green et al. (2007), four phases to the analysis were undertaken: immersion in the data, coding of data, categorisation of data, and finally, the identification of themes. Manifest analysis was first conducted. Data were

independently analysed by one experienced researcher (JG) and one research student (MH). Data were initially coded: this involved condensing interview transcripts, or labelling the text. Codes were revisited and refined as analysis progressed (Graneheim & Lundman 2004). Codes were grouped under sub-categories. The relationship between sub-categories was then considered, and categories were formed. Themes, representing the latent content, were identified from the underlying meaning running through these categories (Graneheim & Lundman 2004; Green et al. 2007; Graneheim et al. 2017). After an initial thematic representation of the data was devised, this was reviewed by a third researcher (AH). A reworking of the themes between the three researchers took place until a final thematic representation was agreed upon; this approach helped in maintaining the rigour of the analysis (Happell et al. 2018; Horgan et al. 2018; Tanaka et al. 2018).

Member checking was not used. Birt et al (2016) argue that member checking does not allow participants to make claims about trustworthiness and as such it may be considered a meaningless endeavour; furthermore, responses to member checking could arguably constitute new data. In this study, clarification from participants was sought throughout the interviews to ensure an accurate transcription of their perspectives. Rigour is enhanced by being transparent in how data was interpreted (Thorne 2016).

RESULTS

Two themes are reported here: “Clinical Medical Approaches and University Psychosocial Approaches” and “Settings in which Medication Education Should Be Delivered”.

"You're not in this… therapies, you know, fairy-tale": Clinical Medical Approaches and University Psychosocial Approaches

This theme focuses on the perceived differences between the university and practice environments in terms of the delivery of medication education, and the tensions that emerged as a result of these differences. It comprises two categories.

Preference for a Medical Approach to Mental Health Nursing

Participants aligned themselves closely with a medical approach to care, viewing the administration of medication as central to their role. It was stated that the focus of education in university was on psychosocial interventions; however, in the clinical setting, medication administration would take priority over such interventions.

> *It was always, like, the psychosocial interventions* [in university] *[…] but when you're in* [clinical practice] […] *and you're dealing with medication, like, we are giving out medication (Focus Group 2; Participant 1 [2.1])*

> *A huge part of our job, as nurses, is administering and monitoring medication, you know, especially in the acute setting (1.3)*

There was the suggestion of a hierarchical system, where nurses are encouraged not to question the medical model of care. Although some nurses may wish to express opinions in relation to the prescription of medication, it was advised that the medical model – and medical professionals – should not be challenged. This hierarchal view suggests that a true trans/interdisciplinary approach to care is not being adopted, as all team members' opinions may not be valued.

Yeah, the delivery of this model of this care, it shouldn't be, "yay or nay medication". Medication is part of our job (1.3)

you're gonna have to forget about [polypharmacy and anti-psychiatry attitudes] *quick, 'cause it's written down in front of you* [by the doctor] *and you're going to have to be aware of: "This is what you're gonna be dealing with, and this is what you're gonna be using" (1.4)*

Participants were dismissive of non-medical approaches to care, such as psychosocial interventions, considering these to be mostly unrealistic and impractical. However, such approaches to care could be considered, but only once medication started to take effect. In fact, it was stated that, without the benefits of medication, service users would be unable to engage in any form of psychosocial therapy or attend to their normal daily duties.

I think what I learned in college, although very good and bla bla bla, but, like, to what the reality of working in the acute mental health unit or any mental health unit are very different (2.5)

medication is good to get the patient to a point where they can get up and wash themselves, or go to therapy (2.4)

Participants commented on the variances between different nursing disciplines. Although they acknowledged that "mental health nursing" was a discipline unto itself, participants emphasised the "nursing" element of this: nursing is connected with the overall health

sciences and should not be limited to psychosocial approaches. Furthermore, general nurses were perceived to be "real nurses" because of their familiarity with medication.

> *I know it's "mental health nursing", but you're doing "nursing". It's a medical—you're in the Health Science Building (2.4)*

> *I just thought they'd* [general nurses] *be much more knowledgeable than me. They probably were as well actually, but they did have the drug book though, and it just to me looked, I said, "God, they're real nurses" (2.3)*

It was noted that many service users present with both mental and physical health issues. In order to provide holistic care, it was considered important for mental health nurses to be competent in the area of general/medical medication, in addition to psychiatric medication. However, because of their mental health-focused education, participants felt at a disadvantage when administering medications for physical health issues.

> *it's also keeping up with the physical meds as well because we deal with an awful lot of physically unwell patients (1.2)*

> *I know myself, a lot of us wouldn't be very familiar with the physical meds (2.2)*

Tension between University and Placement Area

There were tensions voiced in relation to the different approaches taken by university and practice settings, with the former perceived as unrealistic and disconnected from the clinical

environment. In fact, it was stated that the university treats medication as if it does not exist.

> *it's not spoken about in college that it exists, […] and then you come down to here and you see how much it exists (1.4)*

The way in which medication education is delivered by lecturers was perceived to be subjective and predominantly anti-medication. Students were taught that medication was so harmful that it should never be used, and brought these attitudes with them into the clinical environment. Once they had been exposed to the clinical environment, and expanded their knowledge, participants commented that they were able to form their own opinions, concluding that medication can be beneficial to those experiencing mental distress.

> *what I got from college, was that medication is bad, we shouldn't get to use the medication, move away from medication (1.3)*

> *lecturers had been talking about [Clozaril] and I was like, "Oh my god, Clozaril's a horrible medication," but then when you see the reality of it, it gets people well (2.5)*

Instead of educating students about medication, participants commented that the university was more interested in delivering education about psychosocial interventions and complimentary therapies; these were perceived as being impractical. A preference was demonstrated for older models of education and their focus on using medication, considered as fundamental to mental health practice.

There was very little focus on the pharmaceutical side of psychiatric nursing which is undoubtedly a very big part in it. I think the focus was more on all the therapies and the other side of it (2.5)

it's great in one way, it's lovely, but it's all so flowery, it's not going down to the basics, like back to years ago (2.3)

In taking an overtly psychosocial approach, the university environment was perceived as being "out of touch" with the issues faced in clinical practice. The theory delivered in educational settings was viewed in almost diametric opposition to what students should be taught, with students and staff unable to relate this education to nursing practice in a practical way. In fact, it was noted that students were placed in a "bubble", where they were taught about an unrealistic and idealised view of mental health nursing, one that did not reflect the world in which participants worked.

there's just such a wide gap between what's actually being taught in college and when you come out to the ward (1.1)

I remember when I came out even to 3rd Year, we had this little bubble that we created inside in the college to the reality and what we were dealing with were polars apart (2.5)

The fundamental problem reported with this idealistic approach is that nurses miss out on essential educational opportunities. Participants stated that they would like to be more knowledgeable about the medications they use in practice, and the risks associated with

these medications. However, because of the biased approach to education to which they had been exposed, this knowledge was perceived as limited, preventing them from making more informed decisions. Rather than taking one very strong position on medication management, a more balanced and objective approach was recommended. It was suggested that such a stance would foster a more informed and less prejudiced outlook.

> *How can we change anything if we don't know how it already works? (1.2)*
>
> *But it is reality and it does work and it might not be long term and it does have bad side effects but it has good effects, you know (2.2)*

However, despite advocating for a more medical approach to care, participants also expressed concerns about the overprescribing of medication. It was acknowledged that there is a need for a critical approach to education, as this signalled the start of a transition towards a "better" model of care. In this sense, the weaknesses of the a predominantly medical approach were identified, albeit implicitly.

> *I do believe that medication is overused at times, and in certain types of presentations, medication is the frontline when it shouldn't be (1.3)*
>
> *I can see now with more experience why the college do challenge us about medication […] it does open our minds to different—like probably a better way of doing things (1.1)*

"It's not all back in the college to be teaching this": Settings in which Medication Education Should Be Delivered

This theme focuses on educating students about medication, and the supports that participants felt needed to be put in place by both the university and practice settings. It comprises two categories.

Guidance and Responsibility

There was uncertainty communicated about whether it was the role of the university or the preceptor in clinical practice to deliver medication education, and participants felt more guidance was warranted in this area. Participants commented that, as students, they had received little direction from both the university and clinical settings, with each area shifting responsibility to the other. It was stated that this reluctance to take ownership was frustrating for students.

> *I think from the college point of view it was always said, "You'll do it on your internship" […] but then you come out on placement […] you were told, "Look, don't worry, you'll do it when you're qualified". So, there was definitely kind of a conflict between which side we were supposed to be learning from (1.2)*

Although the absence of direction was perceived to be frustrating, it was acknowledged that students also lack initiative when it comes to learning about medication. Despite being aware of the requirement to learn medication, engagement with this process would not occur until the student was almost qualified. At this point, it was noted that several learning opportunities are missed along the way.

it seems to be you get your roster and the focus then becomes, "I'm going to be a nurse in October. I better start learning 'em" (1.4)

We kinda let it pass us by the whole way through academia and our initial placements, so just the sheer amount that I felt I needed to know and that I didn't know (1.1)

Having transitioned from students to preceptors, participants continued to express a need for guidance that was not being met. It was suggested that learning outcomes on medication management should be made more explicit in students' booklets, with the Clinical Placement Coordinator (CPC) playing a key role as a bridge between the clinical area and the university. It was expressed that preceptors were often unclear as to the level of competence expected from students and how much input was required when delivering education. Here, the role of nursing management in providing direction to staff nurses was highlighted as important.

if it was a part of the book, at least then, like, the CPCs would be coming out from the college and it'd be giving us more direction as preceptors (1.1)

if the management and the CNM said, "This is what we expect. Staff nurses, you're having students, this is what you need to do" (2.1)

Despite emphasising the importance of engaging with students, it was also communicated that preceptorship duties can be negatively perceived. Participants made a distinct separation between their roles as "nurses" and "preceptors/educators", stating that it was

frustrating having to manage these responsibilities simultaneously. It was noted that it is not always possible for nurses to provide students with medication education due to being kept busy administering medication to service users.

> *It's very hard to try and teach somebody while you're trying to focus on dispensing medication for the patient (2.5)*

In particular, preceptoring junior students was negatively perceived, due to the amount of work required in "starting from scratch" with an individual who had not previously been exposed to medication education. Instead, preceptors spend more time with internship students because these students already have a baseline education and are thus easier to teach, but also because they are close to qualifying as staff nurses and more in need of such knowledge.

> *It's difficult then—you're literally taking somebody that's fresh and you're trying to impart all this information (1.4)*

> *when you have students that are in 4th Year, you try to focus much of your time on those students and trying to get them ready (1.5)*

Where Medication Education Should Be Delivered

Both the university and the clinical environments were regarded as having responsibilities in terms of delivering medication education to students. It was suggested that the concept of medication should be introduced in the university setting, but students should receive most of this education in the practice setting, due to the opportunity for practical exposure.

It can be definitely touched on in college but there's nothing like seeing it in practice (2.4)

In this sense, the role of the university was perceived as providing students with a baseline education. Participants recommended that students should be formally examined on medication in the university setting to ensure that they are theoretically competent. Once this criterion has been satisfied, students should then develop their medication knowledge in the practice environment, complementing theoretical information with practical first-hand experience. In this sense, the responsibility for education students about medication was perceived to be a shared one between the university and clinical settings.

I do think there needs to be a balance of both because by doing the assessment process via the university side of things, you're confident then in terms of your delivery that this person has a basic knowledge (1.3)

DISCUSSION

The aim of this study was to explore undergraduate mental health nursing medication education from the perspective of mental health staff nurses. In the past number of decades, mental health nursing has endeavoured to distance itself from a medical approach to care, in favour of a more holistic, biopsychosocial approach (Department of Health 2006; Walsh 2015; Happell et al. 2019). However, participants in the current study embraced a medical approach to mental health nursing. It has been noted that mental health nurses, despite acknowledging that mental distress is influenced by social/psychodynamic factors, are often constrained by the dominance of the medical model (Carlyle et al. 2012). Hornik-Lurie et al. (2018) reported that mental health nurses only interact with clients for brief

periods, often occurs during medication rounds, while other care professionals – such as social workers – spend more time with service users. Hornik-Lurie et al. (2018) also found that that medication was perceived as central to the role of the nurse, and that other models of care were regarded as "fluffy". Other studies have found that mental health nurses want to enhance their knowledge around physical health care (Bolton et al. 2016), indicating that there may be a preference for a return to a more medical approach to care, but also that there are perceived deficits in this area. Psychiatric medications have many adverse side effects which can affect physical health, and mental health nurses are well placed to recognise these side effects and to provide necessary follow-up care for service users (Wand & Murray 2008; Walker & McAndrew 2015). However, it is important that, while mental health nurses should be educated about and aware of physical health and medications, there should not be such a myopic focus on one particular model of care; instead, mental health nurses should promote positive mental health, adhering to the fundamentals of person-centred care (Wand & Murray 2008; Richard et al. 2018; Happell et al. 2019).

It was suggested that general nurses were "real nurses" because they were perceived as having more knowledge around medication. Additionally, participants wanted to know more about medication for physical care. Taken together, there was a sense that participants wanted to be more like general nurses in their approach to care. Whereas nurses in countries such as Australia, the US, and Canada complete a general nursing qualification and may then choose to specialise in mental health nursing, nursing courses in Ireland and the UK are discipline specific. This is not a weakness of the Irish and UK systems: in fact, in countries where they have moved from separate points of entry, workforce challenges have been observed, especially in fields such as mental health nursing (Happell and McAllister

2015). The Department of Health (2012) in Ireland, following an extensive review of undergraduate nursing and midwifery degree education, recommended that separate entry points for nursing education should remain in order to retain academic and clinical integrity. However, universities need to ensure that mental health nursing curricula sufficiently addresses the physical care needs of service users often observed within the mental health setting.

There was a suggestion by participants that the reason for the dominance of the medical model was owing to the existence of a hierarchy amongst mental health professionals. Historically, the medical model dominated all mental health practice (Goffman 1961), and nursing staff were viewed as subordinate to the medical profession (Williams 1978). Over the years, nurses across all disciplines have strived to distance themselves from being relegated to "handmaiden" status, becoming more respected and autonomous as a profession (Byrne & Happell 2012; De Souza 2017; Scott 2017). However, there is a sense that this traditional hierarchy is still in place. MacLaren et al. (2016) reported that, although mental health nurses regard themselves as skilled and experienced, they continue to experience an in-built inferiority to professions such as medicine and psychology. It is crucial that mental health nurses continue to develop as a profession, and that they instil recovery-orientated values into the organisations in which they work so that such an ethos can influence all members of the inter/transdisciplinary team (Cusack et al. 2016). It is important that nurses incorporate medical approaches – medication administration included – into their holistic approach to care; however, an over-reliance on such approaches could be viewed as a backwards step (Byrne & Happell 2012).

Despite a clear preference for adopting a medical approach to care, it was acknowledged that a "better" approach to care existed, but staff did not feel confident in their knowledge

to be able to challenge the medical model as the dominant model of care. Research indicates that pharmacological competencies should be addressed more structurally. Specifically, a more detailed pharmacology curricula has been called for, including a framework for defined goals for medication education (Dilles et al. 2011). Equipping students with such knowledge would enable them to make more informed decisions as staff nurses and encourage them to advocate on service users' behalf (Eisenhauer et al. 2007; Magennis et al. 2014).

One reason cited for students' lack of knowledge around medication was the owing to the perception that university staff were "out of touch" with the reality of clinical practice. Other studies have reported similar findings (Diekelmann & Gunn 2004; Hinton & Chergwin 2010; Rahman & Applebaum 2010) and have highlighted the importance of faculty staff having a clinical remit (Owen et al. 2005; Rico et al. 2010). Pharmacology curricula should to be developed in conjunction with and partly delivered by those still working in clinical practice in order to ensure education is contemporary and relevant.

There were tensions voiced about who the responsibility lay with for educating students about medication, and owing to such tensions, it appears that students often only concentrate on learning medications at the end of their studentships. University staff and preceptors have a mutual responsibility in facilitating students' knowledge transfer processes (Ewertsson et al. 2017). The educational institution has a responsibility in curriculum development, integration of theory and practice, and in ensuring the development of nurse students' medication competence. While research into the role of the nurses' educational institution as a learning environment for medication is limited (Sulosaari et al. 2012), it has been reported that students often find it difficult to translate information covered in education settings into clinical practice (Preston et al. 2019). The clinical setting is

an ideal setting to facilitate students to think critically, to apply their didactic learning, and to bridge the practice-theory gap of medication education. It is important to ensure there are strong working relationships between the classroom and clinical instruction (Preston et al. 2019). Although some participants voiced dissatisfaction about their role in educating students about medication, preceptors play a key role in educating students about medication (Benner 2015; Koharchik & Flavin 2017). Furthermore, students have identified that medication education is best delivered in the clinical setting rather than in university, although it has been suggested that university settings should thread this education across the curricula, in order to make it more manageable for students (Preston et al. 2019). It is vital that educators in both settings support students' professional development and provide them with the requirements to complete their programme (Jack et al. 2017).

LIMITATIONS

Only staff in acute settings were interviewed; it is possible that staff working in community settings may have offered alternative perspectives. Staff provided their views on university education; however, including current students in the focus groups may strengthened findings. Another limitation is the use of focus groups, which may result in the loss of in-depth interpretations of individual responses (Thorne 2016), or in "group think", where participants refrain from offering their personal responses to avoid the risk of upsetting the harmony of the group (Shirley 2012). Finally, a small sample size was employed, and although participants from two different units were interviewed, they were all working in the same city.

CONCLUSIONS

There are tensions between university and clinical settings in relation to the delivery of medication education. Both environments share a responsibility to enhance the student

nurse experience and ensure that mental health nurses are adequately prepared to deliver holistic care to service users. Medication is one element of such an approach to care, but it is crucial that mental health nurses do not return to predominantly medical approaches; instead, these nurses need to be fully educated about the diverse range of methods that can contribute to a holistic approach to mental health practice. It is also important that nurses working in clinical settings contribute to education, informing students about current practices. In this fashion, a balance can be achieved between relevant clinical practice and contemporary evidence-based approaches to care.

RELEVANCE TO PRACTICE

Current mental health nursing practice is informed by a recovery-focused ethos and the biopsychosocial model. However, findings from the current study indicate that a more medical approach to care may be favoured by nurses. Certain aspects of this approach complement a biopsychosocial model, but it is important that mental health nursing adopts an overall holistic focus, influenced by medical approaches and medication administration, but not dismissive towards its psychosocial foundations. However, it is also important that mental health nurses are educated enough about medication to make informed decisions confidently about service user care. In order to achieve this, it is essential that university and clinical settings develop a shared understanding of student nurse education needs around medication management.

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[redacted at present to ensure anonymity]

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