Check for updates

Psychiatric mental health nursing in the international year of the nurse and COVID-19: One hospital's perspective on resilience and innovation - Past, present and future

Sharon Ward-Miller [*], Elizabeth M. Farley, Linda Espinosa, Mary Ellen Brous, Judith Giorgi-Cipriano, Janet Ferguson

NewYork Presbyterian Hospital, Westchester Behavioral Health Center, 21 Bloomingdale Road, White Plains, NY 10605, USA

ABSTRACT

In the International Year of the Nurse, we are in the midst of a global pandemic. Historically, nurses have been at the forefront of crises influencing standards of care and public health policy. Managing psychiatric patients during the current COVID-19 pandemic has challenged the psychiatric nurses' role within the therapeutic milieu fostering innovative practices to meet patient needs. Our behavioral health center met the challenges with resilience, creativity and commitment. The next challenge is to learn from experience. Building on innovative technology opens the window to new models of care. Understanding resilience is critical to preparing for the next crisis.

"In the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided and experienced in culturally meaningful ways."

(Ungar, 2008, p. 225)

Introduction

In 2020, the International Year of the Nurse, the call to action for nurses across the world has never been louder. Caring for the emotional needs of patients has always been a core value of nurses throughout history, but never more apparent than in times of crisis. Psychiatric nurses bring specialized skills in recognizing the impact of illness on the emotional state of our patients. In the midst of the COVID-19 global pandemic, is the pendulum swinging for psychiatric nurses to develop new models of care? The global pandemic has challenged the resilience and ingenuity of healthcare workers. The profession of nursing, the most trusted and respected, has been on the front lines, racing to care for the physical and emotional needs of their patients and families while struggling to keep their own worries for self and loved ones at bay. In times of crisis, whether it be war, epidemic, famine or natural disaster, nurses have been there to bring care and comfort to those in need.

One hundred and seventy-five years have passed since Florence Nightingale struggled to bring about changes in public health and infection control. Lessons learned caring for wounded soldiers at Barracks Hospital in Scutari during the Crimean War of 1854 set the course that would shape early infection prevention standards deemed critical in today's global pandemic. With 38 nurses under her command, the mortality rate in the hospital in that first winter rose to 42.7%, killing 4077 soldiers, more than died on the battlefield (Hammer, 2020). By March of 1855, the sources of water contamination and infection spread were identified and eliminated bringing the mortality rate to 2.2%. Nightingale dedicated her life's work to public health education (Hammer, 2020, p. 29). For 50 years, Nightingale worked to transform nursing into a respected profession, introduced "sanitary science" to nurses' training, revolutionized India's public health system and pioneered statistical analysis, using data to prove her outcomes (Nelson, 2003). Since Nightingale's foundational work in the mid-1850s, nursing has produced innovative leaders who have advanced the theory of nursing, forging new pathways in the care and comfort of our patients and families through re-examining our core values.

A nursing leader emerged in the 1930's who would transform nursing as a profession and impact psychiatric-mental health nursing as a specialty. Hildegard Peplau enlisted in the U.S. Army Nurse Corps during WWII and was stationed in England. Using innovative approaches to the care of wounded "battle-fatigued" soldiers in a psychiatric hospital, Peplau formed the basis of her groundbreaking theoretical framework. By 1952, she transformed the nursing profession and introduced *Interpersonal Relations in Nursing* (1952). Peplau's impact on American nursing has been compared to those of Nightingale's in Europe one hundred years earlier. Her theoretical perspective was "revolutionary" and represented a paradigm shift in nursing (Calloway, 2002). Peplau believed that persons with psychological disturbances would respond to a "giving, supportive, caring, and thoughtful environment" (Calloway, 2002). She worked to enhance nursing as a profession demanding that nursing "define itself and be able to demonstrate and explain its role" (Calloway, 2002).

The aim of this paper is to describe one hospital's experience with the management and care of psychiatric patients, the impact on the therapeutic milieu and the concern about nursing staff resiliency during the COVID-19 global pandemic. With the strength of nursing leadership in collaboration with interdisciplinary departments, nurses were able to navigate the storm of constant change with a new awareness of the challenges ahead.

Current perspectives: disruptive innovation-gearing up

This article describes the experiences of NewYork-Presbyterian Westchester Behavioral Health Center during the COVID-19 pandemic. NewYork-Presbyterian Westchester Behavioral Health Center is a 263-bed freestanding psychiatric hospital, approximately 25 miles north of New York City, providing both inpatient and outpatient services to children, adolescents, and adults. The behavioral health center is one campus of NewYork-Presbyterian Hospital, a comprehensive academic medical center based in New York City. NewYork-Presbyterian Westchester Behavioral Health Center has received recognition for excellence in nursing from the American Nurses Credentialing Center's (ANCC) *Magnet Recognition Program®.* Designation from the *Magnet Recognition Program®* demonstrates that a hospital acknowledges the "invaluable potential of nurses to lead healthcare change" (American Nurses Association website, n.d.). NewYork-Presbyterian Westchester Behavioral Health Center was also the first behavioral health center in the nation to be named by Planetree Inc. as "Gold Certified for Excellence in Person-Centered Care™". Planetree's Certification for Excellence in Person Centered-Care™ is an evidence-based program representing "the highest mark of achievement for creating an organizational culture that engages patients, families, staff, and the community to improve overall health and well-being" (www.planetree.org). Planetree forged the person centered-care transformation in healthcare and upholds the tenets of quality, compassion, and partnership as the essence of this model.

Soon after the first cases of Coronavirus Disease 2019 (COVID-19) were confirmed in New York State, the devastating implications of the disease on individual, familial and systemic levels began to rapidly unfold. Seemingly, overnight, hospitals were faced with unparalleled circumstances and were called to implement sweeping organizational changes based on information that was continually evolving. What role would a behavioral health center within a large academic medical center play during the COVID-19 pandemic? It soon became clear that our behavioral health site would play a pivotal and multifaceted role in responding to the demands presented by COVID-19. The traditions of resiliency and innovation within the nursing profession were embedded in this response.

Surge planning and enterprise restructuring

The rapid proliferation of COVID-19 cases in New York City created a critical need to increase bed capacity across the entire NewYork Presbyterian enterprise. At NewYork-Presbyterian Westchester Behavioral Health Center, our surge planning efforts were dual focused: Work toward increasing medical bed capacity across the enterprise while also reviewing the utilization of inpatient beds within our behavioral health site. To this end, we began an intense effort to review our systems and plan the restructuring.

The first major undertaking was to prepare for the surge of medically ill patients within our healthcare enterprise. Specifically, the plan involved relocating an inpatient psychiatric unit from one campus in New York City to a vacant space at our behavioral health center. Led by our Vice President (VP) and Chief Nursing Officer (CNO), an interdepartmental and cross-campus group was formed to coordinate this transition and to review the anticipated implications for staff and hospital resources. One considerable implication was that nurses and nursing support staff would need to change their work location from New York City to a northern suburb. The patients on the New York City unit would also be transitioning to a different location and in addition to communicating this fact to the patients and their families, transportation planning was initiated to ensure safe transport on the day of the move. Resources and equipment for the unit, notification and approval from regulatory agencies, psychiatric nurse staffing ratios, orientation of nurses and nursing support staff to a new environment, and logistics regarding electronic medical records and transition of charts were some of the many components of the comprehensive planning process. After frequent meetings led by the VP/CNO, each day over a condensed timeframe, the intense preparation proved efficacious when the successful transition occurred. The former psychiatric unit at the New York City campus was then converted to accommodate the anticipated influx of COVID patients with medical needs.

On a local level at our behavioral health center, the leadership team reviewed the current composition of our 12 inpatient units, each with a distinct focus on age-groups, gender, or specific diagnosis. Review of the child and adolescent programs was an initial priority because a need for more adult beds was anticipated across New York State. In consultation with regulatory agencies and local hospitals, a decision was made to temporarily suspend the inpatient child program and refer child admissions to a local psychiatric hospital. Our adolescent program was maintained, but the adolescent patients were relocated to the smaller space previously occupied by the child program. The former adolescent unit was then converted to an additional adult psychiatric unit. This restructuring led to an increase in adult bed capacity and provided more single room options. However, these changes again were not without staff and programmatic implications. For example, psychiatric nurses and nursing support who had worked primarily with the adolescent population were now working with adults and those staff who had previously been working with children were now working with adolescents. Although psychiatric nurses at the behavioral health center are cross-trained to work with all patient populations, additional age-specific competencies were reviewed during the transition of units to build upon the existing skill sets of psychiatric nurses. For example, regulatory standards regarding the time limits of restraint and seclusion orders differ for adults, adolescents and children. During a time of great uncertainty and fear related to the COVID-19 pandemic, the psychiatric nurses were resilient in their ability to adapt to new settings and new patient populations.

Opening of COVID-19 units

While complex changes were being made to accommodate the expected surge of patients across the entire hospital enterprise, it was not readily apparent to what extent our behavioral health center would receive COVID positive patients. However, when we began to receive patients with suspected and confirmed COVID-19, it became clear that we would need to establish COVID units. We started by opening one COVID unit, but within two weeks, the need for a second COVID unit emerged. With the exponential increase of COVID-19 cases in New York

City, planning and implementation seemed to take place concurrently.

Two adults units at the behavioral health center were converted to COVID units. Psychiatric nurses on these units were initially very apprehensive about working on a unit with only COVID positive patients. As some of the psychiatric nurses recalled, the first few weeks were the most trying. Concerns about adequate supplies of personal protective equipment (PPE) and N-95 masks were expressed as well as worries about personal exposure to the virus and its consequences. One immediate change to alleviate some apprehension was rolling out the hospital scrubs program. Prior to the pandemic, the dress code for psychiatric nurses at the behavioral health center was business attire. The scrubs program was implemented on the COVID units in which the psychiatric nurses and nursing support staff would arrive to work and receive a pair of scrubs to wear for the shift. At the end of the shift, they would leave the scrubs in a designated area and obtain new scrubs on their next scheduled shift. Staff were also provided with N-95 masks, paper gowns, and gloves, booties and head coverings. All nursing staff were expected to watch a video on donning and doffing PPE and the nursing staff would huddle each day and practice before engaging with patients directly. As time went on, this became routine and practice was no longer needed. As additional nurses and nursing support staff were floated to the unit, an experienced nursing staff member would review the process with the new staff.

To minimize staff exposure, certain patient care tasks were divided among all three shifts so no one shift would have increased contact with the COVID-positive patients. For example, nursing staff on the night shift would complete the 6:00 am vitals and the evening shift staff would complete the evening vitals, leaving the day staff to have contact with the patients for other activities including meals, treatment team meetings and medication administration.

Infection prevention and control

Prior to the COVID-19 pandemic, masks, gowns, and other PPE were infrequently indicated and thus sparingly used at our behavioral health center. With the onset of the pandemic, our practices regarding PPE and infection prevention control measures were immediately reviewed. Shortages in PPE supplies as the COVID positive patient population increased was quickly apparent and the need to efficiently preserve and utilize PPE was clear.

The first step was to assess our supplies of PPE. A process was developed in which the nurse manager on each unit provided a daily update on the amount of PPE used and the amount of PPE remaining. All requests for additional PPE were processed through the centralized supply room to better manage and track PPE utilization. This tracking mechanism allowed the hospital to provide a supply of resources to nurses and nursing staff as information regarding isolation precautions and PPE became more defined.

While there were daily and detailed discussions regarding the use of PPE on the inpatient units, additional infection and prevention control measures were also being implemented at the behavioral health center. Visitors were restricted from visiting the adult inpatient units, but one visitor per day was permitted for adolescent patients. All hospital staff entering the psychiatric hospital, regardless of role or department, were required to wear masks at all times. Every patient in the hospital was also required to wear a mask.

In addition to masks for all patients, there was much discussion about patient testing. Only symptomatic patients were initially tested for COVID-19, but processes evolved so that every patient was tested upon admission. Because most psychiatric patients were being transferred from emergency departments within our health care enterprise, concerted efforts were made to learn the COVID-19 status of patients prior to transfer. This information led to more seamless bed assignment and increased safety for patients and hospital staff.

One of our higher risk treatments in psychiatry is Electroconvulsive Therapy (ECT) due to the use of general anesthesia and the aerosolizing nature of the procedure. A psychiatric nurse-led performance improvement project was initiated to reduce the risk of COVID-19 for the ECT healthcare team and to analyze the type and use of PPE and workflow issues. Prior to March 20, 2020, the ECT healthcare team did not regularly wear PPE other than gloves. Performance improvement guidelines were developed for providing ECT with COVID-19 precautions. These guidelines outlined an RN Assessment one-hour pre-ECT, including a betadine nasal swab of each patient prior to leaving the unit, education for all ECT staff regarding donning and doffing and a revised ECT recovery process related to COVID-19. Patients were also tested for COVID-19 prior to their first ECT treatment and weekly thereafter. This performance improvement project raised awareness of the need for expanded policies and practices to reduce risk of exposure and possible infection of both patients and the healthcare team. These enhanced processes had the added effect of reducing anxiety among the ECT healthcare team.

Finally, to limit exposure of patients and staff, the general philosophy of treatment on the inpatient psychiatric units was dramatically altered. Whereas patients had traditionally been encouraged to spend much time out of their bedrooms, patients were now being encouraged to socialize less and isolate more. These treatment changes, along with the other infection prevention measures, were not without barriers. Most patients at our behavioral health center are ambulatory and it was challenging for some patients to adhere to social distancing guidelines. Some patients were also resistant to wearing masks. The psychiatric nurses' communication skills were essential in educating patients about the need for social distancing, mask wearing and handwashing. Additionally, many patients exhibited increased anxiety in response to COVID testing and contracting the virus. One on one conversations between the psychiatric nurse and the patient became an opportunity to acknowledge concerns and attempt to allay anxiety. Patients treated for psychotic disorders had a more difficult time following mask and social distancing guidelines often due to disorganized thoughts or paranoid ideation. Patients treated for personality disorders would challenge the need for masks and social distancing. Nurses and nursing support staff used repetitive reinforcement, active listening and empathy to meet safety concerns of patients and staff alike.

Programmatic restructuring on the units

The layout of all units consists of single and double rooms. To maintain social distancing and quarantine measures, all patient rooms became single occupancy. On admission, patients were assigned to groups of no more than six patients using a cohort model and remained in that same group until discharge. All unit activities were structured by cohort, such as meals, television time and therapeutic groups. The assignment of each cohort was geographic using the unit floor plan and room numbers. This allowed patients to be out of their rooms for meals in separate areas of the unit while maintaining a distance of six feet apart. For example, Cohort 1 ate their meals in the patient dining room, Cohort 2 ate in the dayroom, Cohort 3 ate their meals in a secondary living in the back of the unit and Cohort 4 ate at the end of the opposite hallway. Group activities and television time was rotated by cohort throughout the day, using the unit microphone to call each cohort to an activity. Nurses and nursing support staff were also assigned to work primarily with individual cohorts to minimize the number of staff interactions per patient. For example, care rounds, vital signs, medication administration, and 1:1 suicide watch were assigned by cohort. As new admissions arrived daily, the cohort assignments would be updated to reflect discharges and admissions. Efforts were made to provide patients with individual activities and supplies to be used in their room to help pass the time. Interactions with the treatment teams occurred each morning in person with all members maintaining a six -foot separation and wearing masks. Patients were also expected to wear masks whenever outside of their rooms. If a patient began to exhibit COVID-19 symptoms, they would be placed on contact and droplet precautions,

swabbed for presence of COVID-19, and remain quarantined in their room until a negative test result was achieved. Nurses and nursing support staff would don personal protective equipment whenever they were providing direct care to that patient.

The implementation of cohorts on the inpatient psychiatric units was a significant departure from traditional milieu treatment on the inpatient units. Prior to the pandemic, the cohort model did not exist. All patients ate meals together, attended therapeutic groups with large numbers of patients and were generally encouraged to spend much time out of their bedrooms and to interact with other patients in the milieu. The cohort system required a great deal of coordination and innovation to limit exposure to certain individuals throughout the hospitalization while also providing a therapeutic environment in which patients can heal and learn.

In addition to the programmatic changes on the units, local mental hygiene court appearances were also restricted, necessitating weekly virtual court hearings to be held in the hospital. Prior to the pandemic, court hearings for treatment over objection and retention/release would be held every Friday at the local county courthouse. Patients would be transported to the courthouse via either van or ambulance depending upon the patient's risk assessment and clinical presentation. With decreased access to the courthouse during the pandemic, a hospital conference room was set up each Friday so that patients, psychiatrists, and attorneys could communicate with the judge via video technology. This accommodation has prevented delays in treatment and in granting hearings to patients. Additionally, patients who would have required transport on a stretcher via ambulance, can now walk to the conference room and participate in the hearing with less restrictions.

Regulatory considerations

In 2017, to prevent suicide in inpatient hospital environments, the Joint Commission (TJC) and the Centers for Medicaid and Medicare Services (CMS) enhanced their position on suicide risks. Despite prevention initiatives, suicide continues to be a major public health concern nationwide and in New York State. It was no longer acceptable for hospitals to only identify existing risks with an eventual plan of correction. Regulatory agencies now required hospitals to submit time-limited and specific remediation plans for the physical plant and clinical risk mitigation strategies (*Safety Standards,* 2020). Psychiatric nursing plays a significant role in both the identification of clinical risk (comprehensive suicide risk assessment) and the mitigation of clinical risk (observation checks, safety scan, inter-shift rounds). Although these strategies are accepted by regulatory agencies, we need to demonstrate constant awareness and safety assessment of our treatment environment. As psychiatric nurses, we have become risk averse to the point of considering whether to allow paper clips or even magazines fastened with staples to be provided to the patients.

On March 25, 2020, in response to the challenges presented by COVID-19, the New York State Office of Mental Health (OMH) issued a memorandum supporting the easing of regulations, statutes, and hospital policies for New York State Article 28/31 hospital psychiatry providers. Documentation requirements were modified to include the treatment plan and progress notes. Seclusion and restraint could be ordered by a nurse practitioner or physician assistant. Also, the use of Tele-Mental Health for routine treatment was endorsed by OMH (Smith, 2020).

The nurses responded positively to the relaxing of documentation requirements and acknowledged that there was increased time available to care for patients. As we look to the future, it is essential for psychiatric nursing to evaluate the effect of these practices on both patients and staff. If we decide the benefit outweighs any risk involved, then we must advocate to regulatory agencies for the continuation of the current modifications.

Teamwork during a crisis

In behavioral health, the interprofessional team is fundamental to the treatment of our patients and families. In the *New Normal* at our behavioral health center, our focus became mitigation of the infectious process while continuing to provide safe, effective psychiatric care to our patients and safety and protection of all staff. This required coordination and collaboration from all departments in the hospital in real time to address the rapidly changing measures needed to meet patient care needs. Nursing leadership communicated to nurse managers daily, and sometimes more often, what actions needed to be carried out at the unit level and these directives were then communicated to the nursing staff and the other team members. As previously discussed, nurses were required to plan and organize nursing staff assignments by cohort to minimize patient and staff exposure. Nurses needed to work closely with the admissions/evaluation center to assign new patients to the correct cohort, to determine if the patient had been tested for COVID-19 or was awaiting the test results. The family nurse practitioners worked closely with the unit nurses to both assess and test patients with emerging COVID-19 symptoms. One nurse practitioner joined the daily morning huddle with nursing leadership to review the status of COVID-19 positive patients and patients under investigation (PUI).

Leadership

Innovative and resilient leadership across the NewYork-Presbyterian Hospital Enterprise was essential not only to survive, but also to flourish as an organization. Communication was a critical factor in leading our teams through the early stages of the pandemic. During times of crisis, communication should be early, frequent, transparent, and accurate (Edmonson, Sumagaysay, Cueman, & Chappell, 2016). As the information regarding COVID-19 continued to evolve, so too did the questions and concerns raised by nursing. One of the first measures taken by the healthcare organization was to institute an extensive communication strategy to help explain the deluge of COVID-19 information as well as to share the diverse resources available to support staff through the crisis. In our *war* against COVID-19, NewYork Presbyterian set up a virtual command center as the hub of all communications and operations. However, in our Planetree Model of Person Centered-Care™, the words leadership choose to define their actions may convey a message that is more negative than intended. Words were powerful in shaping the outlook of the pandemic. Going forward we may change our language choices to evoke a more positive outlook and instead of implementing a virtual "command center", we may instead institute an "assessment and monitoring center" to best convey our efforts to assess and meet needs ("Re-Thinking Word Choice", 2020).

The information was relayed through various communication channels. On an enterprise-wide level, the President and Chief Executive Officer and the Executive Vice President and Chief Operating Officer provided daily video updates to the team across the entire health care system. At our behavioral health center, the VP/CNO instituted daily nursing leadership huddles to convey new information and to discuss the resiliency of the nursing department as they navigated the challenges of COVID-19 on nursing practice. During this time, increasing numbers of staff were reporting COVID-19 symptoms requiring them to remain off duty for a minimum of seven days or longer depending on positive COVID-19 disease. Unit staffing patterns were affected requiring skillful planning for each shift as well as future planning by the staffing coordinator in consultation with the nurse managers. Beginning in early
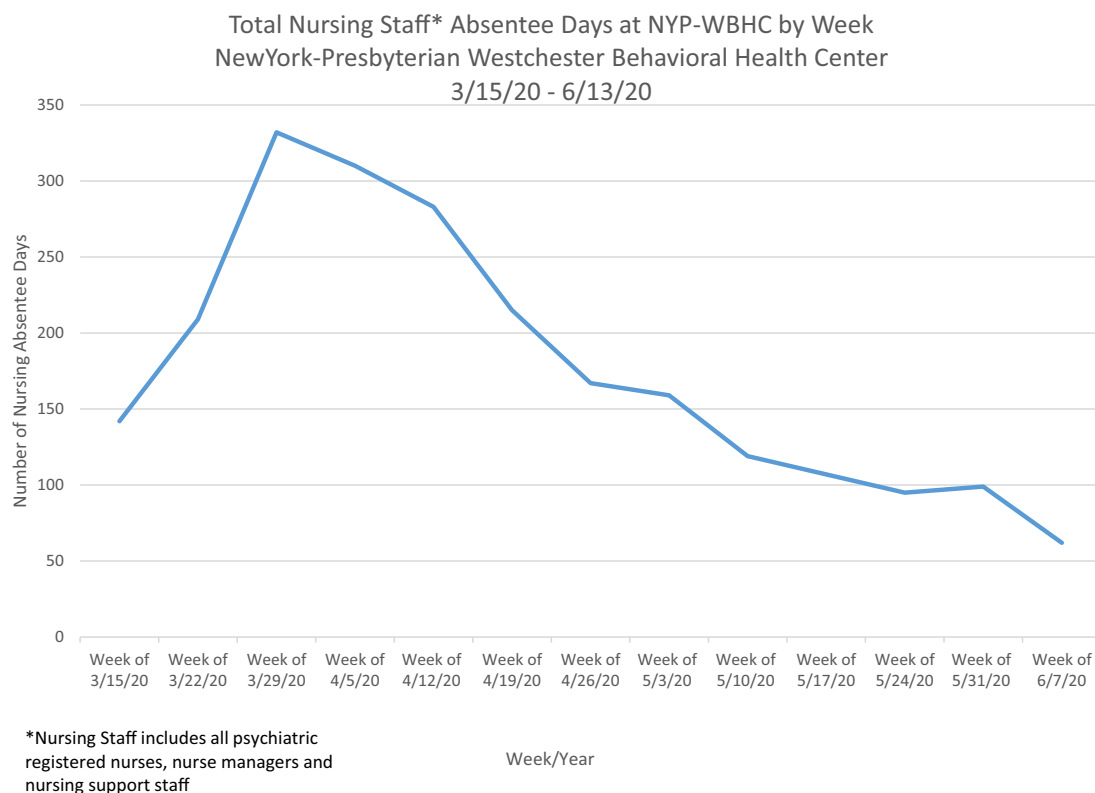
Total Nursing Staff* Absentee Days at NYP-WBHC by Week
NewYork-Presbyterian Westchester Behavioral Health Center
3/15/20 - 6/13/20

*Nursing Staff includes all psychiatric registered nurses, nurse managers and nursing support staff

Week/Year

Fig. 1. Depiction of nursing staff absentee days by week at NewYork-Presbyterian Westchester Behavioral Health Center during the first months of the COVID-19 Pandemic.

March 2020, the number of nursing staff sick calls began to increase significantly, peaking during the last week of March with 332 nursing staff sick calls. To meet nursing staffing ratios, a combination of travel nurses, per diem staff and overtime was utilized (Fig. 1).

In addition to the daily nursing leadership huddles, the nursing-led tiered communication system already in place was leveraged to receive and provide COVID-19 related communication on unit, departmental and leadership levels. Through this tiered structure, concerns or questions could be escalated and feedback would then be provided back to the units or departments to promote communication and responsiveness. As leaders of the largest hospital workforce, it is essential that nurses be at the forefront of managing crises (Edmonson et al., 2016, p. 419). As a member of the senior leadership team, the VP/CNO facilitated communication across all departments at the behavioral health center. Management of patient flow within each unit was the responsibility of the nurse manager. Morning leadership huddles became the forum for reviewing pending discharges, transfer of patients between units, COVID-19 positive patient numbers and patients under investigation (PUI) awaiting test results. A second midday leadership huddle was added by the VP/CNO to check in with the nurse managers and take the pulse on staff morale. Effective communication and collaboration throughout each day and evening remained essential as the crisis evolved.

Future perspective: challenges, resilience, innovation

Challenges

The full effects of the COVID-19 crisis on the mental health field are not yet known. However, the mental health consequences are likely to be present for longer and peak later than the COVID-19 pandemic (Gunnell et al., 2020, p. 470) and the pandemic "has potential to create a secondary crisis of psychological distress" (Choi, Heilemann, Fauer, &

Mead, 2020, p. 1). Nurses and nursing leaders have been at the center of addressing patient needs during the pandemic (Choi et al., 2020) and they will continue to be at the forefront of responding to the mental health impact of the crisis. The immediate challenge for psychiatric nurses and healthcare organizations will be to identify risks and support innovations that address the needs of patients and families while also caring for the caregivers both individually and collectively. Empowering nurses to have a voice in determining best practices within expanding models of care can support resiliency and decrease the effects of burnout. The ongoing challenge will be to resist falling back to old ways and develop disruptive innovative ways to think, plan and implement comprehensive interventions using all the new technological tools and management models available. Building on the resourcefulness and resiliency of nurses on the front lines will open a window on what needs to be done to prepare for the next crisis.

Resilience

The impact on our healthcare workforce may have far-reaching sequalae and may develop into a crisis if not addressed in the early days post-pandemic. Post-traumatic stress disorder in front line healthcare workers has been identified as a mental health concern. Resilience in the face of adversity assumes an individual can "adjust, maintain equilibrium, sustain some control over emotions and continue to move on in a positive manner" (Jackson, Firtko, & Edenborough, 2007). Nurses often neglect their own self-care in lieu of caring for others leading to burnout and stress related consequences (Khamisa, Peltzer, Ilic, & Oldenburg, 2016). Building on the positive strengths of nurses will increase their resiliency reserves allowing them to care for others especially in times of crisis. The *Scope and Standards of Practice Psychiatric-Mental Health Nursing* describes nursing interventions as an "art and a science, employing a purposeful use of self and a wide range of nursing, psychosocial and neurobiological evidence to produce effective
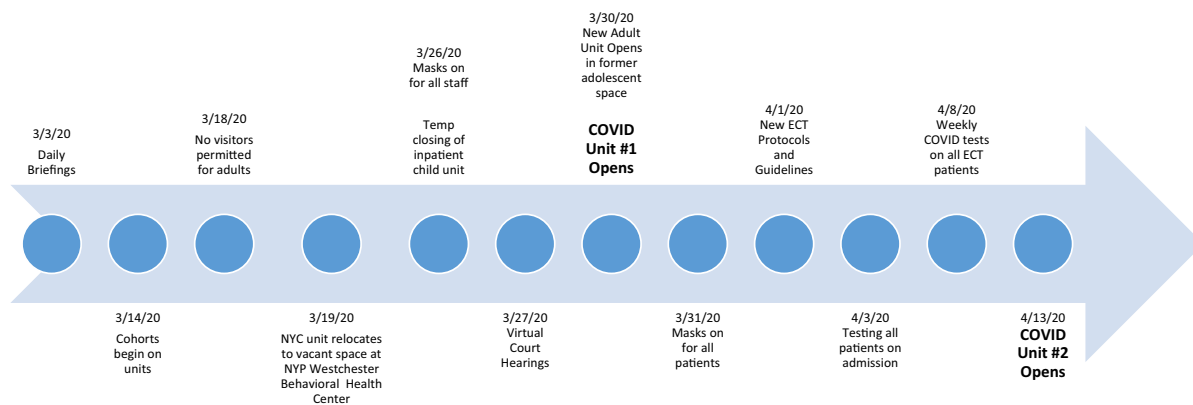
Fig. 2. Significant actions taken by NewYork-Presbyterian Westchester Behavioral Health Center during the first months of COVID-19 Pandemic.

outcomes" ("PMHN Standards", 2014, p. 1). To employ a "purposeful use of self", psychiatric nurses need to understand the importance of emotional self-awareness, empowerment, autonomy, and self-care as key factors in supporting and enhancing resilience. Investment in a sustained response by leadership that fosters resilience in both staff and the healthcare organization will have long-term benefits beyond the current crisis. Resilience research in clinical practice identified key factors that increase resilience levels, and support staff "bouncing back". These include self-determination, positive relationships, self-esteem, self-efficacy, and hopefulness (Earvolino-Ramirez, 2007). Hart (Hart, Brannan, & DeChesnay, 2012) described individual resilience characteristics of nurses. Hope, coping, self-efficacy, control, competence, flexibility, adaptability, hardiness, sense of coherence, skill recognition and decreased focus on deficiencies were seen to increase levels of individual resilience (Hart et al., 2012). As defined by McManus, organizational resilience is a "function of an organization's overall situation-awareness, management of keystone vulnerabilities, and adaptive capacity in a dynamic, and interconnected environment" (McManus, Seville, Vargo, & Brunsdon, 2008). At our behavioral health center, all new graduate nurses participate in a yearlong nurse residency program, which promotes successful entry into practice. During the pandemic, one graduating class of nurse residents noted that the program also served the purpose of supporting them and fostering their resilience.

Innovation

Innovation has been an overarching and necessary principle in the nursing response to the COVID-19 pandemic. With the presentation of a novel coronavirus and the particularly devastating impact of the disease on New York City, the interventions often needed to be disruptive as well as innovative. While innovations strive to improve existing products or services, disruptive innovations are developed by asking new questions and focusing on the work that needs to be done (Blakeney, Carleton, McCarthy, & Coakley, 2009), (Boston-Fleischhauer, 2015). While the innovative procedural and programmatic changes at our behavioral health center were adopted to meet the needs of the rapidly evolving pandemic, it is evident that many of these disruptive innovations will not be fleeting and will instead continue to shape the delivery of inpatient psychiatric care well after the crisis has passed (Fig. 2).

A. Technology

Pre-COVID-19, technology was used by patients on the inpatient psychiatric units on a limited basis and generally under strict parameters and supervision. Each unit was equipped with two iPads located in a shared dayroom space and enclosed in a stationary, safety kiosk. The limited use of technology was primarily due to safety and privacy concerns. In the wake of the pandemic, it was evident that the implementation of technology must be rapid and widespread and that our conservative stance must be relaxed to counteract the restrictions created by the pandemic. Now, iPads are available to patients to promote visitation with family and friends. For COVID positive patients, who are under isolation precautions, the iPads also provide the opportunity to participate in group therapy and communicate readily with staff. While the increased use of technology has been a significant change on the inpatient psychiatric units, "the premise of disruptive innovation isn't about the technology itself, rather it's about applying that technology in a simpler, more radical way to create a new product or a new environment for using the product that didn't previously exist" (Sensmeier, 2012, p. 13). Increasing the use of technology will not singularly shift the status quo for inpatient psychiatric treatment, but the application of that technology in a new environment will be the catalyst to transform inpatient psychiatric care.

Group therapy has traditionally been a primary component of psychiatric treatment. Patients gather and attend groups, generally led by trained staff, to address symptoms and acquire new skills and learning. With the current pandemic, group sizes have been reduced to six or less. On COVID units, the use of virtual groups and technology has allowed patients to still engage in scheduled group activities. Mental health and wellness applications (apps) are increasingly available for individual use with topics such as mindfulness, meditation and relaxation, cognitive behavioral skills, and grounding to reduce anxiety. It is likely that these technological tools will increase in number and complexity in response to the pandemic social isolation requirements. Nursing research on the impact and effectiveness of these tools on patient outcomes can advance our knowledge, improve care delivery systems, and support new models of care.

While the COVID-19 pandemic led us to reimagine our use of technology very quickly in the inpatient psychiatric setting, we must seize on this momentum and continue infusing more technology into our treatment models. Whereas the previous restrictions on using technology may have stifled our creativity, it now seems the full potential of technology in inpatient psychiatry will only be limited by our imaginations. How can we leverage technology to better empower patients to participate in their care? Can technology be used to assess patients for metabolic syndrome or to promote more meaningful interactions between patients and nurses during care rounds or observation checks? We brainstorm new ideas with awareness that "although the outcomes of disruptive innovation cannot always be anticipated, the disruption in and of itself is invaluable in stimulating dialogue, advancing innovative thinking, and transforming models of service delivery" (Blakeney et al., 2009, p. 3).

The potential of technology is nevertheless associated with certain risks. While there is a plethora of mental health apps, research suggests that mental health apps are heterogonous in terms of features, attributes, and quality. Privacy concerns also exist with some health applications. While mental health apps have the potential to be beneficial, consideration should be given when evaluating apps for patient use (Wisniewski et al., 2019).

Other potential challenges with the increased use of technology are that patients may feel more isolated with less face-to-face interactions and reduced group size could lead to a feeling of social isolation on the inpatient units (Li, 2020). Additionally, patient assessments by psychiatric nurses include assessing the patient's behavior in the milieu, including whether they are engaged or more isolative. Nurses may assess that a patients' symptoms are improving if they are spending less time in their bedrooms and more time interacting with others. However, our nurses observed for some patients, most notably those patients quarantined on the COVID-19 units, that they seemed to thrive despite concerns about social distancing. From the patient experience perspective, they were the center of all staff attention. Treatment team members came to their doors to discuss their care. Patients used their individual iPads to reach out to nursing staff and had their needs responded to more immediately. Routine tasks became an opportunity for nurses to engage patients, provide human touch during administration of medication and vital signs assessment. Observation checks every 15 min were maximized to include not only patient safety, but to also provide the vehicle for a therapeutic one to one connection that is the basis of psychiatric nursing.

Thus, the challenge going forward is to rethink the ways in which we assess patients in the inpatient setting and the meaning and structure of the therapeutic milieu. What will the therapeutic milieu of the future post COVID look like?

B. Design - Behavioral Health Inpatient Units

As we go forward with unit renovation plans, this experience has taught us the importance of the single patient room with bath. Converting double rooms to single occupancy allowed us to isolate patients, develop patient cohorts of six or less for group activities and meals, while meeting social distancing criteria. Using technology through the provision of individual iPads for patients to visit loved ones and engage with their treatment teams while in isolation was successfully instituted. These changes led us to take a hard look at the ways treatment and milieu therapy are defined and implemented. One measure of progress for patients was the amount of time spent out of their rooms socializing with peers and engaging in therapeutic groups. Regulatory standards and requirements have defined the inpatient environmental structure to date, but as some of these requirements were relaxed during this healthcare crisis, we need to reevaluate the risk factors defined by these previous standards and look to a new normal for both patient and staff safety and for improving the patient experience. How will we measure safety for patients and staff? Have we been too restrictive and reactive in setting policy? Further evidence-based research is needed in patient and staff safety.

C. Health Promotion in the Workplace

During the COVID-19 crisis, our hospital opened a Recharge Room where all staff could drop in for a break and have a snack, a cup of coffee or tea, listen to a relaxation video or see messages of gratitude from the community at large. It also provided a place where staff could leave messages of encouragement and support for each other.

D. Education

Nursing education programs that support and teach staff resilience skills need to be included in overall future prevention planning including methods to address organizational resilience needs. Wellness programs designed to facilitate identifying those staff at risk post-pandemic can offer early preventive intervention thereby preserving the workforce. One article suggested a nursing research study involving trauma-informed resilience, post-traumatic growth, and PTSD in the nursing workforce (Duncan, 2020).

E. Patient Centered Innovation

Healthcare organizations are primarily focused on managing the disease burden of individuals, but during a pandemic, the focus needs to address a population-focused model of care. "Health systems with a strong community focus that value preventive interventions and integrate community engagement and empowerment may have an advantage in pandemic response compared to more traditional biomedical, hospital-centric systems" (Schwerdtle et al., 2020).

Telehealth innovations will form the basis of such community connection programs. Engaging with families and significant others during an inpatient admission needs to be maximized via the technological avenues used to maintain social distancing during the pandemic.

Using lessons learned to explore disruptive innovative strategies and new models of care will be important as we, as psychiatric nurses in the International Year of the Nurse, re-examine and recommit to our core values in the year of the COVID-19 pandemic.

F. Nursing Research

In the aftermath of the pandemic, how nurses respond to the mental health concerns of our mentally ill patients and our front-line healthcare workers will have immeasurable importance. Aligning with academic nursing centers of excellence to foster joint quality improvement and nursing research projects and share resources will advance psychiatric mental health nursing practice. Knowledge gained from this healthcare crisis will create research opportunities designed to improve not only patient outcomes, but also workforce outcomes. Storytelling and other narrative initiatives can provide a reflective outlet and a source of data for understanding the unique and common experiences of those directly involved in crisis management.

Discussion

In 2020, the International Year of the Nurse, psychiatric mental health nurses at NewYork-Presbyterian Westchester Behavioral Health Center responded to the COVID-19 global pandemic with the tenets of nursing resiliency and innovation as their foundation. Building upon the example of nursing leaders in history, nurses assessed and responded to the needs presented by the pandemic, even as these needs continually evolved, putting patient care above their own health care risks. The challenge will be to sustain the innovative changes and use this experience to prepare for the next crisis. Areas for future research include nursing resiliency during times of crisis, new models of care delivery in mental health nursing using technology and structuring a more adaptable milieu to respond to complex patient needs.

References

American Nurses Association website. (n.d.). Nursingworld.org.

Blakeney, B. A., Carleton, P. F., McCarthy, C., & Coakley, E. (2009). Unlocking the power of innovation. *OJIN: The Online Journal of Issues in Nursing, 14*(2), 1–11. Retrieved from http://www.nursingworld.org/MainmenuCategories/ANAMarketplace/ANA Periodicals/OJN/TableofContents//Vol142009/No2May09/Innovation.aspx.

Boston-Fleischhauer, C. (2015, October). Disruptive innovation - Latest buzzword or new reality? Journal of Nursing Administration, 45. *No., 10*, 469–470.

Calloway, B. J. (2002). Conclusion: "Well done". In *Hildegard Peplau psychiatric nurse of the century* (pp. 440–448). New York: Springer Publishing Company.

Choi, K. R., Heilemann, M. V., Fauer, A., & Mead, M. (2020). A second pandemic: Mental health spillover from the novel coronavirus (COVID-19). Journal of the American Psychiatric Nurses Association, 00(0). DOI: https://doi.org/10.1177/107839032091 9803.

Duncan, D. (2020). What the COVID-19 pandemic tells us about the need to develop resilience in the nursing workforce. *Nursing Management.*. https://doi.org/10.7748/nm.2020.e1933.

Earvolino-Ramirez, M. (2007, May). Resilience: A concept analysis. *Nursing Forum, 42*(2). https://doi.org/10.1111/j.1744-6198.2007.00070.x.

Edmonson, C., Sumagaysay, D., Cueman, M., & Chappell, S. (2016, September). The nurse leader role in crisis management. Journal of Nursing Administration, 46. *No., 9,* 417–419.

Gunnell, D., Appleby, L., Arensman, E., Hawton, K., Kapur, N., Khan, M., … Pirkis, J. (2020, April 21). Suicide risk and prevention during the Covid-19 pandemic. *The Lancet* (Vol. 7). https://doi.org/10.1016/S2215-0366(20)30171-1.

Hammer, J. (2020, March). Thou shalt not underestimate Florence Nightingale. *Smithsonian, 50*(10), 24–33.

Hart, P. L., Brannan, J. D., & DeChesnay, M. (2012, November). Resilience in nurses. Journal of Nursing Management, 22. *Issue, 6*. https://doi.org/10.1111/j.1365-2834.2012.01485.x.

Jackson, D., Firtko, A., & Edenborough, M. (2007, June 18). Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: A literature review. *Journal of Advanced Nursing, 60*(1), 1–9. https://doi.org/10.1111/j.1365-2648.2007.04412.x.

Khamisa, N., Peltzer, K., Ilic, D., & Oldenburg, B. (2016). Work related stress, burnout, job satisfaction and general health of nurses: A follow-up study. *International Journal of Nursing Practice, 22*, 538–545. https://doi.org/10.1111/ijn.12455.

Li, L. (2020, April 23). Challenges and priorities in responding to COVID-19 in inpatient psychiatry. *Psychiatry Online, 1-5*. https://doi.org/10.1176/appi.ps.202000166.

McManus, S., Seville, E., Vargo, J., & Brunsdon, D. (2008, May). Facilitated process for improving organizational resilience. *Natural Hazards Review, 9*(2), 81–90. https://doi.org/10.1061/(ASCE)1527-6988(2008)9:2(81).

Nelson, R. (2003). Good night, Florence: With nursing in crisis, some say it's time to retire nightingale as a symbol. *Nursing Leadership, 16*, 46–50.

Patient Safety Guidelines [Safety Standards]. (2020). Retrieved from www.omh.ny.gov/omhweb/patient_safety_standards www.omh.ny.gov.

Re-Thinking Word Choice During This Pandemic. (2020). Retrieved from www.planetree.org.

Schwerdtle, P. N., Connell, C. J., Lee, S., Plummer, V., Russo, P. L., Endacott, R., & Kuhn, L. (2020). Nurse expertise: A critical resource in the COVID-19 pandemic response. *Annals of Global Health, 86*(1), 1–5.

Scope and Standards of Practice Psychiatric-Mental Health Nursing. (2014). In (2nd Edition, pp. 1–4). Silver Spring, Maryland: American Nurses Association.

Sensmeier, J. E. (2012). Disruptive innovation and the changing face of healthcare. *Nursing Informatics*, 13–14. https://doi.org/10.1097/01.NUMA.0000421681.71712.86.

Smith, Chief Medical Officer, T. (2020). Office of mental health memorandum, March 25, 2020 [Memorandum]. Retrieved from New York State Office of Mental Health https://omh.ny.gov/omhweb/guidance.

Ungar, M. (2008). Resilience across cultures. *British Journal of Social Work, 38*, 218–235.

Wisniewski, H., Liu, G., Henson, P., Vaidyam, A., Hajratalli, N. K., Onnela, J., & Torous, J. (2019). Understanding the quality, effectiveness and attributes of top-rated smartphone health apps. *Evid Based Mental Health, 22*, 4–9. https://doi.org/10.1136/ebmental-2018-300069.