Detecting nurse-perceived patient treatment difficulty of psychiatric patients in hospital: an evaluation of a patient assessment sheet

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Many changes have occurred in hospital psychiatric care, including decreased length of hospital stay and increased patient acuity. These changes highlight the need for nurses to adequately assess and formally document patient treatment difficulties. The purposes of this study were to determine the ability of the Patient Assessment Sheet (PAS) to predict patient 'problems' that psychiatric nurses perceived as associated with patient treatment difficulty, and to identify the patient problems missing from the PAS. These purposes were accomplished by comparing the PAS to the Hospital Treatment Rating Scales (HTRS). A correlational design and multiple linear regression technique were used. Eight psychiatric registered nurses assessed a total of 110 patients, admitted consecutively to one inpatient psychiatric unit. The HTRS and the PAS were used independently for each patient. Four PAS items (active affect, passive affect, aggression toward self, and patient confusion) significantly predicted 38% of the variance from the HTRS; and three HTRS items (isolation and withdrawal from relationships, noninvolvement in treatment, and wide variability in mood) significantly predicted 22% of the residual variance from the HTRS. The identified PAS and HTRS items help to make visible patient problems associated with nurse-perceived patient treatment difficulty. This identification is potentially important for both clinical and political purposes.

Keywords: nursing practice, patient assessment, psychiatric staff nurses, patient treatment difficulties

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Introduction and literature review

The many changes in health care such as the decreased length of hospitalization (Thomas 1993, Nursing Task Force 1999), the reduction in the number of hospital beds with concomitant increase in patient acuity, and the decreased staffing levels of registered nurses (Huston 1996, Nursing Task Force 1999) underscore the urgent need for psychiatric nurses to adequately assess and formally document patient problems associated with nurse-perceived patient treatment difficulty on daily measures, such as the Patient Assessment Sheet (PAS). Daily measures of patient acuity in inpatient psychiatric settings are used for two critical functions: (1) the assessment of patient problems; and (2) the determination of nurse staffing needs. These functions may be related because as patient problems increase, more nurses are required if appropriate levels of care and treatment are to be provided. Hence any assessment instrument needs to be accurate and effective in assessing patient problems associated with nurse-perceived patient treatment difficulty in hospital.

In this study the Patient Assessment Sheet (PAS), used in

an acute psychiatric hospital setting, was compared to a published valid measure, the Hospital Treatment Rating Scales (HTRS) (Colson *et al*. 1985) for its ability to predict patient problems associated with nurse-perceived patient treatment difficulty. According to Colson *et al*. (1985), patient treatment difficulty as perceived by psychiatric clinicians is defined as the clinician's subjective appraisal of three variables that include: the patient variable (i.e. problems exhibited by the patient); the clinician variable (i.e. nurses' affective reactions to the patient); and the treatment quality variable (i.e. relationship with the patient, availability of treatment resources and quality of team work). In this study, only the patient variable aspect of nurse-perceived patient treatment difficulty was examined. This was done because the main objective of this study was to predict 'patient problems' that psychiatric nurses perceived as associated with patient treatment difficulty. The patient variable aspect of patient treatment difficulty is defined as the nurse's subjective appraisal of a patient based on: (1) the nurse's overall sense of difficulty in working with the patient in terms of the treatment difficulty a patient poses in relation to other patients in the setting; and (2) specific patient problems that interfere with treatment (Colson *et al*. 1985).

Patient problems associated with clinician perceived patient treatment difficulty

A number of investigators have identified patient problems that predict clinician perceived patient treatment difficulty. Patient problems predictive of patient treatment difficulty include withdrawn psychotic behaviours, help rejecting behaviour, suicidal depressed behaviour, violence agitation or dangerous behaviour, and attention seeking and manipulative behaviour (Colson *et al*. 1985, 1986a, 1986b; Colson 1990, Lancee & Gallop 1995). These problems are found to generate staff affective reactions such as a sense of provocation, intolerance, anger, frustration, helplessness, guilt, withdrawal, avoidance, confusion, fear, and divisions among staff (Gallop, Lancee & Garfinkel 1989). Other reactions include a sense of lack of control, powerlessness, feeling drained, and in some situations feeling protective of the patient (Gallop & Wynn 1987, Colson 1990, Lancee & Gallop 1995, Breeze & Repper 1998). These problems make it difficult for staff to adequately assess patient problems and to effectively communicate and empathize with patients (Neill 1979, Colson *et al*. 1986a; Robbins, Beck, Mueller & Mezener 1988, Gallop *et al*. 1989, Gallop, Lancee, & Shugar 1990, 1993, Gallop & Wynn 1987, Breeze & Repper 1998). Inadequate, inaccurate, and/or delayed assessment of patient problems associated with patient treatment difficulty have resulted in delayed patient recovery (Modestin, Greub, & Brenner 1986); job dissatisfaction and lowered morale among staff (Kelly & May 1982, Colson *et al*. 1985, 1986b; Jones 1986, Modestin *et al*. 1986, Gallop *et al*. 1993), premature termination of treatment (Breeze & Repper 1998) and readmission to hospital or 'revolving door' hospital care (Thomas 1993, p. 698). Thus, when inadequate identification of patient problems associated with patient treatment difficulty occurs not only may treatment plans be delayed and inadequate, but also may pose complications for the patient, the healthcare team, and hospital resources.

Patient treatment difficulty specific assessment measures

The literature contains an abundance of instruments used for patient assessment in psychiatric nursing (Raskin 1982, Van Riezen & Segal 1988, Savage 1994). However, few have been shown to be inclusive enough to address patient problems associated with nurse-perceived patient treatment difficulty. It is suggested that neither the research or clinical assessment measures (Albiez-Gibbon 1986, Mohr & Noone 1997), or patient classification or computerized documentation measures (Cockerill & O'Brien-Pallas 1990, Fagerstrom & Engberg 1998, Fagerstrom, Engberg & Ericksson 1998) sufficiently capture the complexity of patient care requirements in terms of patients' behavioural problems and interpersonal aspects of care that go beyond the physical care and biomedical treatment of the patient.

There is a lack of assessment measures that are designed to assess patient treatment difficulty as a unique phenomenon. Several assessment measures such as: the Nurses' Observation Scale for Geriatric patients (Spiegel *et al*. 1991), the Rating Scale for Aggressive Behaviour in the Elderly (Patel & Hope 1992), the Nursing Observation of Behaviour Scales (Brawley, Lancee, Alion, & Brown 1978), the Nursing Observation of Behaviour Syndromes (Craig 1970), and the Manchester Nurse Rating Scales (Brierley, Szabi, Rix & Bradshaw 1988) include single behaviours that might correspond to patient treatment difficulty. However, these assessment measures have limitations, including a lack of a conceptual framework for patient treatment difficulty and an absence of combinations of patient problems that reflect patient treatment difficulty dynamics.

Furthermore, several assessment measures in psychiatric nursing were designed to assess for the presence of patient problems associated with psychiatric disorders, and not for assessing patient treatment difficulty. These include, but are not limited to the: Brief Cognitive Rating Scale, Beck Depression Scale, Hamilton Rating Scale for Depression, Hamilton Anxiety Rating Scale, Folstein Mini-Mental

State Exam, and Yale-Brown Obsessive Compulsive rating Scale (Shives 1998).

The lack of assessment measures for treatment difficulty has meant that the studies conducted to evaluate or compare assessment instruments may have limited applicability to assessing patient treatment difficulty. For example, the Risk Screening Instrument (RSI) was designed for assessing suicide and violent behaviour risk for the psychiatric inpatient setting (Holdsworth, Collis, & Alliot 1999). Although the RSI may capture some of the behaviours associated with patient treatment difficulty, the underlying dynamics of the behaviours on the RSI are attributed to suicide risk and violent behaviour risk, and not to patient treatment difficulty. Moreover, Davidhizar *et al*. (1991) compared three rating scales used with psychiatric patients. These were: the Nurses' Observation Scale for Inpatient Evaluation (NOSIE), the Pardue-Dick Patient Classification System (PDCS), and the Allen Cognitive Level Test (ACLT). However, each of these three rating scales were designed for a specific purpose, and not for assessing patient treatment difficulty. The NOSIE was designed to evaluate medication effects and behaviours associated with chronic schizophrenia (Honigfeld & Klett 1965, Davidhizar *et al*. 1991). The PDCS was designed to group or to classify patients for treatment and care (Pardue & Dick 1986, Davidhizar *et al*. 1991). In contrast, the ACLT was designed to predict and measure the patient's performance in routine activities of daily living (Davidhizar *et al*. 1991). Davidhizar *et al*. (1991) concluded that

> 'each of the [three] tools measured different aspects of patient behaviours and needs . . . [and that] more was learned about the 60 subjects through the three tools combined than through any one of them alone' (p. 24).

Moreover, Davidhizar *et al*. (1991) reported that 'in no area was there enough correlation to suggest that one tool could be preferred over the other two' (p. 24).

The Hospital Treatment Rating Scales (HTRS) is a clinical measure that accounts for both patient behavioural problems and the interpersonal aspects of care. Although, the HTRS was not specifically designed for daily use, the different subscales of the HTRS were shown to be comprehensive enough to address patient problems associated with perceptions of patient treatment difficulty in a short stay acute psychiatric hospital setting, where hospitalization stays are 35 days or less (Gallop *et al*. 1993). It is for this reason that the HTRS is used to examine the research questions in this study. The HTRS is a valid instrument for assessing patient treatment difficulty, but the HTRS was not substituted for the PAS because the HTRS only contains patient 'problems'. In contrast, the PAS contains both patient 'problems' (26 items used in this study) and patient 'progress' items (22 items not used in this study). Examples of patient progress items included, but were not limited to; ate well, voiding adequately, slept, well groomed, logical, adequate fluids, and settled. These patient progress items on the PAS are necessary for the daily assessment of patients in psychiatric settings, but were not relevant to the objective of this study. The main objective of this study was to predict patient 'problems' that psychiatric nurses perceived as associated with patient treatment difficulty.

Research questions and aims of the study

1 How effective is the PAS in predicting the variance in nurse-perceived overall patient treatment difficulty as measured by the Overall Extent of Treatment Difficulty scale (OETDS) of the HTRS in psychiatric patients in the inpatient hospital setting?
2 Are there critical patient problems missing from the PAS that can be identified by analysis of the residual variance of the OETDS?

Methodology

Description of the design, setting and sample

A correlational design was employed in this study. Eight psychiatric nurses consented to participate, and provided nurse ratings of 110 consecutively admitted patients. Nurse ratings were included if the nurse had completed the two study instruments, the HTRS (Colson *et al*. 1985) and the PAS between the 14th and 21st day of hospitalization.

Moreover, if a patient, already in the study, was readmitted during the 11-month study period, nurse ratings for the patient's readmission hospital stay were not included. The setting is an acute care 20-bed general psychiatric unit within a metropolitan teaching hospital. The average length of hospital stay, during the time of data collection, was 32 days. This psychiatric unit has approximately 350 admissions a year and within a 6-month period, approximately 33% of the patients are readmitted once and five to ten percent are readmitted more than once. The unit is staffed by eight full time registered nurses, all of whom participated and stayed in the study.

Instruments

The Hospital Treatment Rating Scales

The HTRS consists of six subscales. Each of these subscales has an acceptable level of reliability and validity as documented by studies (Colson *et al*. 1985, 1986a; Gallop *et al*. 1993). For this study, two of the six HTRS subscales were

used. These were the Overall Extent of Treatment Difficulty Scale (OETDS) and the Patient Problem List (PPL).

The OETDS renders a single statement score, on a one-to-six point rating scale, ranging from 'the treatment of this patient is relatively free from difficulty' to 'treatment difficulty for this patient is among the most extreme I have experienced'. The nurses gave a one time rating by selecting one of the six statements on the OETDS that reflected their experience with the patient over the last 21 days. The interrater reliability of the OETDS is reported to be .80 (Colson *et al*. 1985, 1986a; Gallop *et al*. 1993).

The PPL consists of 27 problem areas that might be descriptive of the patient during hospitalization. Examples of problems are verbal hostility and anger, excessive or inappropriate demands, poor impulse control, self abuse, and wide variability in moods. The PPL asks nurses to rate the patient for each problem on a one-to-five Likert-type scale (ranging from 'does not apply, irrelevant' to 'extremely descriptive of person'). Nurses gave a one time rating by selecting one of the five statements that best represented their experience with the patient during the last 21 days. The internal consistency reliability of the specific items from the PPL items was reported to range from .54 to .90 (Colson *et al*. 1985, 1986a; Gallop *et al*. 1993). Data from the OETDS and the PPL from the HTRS were collected during the 14th to 21st day by the patient's primary nurse whenever possible. For eight of the 110 HTRS' completed, data were provided by the patient's secondary nurse.

The Patient Assessment Sheet

The Patient Assessment Sheet (PAS), developed by the hospital, is a checklist of 26 problem areas reflecting possible patient problems that can occur during hospitalization. Examples of problems are disorganization, restless, wide range mood, aggression to others, and guarded behaviour. Nurses completed the PAS flowsheet daily as part of their 24 hour assessment of patients. The PAS asks nurses to place their initials next to the problems that were exhibited by the patient and to place a vertical line in all the other remaining items that did not apply to the patient.

Data collection procedure

The data for the HTRS questionnaire component (i.e. the OETDS and the PPL scales) of this correlational study were derived from a database collected at the setting for a parent study. The parent study investigated the validity of the HTRS for use in acute care psychiatric settings (Gallop *et al*. 1993). The data from the HTRS and the PAS were selected to correspond to the same patient assessment period.

Data reduction and analysis

In order to compare the one time rating on the OETDS and the PPL (i.e. nurse asked to reflect on past 21 days with the patient) with the multiple ratings of the PAS (i.e. nurse instructed to reflect on each individual day with the patient), the following procedure was followed for each item on the PAS list:

1 Any occurrence of a patient problem on the PAS during a 24 hour period was counted as one occurrence; therefore, the range of occurrences for any patient problem on the PAS was from zero (no occurrence over 21 days) to 21 (21 occurrences over 21 days);
2 when data collected were less than 21 days (i.e. the patient was discharged at day 15) a weighted mean item score was substituted so that a score for 21 days was calculated for each item.

Two multiple linear regressions were conducted. One multiple linear regression was used to describe the strength of PAS items to the prediction of nurses' OETDS scores (research question one). The second regression model was used to describe the strength of PPL items to the prediction of OETDS residual to identify PPL items missing from the PAS (research question two).

Results

There were 130 psychiatric patients admitted to the general psychiatric unit during the 11-month data collection period. Of these patients, 20 patients were not eligible (11 patients were readmissions and no HTRS data were available for nine patients); and, 110 patients (85.0%) met the criteria for this study. All eight nurses on the unit consented to participate in the study and none withdrew from the study.

Regression analyses

Strength of PAS items to predict OETDS

In order to conduct multiple linear regression, several steps were taken first to reduce the problem of multiple items and problems of multicollinearity (i.e. situations in which there is a high correlation between variables). First, only PAS items (independent variables) significantly correlated ($p \leqslant 0.05$) with the OETDS scores (as the dependent variable) were selected for entry (see Table 1).

Table 1 shows that 18 PAS items were significantly correlated with the nurses' OETDS scores. Secondly, examination of the intercorrelations between these 18 PAS items showed that certain PAS items (irritable, impulsive, unpredictable as well as withdrawn, isolated, subdued, down-

Table 1
PAS items significantly correlated with eight nurses' OETDS scores (n = 110 patients)

PAS items	Pearson r	$p \leq$
1. absence without leave risk	0.30	0.01
2. aggression to self	0.40	0.01
3. aggression to environment	0.23	0.05
4. blunted	0.28	0.01
5. irritable	0.33	0.01
6. subdued	0.23	0.05
7. downcast	0.35	0.01
8. disorganized	0.21	0.05
9. guarded	0.22	0.05
10. impulsive	0.48	0.05
11. restless	0.23	0.05
12. unpredictable	0.37	0.01
13. withdrawn	0.26	0.01
14. confused	0.30	0.01
15. vague	0.27	0.01
16. dishevelled	0.28	0.01
17. isolated	0.35	0.01
18. remained on unit	0.24	0.05

cast) were highly interrcorrelated ($r \geqslant 0.7$). Before the regression procedure was conducted, these PAS items of irritable, impulsive, unpredictable were combined (as a sum) (Cohen & Cohen 1983) in one index called active affect, while the PAS items of withdrawn, isolated, subdued, and downcast were combined (summed) as passive affect.

A stepwise multiple regression procedure showed that a group of specific PAS items: active affect, passive affect, aggression to self, and patient confusion were, as a group, most predictive of the nurses' OETDS. These four patient problem areas in the regression model (based on PAS items) significantly explained 38% of the variance in the nurses' OETDS scores (Table 2).

As a further check, the residual of the OETDS was correlated with all the remaining PAS items not already in the regression model. There were no more PAS items correlated with the residual of the OETDS. Further testing demonstrated that no alternative model was found that accounted for, as much, or more than the 38% of the variance in the nurses' OETDS scores.

Examination of OETDS residual to identify patient problems missing from the PAS

Because the optimal regression model (based on PAS items) only explained 38% of the variance from the OETDS, stepwise multiple linear regression was used to examine the residual variance from the OETDS to see if patient problems from the PPL of the HTRS could be identified to explain further, the variance in the OETDS residual. A similar plan to reduce the difficulty of multiple problems, and for regression was followed for the PPL items that was used with the PAS items. Table 3 shows that 20 PPL items

Table 2
PAS patient problems attributed to patient treatment difficulty on OETDS by eight psychiatric nurses (n = 110 patients): Variance explained in OETDS by PAS

Patient problems	Beta	$p <$	Adjusted R^2
Active Affect			
Group	0.28	0.01	
Irritable			
Impulsive			
Unpredictable			
Passive Affect Group	0.36	0.01	
Withdrawn			
Isolated			
Subdued			
Downcast			
Aggression to self	0.25	0.01	
Confusion	0.18	0.05	
Optimal Regression Model (using PAS)			0.38

Table 3
PPL items significantly correlated with residual variance in OETDS (n = 110 patients)

PPL items	Pearson r	$p \leq$
1. self destructive behaviour (suicidal intent)	0.21	0.05
2. verbal hostility and anger	0.21	0.05
3. dishonesty or antisocial behaviour	0.26	0.01
4. isolation and withdrawal from relationships	0.38	0.01
5. psychotic symptomology	0.24	0.05
6. bizarre, socially inappropriate	0.20	0.05
7. excessive or inappropriate demands	0.27	0.01
8. manipulative and controlling behaviour	0.33	0.01
9. plays one person against another	0.21	0.05
10. wide variability in moods	0.25	0.01
11. depression	0.21	0.05
12. agitation and anxiety	0.30	0.01
13. somatization	0.23	0.05
14. poor impulse control	0.25	0.05
15. patient is slow to change	0.37	0.01
16. actively sabotages treatment	0.28	0.01
17. regresses after making progress	0.27	0.01
18. not involved in treatment	0.38	0.01
19. family blocks the treatment process	0.21	0.05
20. other treatment difficulties(legal issues, staff changes, family tragedy)	0.30	0.01

were significantly correlated ($p \leqslant 0.05$) with the OETDS residual.

The PPL items (independent variables) were entered into a stepwise multiple linear regression procedure with the OETDS residual as the dependent variable. Three PPL items (isolation and withdrawal from relationships, not involved in treatment, and wide variability in mood shown in Table 4), significantly ($p \leqslant 0.05$) explained 22% of the OETDS residual variance.

There were no more PPL items correlated with the residual of the OETDS. It should be noted that the PPL item of 'wide variability in mood' was significantly correlated with the OETDS residual (Table 4); yet, a similar sounding PAS

Table 4
Residual variance explained in OETDS by PPL: Patient problems from PPL not explained by the PAS (n = 110 patients)

Patient problems	Beta	$p \leq$	Adjusted R^2
Isolation and withdrawal from relationships	0.25	0.01	
Not involved in treatment	0.25	0.01	
Wide variability in mood	0.19	0.03	
Regression Model (using PPL items)			0.22

item, 'wide range mood', did not emerge as one of the PAS items significantly correlated with the OETDS.

Discussion, conclusions and limitations

The two regression models in this study demonstrated that a combination of PAS and HTRS items provide the best model for predicting patient treatment difficulty. It is not surprising that nurse-perceived patient treatment difficulty is predicted by a combination of patient problems, as opposed to separate patient problems. What these findings do demonstrate are the risks inherent in simple behavioural checklists for capturing combinations of patient problems associated with nurse-perceived patient treatment difficulty. Although a measure such as the PAS captures the hour to hour behavioural observations of patient problems from regression model one (active affect, passive affect, aggression to self, confusion), the PAS fails to capture the summative effect of combining these four items. The PAS also fails to capture three items from the PPL ('isolation and withdrawal from relationships', 'noninvolvement in treatment', ' wide variability in mood'). The PAS describes patient problems as unitary events (present or absent), and as such the risk for overlooking summative effects (different ranges and combinations) of problems and overall interpersonal processes is high.

The risk as it relates to summative effects of problems is exemplified by the study finding related to 'wide range mood' item from the PAS as compared to the 'wide variability in mood' from the PPL of the HTRS. The PAS item 'wide range mood' was not significantly correlated with the OETDS, while the similar sounding PPL item, 'wide variability in mood' was significantly correlated with the OETDS residual. Because on the PAS, 'wide range mood', is described as a unitary event (present or absent), the different ranges and combinations of patient mood are not captured. This could mean that if a patient exhibits an elated mood at one time and a depressed mood at another time, the nurse using the PAS is likely to record these moods as two separate events, and less likely to record these as representative of 'wide range mood'. The PAS item, 'wide range mood', is probably under reported and perhaps explains why 'wide range mood' from the PAS was not significantly correlated with the nurses' scores on the OETDS. This is one example of how the PAS, because it describes patient problems as unitary events over a short period of time, does not allow for combinations of patient problems associated with nurse-perceived patient treatment difficulty to be accurately identified. Similarly, although the PAS items from the first regression model (active affect, passive affect, aggression to self, and confusion) account for 38% of variance in OETDS, the items need to be assessed as one group and not as separate events, if nurse-perceived patient treatment difficulty is to be accurately identified. Mohr & Noone (1997) noticed a similar problem in their exploratory study of clinical progress notes used for assessment documentation. They indicated that often in psychiatric settings 'fragments of patient behaviour' (Mohr & Noone 1997, p. 330) are presented in assessment records, as was the case with the PAS (i.e. PAS presents patient problems as separate entities). The inability to accurately identify the combinations of patient problems on the PAS is problematic since the accurate assessment of patient problems is critical to planning patient care and determining the nurse staffing needed for providing appropriate levels of care and treatment. In contrast, the PPL item, 'wide variability in mood' (from the HTRS) captures the different ranges of patient mood, allows the nurse to examine patient assessment parameters in relationship to each other, and allows nurses to assess for continuous interpersonal patterns over a longer period of time (i.e. the PPL asks nurses to describe 'wide variability in mood' at one point in time covering a two to three week period). Mohr & Noone (1997) corroborate the importance of examining patient behaviours in relationship to each other in psychiatric settings. They indicate that assessments of patient 'behaviour should be interpreted in relationship to other behaviours…[and] not focus exclusively on just a behaviour' (Mohr & Noone 1997, p. 329).

In addition to the above risks associated with overlooking summative effects of patient problems, the risk of overlooking overall interpersonal processes on the PAS is high. In hospitals, nurses are in the unique position of being constantly available, and in close proximity, to patients remaining on the nursing unit (Larsen & George 1992) yet assessment parameters on the PAS are not designed to enable the nurse to formally document the patient's behaviour as occurring in a continuous interpersonal context (i.e. only detects presence or absence of patient behaviour over a short period of time). The absence of continuous interpersonal parameters on clinical measures such as the PAS, is a serious clinical and political problem in caring for

patients from a nursing perspective, as the meaning of a patient's behaviour in a continuous interpersonal context is minimized, and at the same time promotes the invisibility of the nurse's interpersonal work.

Historically, the integrating and co-ordinating functions of the nurse on the unit, as well as the interpersonal and emotional work of the nurse have been cited as some examples of the 'taken for granted' aspects of nursing (Larsen & George 1992, Wolfe 1989, Wolfe 1999a). One of the clinical consequences of overlooking the continuous interpersonal context, and specific combinations, patient problems on clinical measures, such as the PAS, is the emergence of situations in which the health care team may feel increasingly engulfed and frustrated by patient problems as separate entities. As demonstrated by the two regression models built, each patient problem alone is subtle, but as a group the patient problems identify the overarching problem of nurse-perceived patient treatment difficulty. Given the subtlety of the individual patient problems associated with nurse-perceived patient treatment difficulty, it is not surprising then that patients linked with nurse-perceived patient treatment difficulty have been noted to become 'victims of a curiously stable breakdown in communication which in some cases lasted for years' (Neill 1979, p. 211). It is conceivable that this breakdown in communication may be perpetuated by daily patient assessment sheets that do not enable the psychiatric nurse to adequately assess, identify, and document specific patient problems in relationship to each other and as a group. It follows then that interpersonal difficulties may become chronic. These difficulties are problematic in view of short hospital stays (Ministry of Health Ontario 1988, 1993a, 1993b; Thomas 1993, Nursing Task Force 1999) and frequent readmissions or 'revolving door' hospitalizations of patients (Roy, Williams, & Dickens 1994, p. 271).

On a political level, clinical measures that are not designed to account for the interpersonal processes encountered by nurses may also perpetuate the social and economic invisibility and obscurity of nurses' interpersonal work and roles (Diers 1986, Larsen & George 1992, Machin & Stevenson 1997). Because managing patient treatment difficulty issues in terms of the specific group of problems generated in the regression models are not part of formal and paid accounts of work (i.e. assessment parameters on clinical measures such as the PAS) in the hospital, nurses may themselves overlook the interpersonal work they do and nurse-staffing needs may be underestimated. For example, Braj (1994) and Wolfe (1999b) observed that nurses often do not speak of the distress that patients manifest and nurses might believe that interpersonal work 'is more of a personal choice or obligation rather than a valued quality or skill deserving of recognition' (Braj 1994, p. 38).

Although the findings of this study are limited to one urban site, and may not be generalizable to other acute hospital settings, the issue still remains that assessment instruments need to accurately assess and document patient problems associated with nurse-perceived patient treatment difficulty. It follows then that future research and development of clinical assessment and documentation measures needs to take into account the clinical and political 'value' (as well as the consequences) of including combinations of patient problems. It is suggested that nurse-perceived patient treatment difficulty is much more than assessing unitary patient problems as they relate to acuity, symptoms, and patient responses to medication, it is about assessing patient problems, as combinations, as they relate to the continuous interpersonal context of nursing care.

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