Improving Inpatient Care

The Therapeutic Engagement Of Nurses On Acute Mental Health Wards:
A Practice Development Project

Centre for Research in Nursing and Midwifery Education

Division of Health and Social Care

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Content

Summary

This report outlines a three-phase piece of practice development work centred on the improvement of nursing engagement on a NHS Acute Mental Health Inpatient Unit in the South East of England following the implementation of the Tidal Model of psychiatric nursing. This work was sponsored by the Foundation of Nursing Studies and supported by the local mental health NHS Trust.

Phases of the project were:
    Phase 1: Staff and patient evaluation of the current model of engagement
    Phase 2: Practice development work through staff support groups
    Phase 3: Staff evaluation of support groups and future recommendations

Recommendations:

The experiences from the project highlight the importance of the process and *ownership* in implementing these recommendations:

- 'Front-line' staff and service users must take a key role in driving the design of explicit and concrete action plans to address each of the above recommendations.

Managers, clinicians and service users need to work together to:

- Establish ongoing training, support and supervision in the use of focused, collaborative interview skills for Acute Inpatient Nurses.

- Ensure meaningful structural changes – in terms of time, space and reprioritising of nursing roles – in order to enhance interpersonal skills, and ensure available space and time for patients and staff to 'tell their stories' and to collaborate in 'reauthoring' existing stories.

- Actively explore ways to reduce unnecessary documentation, perceived by staff as 'irrelevant' and 'repetitive' paperwork.

- Develop new approaches – through training, discussion and ongoing supervision – to 'paperwork', incorporating into the process of care as an essential tool for adding meaning, depth and enrichment to stories, rather than as mechanised dictator of the story.

- Develop regular, externally-facilitated and story-focused supervision engaging with staff development needs and current priorities.

- Follow-up and re-evaluate therapeutic engagement patterns, strengths and challenges in the end of 2008.

1. Introduction

This report describes practice development work supported by action research on acute mental health wards in the South East of England intended to enhance nurses' engagement with inpatients. Through interconnected practice development and research activity the project spanned a period from 2003 to 2007, originating with a focused practice development project to implement the Tidal Model of mental health nursing (Larsen et al 2005b) and a study of nurses' perceptions of the therapeutic relationship (Acott 2006).

This report concerns the latest period of intervention during 2006-2007 when the Foundation of Nursing Studies (FoNS) supported a follow-up study of patients' and nurses' views on the implementation of the Tidal Model and the establishment of a practice development intervention to address the findings.

1.1. Background: therapeutic engagement and the Tidal Model

Mental health service users, carers, staff and managers have over a number of years voiced concerns that both the quantity and quality of nurse-patient interactions were hindering recovery (Sainsbury Centre For Mental Health 1998, 2004; DoH 2002a, 2002b; Haigh 2002; Birmingham and Solihull Mental Health NHS Trust 2005). This concern is supported by research evidence pointing to the therapeutic relationship as being of significant importance in supporting recovery from mental illness. Research suggests a correlation between the experience of a relationship as being therapeutic and better outcomes (Hewitt and Coffey 2005). Reviews of the literature have suggested that 'the therapeutic relationship is a reliable predictor of patient outcome in mainstream psychiatric care' (McCabe and Priebe 2004: 115) and that 'the level of evidence supporting the link between the therapeutic alliance of patients with mental illness and improved outcomes, although sparse, is encouraging' (Howgego et al 2003:169).

However, UK acute mental health services do not appear to offer sufficient quantity or quality of this type of therapeutic support. An overview of research on staff-patient therapeutic engagement on acute mental health wards suggested that 'when interactions do occur they are neither purposely therapeutic nor theoretically informed' (Cameron et al 2005: 69). An empirical study found that hospitalised mental health patients thought that a therapeutic relationship did not come instinctively to mental health nurses, and that there was a dichotomy between the close relationship expected by patients and the distant relationship actually offered (Moyle 2003). This situation may have been influenced by mental health nurses' uncertainty regarding their credibility and effectiveness, and ambiguity over the perceived dominating control functions of their role (Hall 2004). Some critical observers point out that the contradictions inherent in the control/therapy discord on acute inpatient wards may cause particular problems for the nurse-patient relationship (Cleary and Edwards 1999; Needham et al 2005).

The Tidal Model has developed in response for this need to improve therapeutic engagement in mental health nursing. It is a person-centred and solution-focused model of care for acute mental health inpatient units which has developed over the last decade, initially in Newcastle and North Tyneside and quickly (though sporadically), thereafter, internationally. The Tidal Model has grown in influence during a period of system re-configuration, renewed public and governmental emphasis on the quality of people's experience whilst inpatients and on more hopeful, optimistic 'recovery' models of mental health care (Turner-Crowson and Wallcraft 2002; Allott and Loganathan 2002).

As pointed out by Stevenson et al (2002), 'the Tidal Model is anchored in beliefs about the importance of emphasizing the 'voice' of people who are patients' (p. 274). This requires of the nurse to be actively listening to and engaging with the person's own experience and

perspective, and hence challenges the diagnostically and observationally objectifying perspective of traditional psychiatry and psychiatric nursing.

Placing the person's 'story' at the very centre of the process of care, the Tidal Model, whilst having much to offer nurses, also demands a huge amount: a positive, hope-filled commitment to the inevitability of change, a respect for the language (verbal and non-verbal) the person expresses their 'story' in and a genuine curiosity and interest in re-constructing or 'reauthoring' that story alongside the person. The approach places emphasis on the nurse-patient conversation where the nurse assumes the role of an 'apprentice' and listens – actively and empathically – to the patient. It also demands:

- a willingness to learn from people themselves what has worked and works for them,
- to be open and transparent in relationships with people who are inpatients and with carers and other staff and
- a desire to give real, focused time to people in order to identify pragmatic, stepped solutions to here-and-now problems.

Above all, the Tidal Model demands energy and optimism and a belief that nurses, long marginalised within their own and by other professions, and the nurse-patient relationship, are critical to the recovery process (Gordon et al 2005; Barker and Buchanan-Barker 2005a, 2005b).

Literature on the Tidal Model confirms its demand on nurses. Barker says that 'rather than engaging with the disorder or illness, the Tidal Model focuses on contacting the person' (2003: 234). Crucially, he points out that 'the Model assumes that, apropos Rowan (1993), no-one can bring someone to a level of personal understanding or knowledge who has not already reached it themselves' (Barker 2003: 234) and that 'the Tidal Model *assumes* that nurses need to get close to the people in their care, so that they might explore (together) the experience of health and illness' (2003: 237, italics added).

Although critical voices have raised concern over the quality of the claimed research-based and theoretical development of the approach (McKenzie 2005), the Tidal Model appears to demonstrate a real concern with enhancing nurses' engagement with person-centred and recovery oriented work with acute mental health patients. Previous evaluations of the implementation of the Tidal Model (Stevenson et al 2002) showed some limited but positive patient outcome, primarily related to length of stay and level of observation required. This result reflects the significant attention in the Tidal Model approach to comprehensive and rapid assessment (p. 275).

Its implementation in Birmingham suggested a decrease by 57% in the total number of serious untoward incidents such as physical assault, violence and harassment; and nurses' satisfaction with their work also improved: nurses rated the model superior to their previous way of working (Gordon et al 2004). One Canadian study (Berger 2006) associated the introduction of the Tidal Model with client and caregiver satisfaction, understanding of the patient's situation, and the interdisciplinary mental health team's ability to document a care plan that reflected the patient's specific goals and the goals of the team. Reports on experiences with implementing the Tidal Model (Cook et al 2005; Brookes et al 2006) have overall been positive and celebratory.

1.2. Introducing the Tidal Model on Acute Wards

When the Tidal Model approach during the period 2003-2004 was implemented on the wards, these key elements were adopted: Provisional Care Assessment; Provisional Care Plan; Personal Safety Assessment; Personal Safety Plan; Continuation Sheet; Care Plan; Holistic Assessment; One-to-One Sessional Records; and Solutions Group.

Particular aspects of wording and structure in the original Tidal Model documentation were altered following consultation sessions with staff. However, correspondence with the essence of the approach – its 'philosophical underpinning' – was maintained in supervision and training from the Tidal Model's inventors, Phil Barker and Poppy Buchanan. For example, it was recognised that the 'Holistic Assessment', a six-page document, would need to be completed, where appropriate, in more than one session. In addition, suggestions for staff on completion of all documents were provided, in particular offering possible questions and structure for 1:1 sessions. It was emphasised that, wherever possible, inpatients be offered the opportunity to fill in documentation themselves and play an active role in the implementation and evaluation of the approach.

Following the introduction of the Tidal Model on the three wards Acott (2006) explored inpatient nurses' perceptions of the therapeutic relationship. He found that the development and maintenance of effective nurse-patient relationships required a range of support and training functions, and a certain attitude or 'willingness' on the part of the nurse to achieve a relationship that balances affective, validating 'sympathy' with a more cognitive, solution-focused 'empathy'. The study suggested a need for further critical examination of organisational, team, interpersonal and intrapersonal dynamics in the process of implementing and making the Tidal Model approach work effectively. Acott also found a need to focus on the meaning and operationalisation of concepts such as the 'therapeutic relationship', 'empathy', 'sympathy' and 'compassion', the need for a refocusing of time-demands on qualified inpatient nurses, in particular reducing the amount of time spent on paperwork.

The study suggested a need for clinical supervision and other formal and informal support systems – including access to psychotherapeutic support – to be fully established, audited and researched. More training and development opportunities – both University-based and workplace-based – were needed in brief, solution-focused interventions and cognitive-behavioural approaches. These should be complemented by psychodynamic perspectives on Acute Ward systems and relationships. Finally, the study suggested that the impact of the increasing acuity of patients and their shortening periods of stay on Acute Wards need to be explored in terms of requirements for additional training, support and re-examination of notions of 'the therapeutic relationship'.

1.3. Practice development and collaboration

The practice development project reported on here addresses the ambition of the National Institute of Mental Health in England (NIMHE), as presented in the publication *Acute Inpatient Mental Health Care* (Clarke 2004) to take a holistic, strategic and long-term perspective to ensure effective and sustainable practice development:

> Developing capacity for ongoing learning and development in acute in-patient care involves more than just changing processes and refocusing activity. A range of educational and learning activity is required to improve the skill and knowledge base of practitioners. Neither the education or service providers have significant amounts of capacity at present to meet these needs. A long-term view on how to develop and sustain learning activity is required. (Clarke 2004: 33)

Practice development initiatives have shown that although skills-focused interventions can have important effects in upgrading staff knowledge and capabilities, these and other valuable skills in the workforce are not always sufficiently utilised and implemented in the practice culture. Indeed, this approach to learning may prove counter-productive, leading to 'burn-out' and disengagement: existing evidence suggests a need to shift from a technical to an emancipatory practice development approach (Manley and McCormack 2003).

Experiences from work-based learning and practice development initiatives (Larsen et al. 2005a, b, 2007. n.d.) suggest that considerable attention must be given to address the clinical

practicalities of care management (Richards et al. 2005). Staff need not only to have the necessary skills, but also to be in a position to use these skills in patient-work, and to have them recognised and valued in the team environment. As observed in a study on practice development supported by the Foundation of Nursing Studies:

> [S]uccessful changes to nursing on acute psychiatric wards require stable staffing and good leadership as a prerequisite. … A further, and somewhat depressing, implication of these findings is that practice development can only produce effective change on wards that are already functioning at a reasonably good level. (Bowers and McCann 2003: 3)

However, rather than simply relying on a stable and supportive environment to embed positive engagement with change programmes, 'practice development' can more ambitiously be seen to involve significant cultural change – attitudinal as well as behavioural change, that is, at individual, team and organisational levels. In order to bring about effective service improvement it is not sufficient to merely focus on individual staff's skills and competencies, it is necessary to work with a 'whole system approach' to address the values and environment of practice (Larsen et al n.d.). This involves working actively alongside *all* stakeholders and seeking to establish shared ownership of any change intervention (Larsen et al 2007).

1.4.   The project design

The project was designed in accordance with an action research and participatory approach, integrating phases of clarification and knowledge-gathering with phases of targeted implementation in a feedback circular movement towards practice development (Bate 2000). This approach is designed to draw on existing resources and utilise these to build further resources to achieve sustainable practice change and improvements of patient care. When applied to the practice development process the action research circle takes the shape as illustrated in Figure 1 (below).

Figure 1: The practice development action research circle
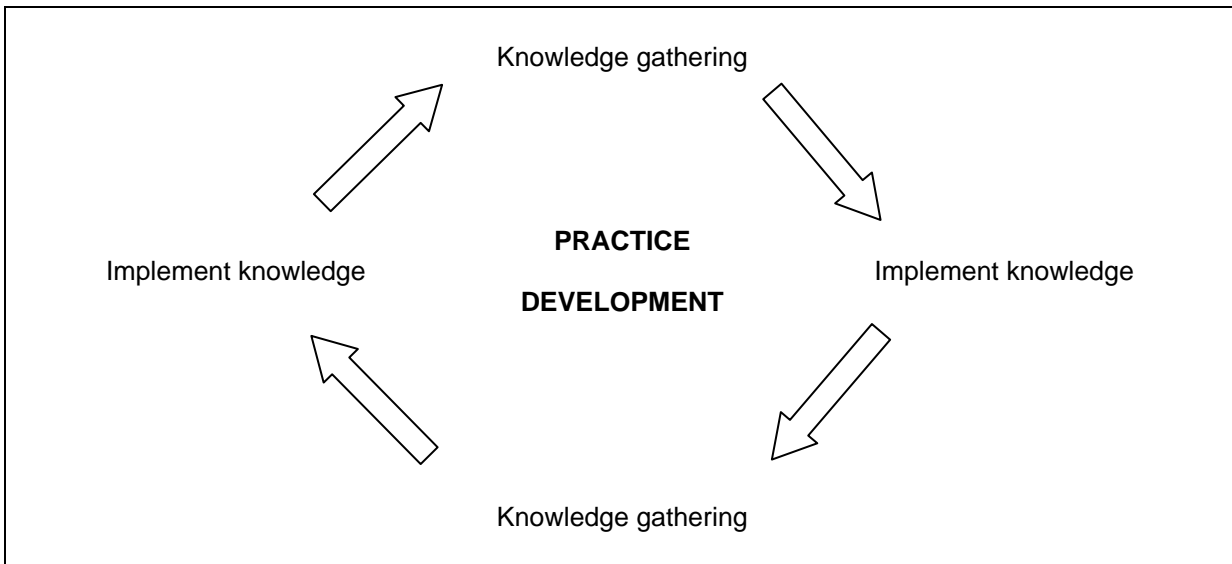
The active involvement of stakeholders at all levels is key to the success of the process, both in respect of knowledge gathering and the implementation of this knowledge to improve practice.

Our evaluation approach attempts to demonstrate how learning takes place, and how changes are made to improve clinical practice *and* the organisational structure within which it is embedded. Hence, this report primarily documents the higher levels of educational outcomes, as demonstrated in Kirkpatrick's model (see Table 1, below).

Table 1: Kirkpatrick's (1967) model of educational outcomes

Level of outcome	Type of outcome	Description
One	Learner reaction	Learners' views on the learning experience
Two	Acquisition of learning	Changes in knowledge, skills, competencies and attitudes
Three	Behavioural changes	Transfer of learning to workplace behaviour as a result of an educational intervention
Four	Changes in organisational practice	Changes to the organisation of professional practice as a result of educational intervention

(Referenced in Reeves [2001: 535])

The practice development project involved three interrelated phases of data gathering and practice development activity:

Phase 1: Staff and patient evaluation of the current model of engagement
Phase 2: Practice development work through staff support groups
Phase 3: Staff evaluation of support groups and future recommendations

The process and key outcomes of each of these are described in the following sections.

2. Patient and nurse perspectives on therapeutic engagement

In April and May 2006 a series of focus group interviews involving patients and nursing staff were conducted at the three acute mental health wards (two 'open' acute wards and one psychiatric intensive care ward).

2.1. Method and research ethics

This first phase of the project focused on collecting patient and staff experiences with and views on the existing approach to therapeutic engagement. The focus group interview method (Morgan 1997) was chosen as best suited for this exploratory study, which had a rather broad scope of focus and sought to generate a rich discursive reflection on experiences and views of inpatients and nursing staff in respect to implementing the Tidal Model and its benefits or weaknesses in terms of supporting nurse-patient engagement.

In contrast to data generated through other methods, such as individual interviews or surveys, data elicited in focus group discussions are interpersonal and negotiated, allowing different and differing views to be presented and challenged (Kitzinger 1994). Focus group interviews 'capitalize on the interactions within a group to elicit rich experiential data' (Ashbury 1995: 414).

The study received ethical approval from the local NHS Research Ethics Committee and the ethics committee of the University of Surrey, and further approval was obtained from the Trust Research and Development Board. The research ethics approval covered both the phase 1 explorative focus groups and validation meetings, as well as the follow-up staff focus groups in phase 3 of the project. Study information sheets were distributed to all research participants, and informed consent obtained prior to their involvement.

The groups were arranged in order to allow patients and nursing staff to speak freely. On each of the three wards a separate focus group interview was held for patients and for nursing staff, to prevent power and experience asymmetries from dominating the group interaction. The patient groups were moderated by an experienced mental health nurse and educator (KA), which allowed the group to proceed with the (per definition) 'acutely ill' patients without the

presence of ward staff. Clarity and transparency was essential in order to encourage the patients to talk freely about their relationships with staff. The focus group interviews with nursing staff (registered mental health nurses and nursing assistants) was moderated by an University-based researcher (JAL) who had no previous involvement with the staff, allowing a free discussion and possible critical views regarding practice development initiatives to emerge.

The interviews focused on the key elements of the clinical and systemic developments involved in introducing the Tidal Model: the quality and type of relationships between patients and staff, the type and content of patient-staff conversations and what is considered more and less helpful and, finally, the use of documentation and how this could be seen to influence the relationships and conversations. The latter issue had been mentioned anecdotally by some staff as a particular problem with respect to the use of the Tidal Model approach, and we sought to explore it further in the study.

As a result, the focus group discussions centred on these three questions:

1. What are your relationships with staff/patients like?
2. In your experience, which types of conversations with staff/patients have been helpful, and which have not been helpful?
3. Has documentation/paperwork been used during conversations with staff/patients? If so, what do you think of it?

The same questions were used in all focus group discussions, in such a way that in the focus groups with patients the questions were phrased to address relationships/conversations with staff, and in focus groups with staff, questions focused on patients. During and shortly after each focus group the researcher made notes on group dynamics and key issues emerging. The interviews were audio recorded and transcribed verbatim by an assistant. The interview transcripts were analysed using a thematic and interpretive approach in dialogue between the two researchers (JAL and KA).

To validate the data and invite further discussion and reflection, the findings were presented to staff and patients. Feedback meetings were again held separately for patients and staff. Nursing staff from all three wards were invited to one joint meeting. For practical and safety reasons feedback meetings for patients were held during two separate meetings: one for the intensive care ward and another for the two acute wards combined. Both researchers attended these feedback meetings, which were recorded by note-taking.

A total of 16 nursing staff took part in the focus group discussions, with varying attendance in the three groups: 5, 7 and 4. In addition, 15 staff from across the three wards took part in the feedback validation meeting. A total of 12 patients attended the initial focus group discussions, with numbers in each of the groups being 3, 5 and 4 respectively. Additionally, eight people in total attended the two feedback validation sessions for patients (5 from the two acute wards combined and 3 from the intensive care ward).

In the sections below we present the key findings emerging from the focus group discussions and validated by the follow-up meetings. We discuss each of the three questions in turn, presenting first the patients' views and then the nurses'.

2.2. Patients' relationships with nurses

Patients agreed that it is very important for them that the nursing staff express a friendly, positive and respectful attitude. As this exchange from one group illustrates:

> **Pt 1**: Well there are some shining…for my sake there are some shining examples, like [mentioned particular staff].
> **Pt 2**: I totally agree with you.

Pt 1: [Mentioned one staff member] goes out of his way to give you a smile and pick you up; he never walks down the corridor and ignores you unless there is an emergency. He is just always happy and joking and caring. Um…and [another mentioned staff member] is very…
[patients mention a number of staff whom they like]
Interviewer: So what is it about those people that…what is it that they do, what is that they have got that makes […]?
Pt 3: They talk to you properly, like you are supposed to be talked to, not like little kids like [another mentioned staff member] does.
(Patient group 2: par. 132-150)

Discussions in the other groups confirmed the importance of staff adopting a positive and caring attitude. One patient mentioned the importance to her of staff also showing caring through physical contact:

Staff [are…] very good here on the whole, they give me empathy, you know they put their arm around me and give me a bit of encouragement and that. And I am sort of person that needs that sort of tactile sort of hug, and kiss, […]. I think that's very important.
(Patient group 3, par. 90)

Other patients explicitly mentioned the importance to them of positive physical contact, but negative physical contact was mentioned on another occasion when patients discussed the need for staff to be tolerant and show empathy; not being 'bullies':

Pt 1: A couple of things I have notice is obviously people are different and each staff member, they are different individuals and I accept that. But one of the things that certainly isn't the case is I have witnessed the way they treat…or certainly some of the staff members treat patients depending on the severity of their illness, almost bordering on bullying I would say, not far off.
[All talking at once]
Pt 2: I have seen patients pushed by staff.
Interviewer: Really?
Pt 2: Yeah.
Pt 1: That's not good. You know, everyone has bad days and […] and they have had days but you know, […] people who are really ill, […] mentally ill and that might mean that occasionally they do or say things which aren't totally appropriate. And you know…I know there have to be rules and […] but there needs to be I think a larger slice of empathy involved.
(Patient group 3: par. 16-26)

During the feedback validation meetings with patients others reiterated that nursing staff at times act in ways that are experienced as bullying and disciplining. For example, one patient mentioned that staff had temporarily taken away personal property, such as a radio, as a way to discipline patients who had broken the ward rules. This reflected a notion of mental health nurses as 'prison guards':

They are more prison guards than they are nursing. I mean, it's something I don't understand about psychiatric nursing maybe.
(Patients group 1, par. 246)

Later in the same group another patient described some nursing staff's attitude as paternalistic and stigmatising:

They try and treat you like kids some of them, they tell you to go to bed and everything, and they keep telling you to take your tablets. And when you say that you don't have them at night they tell you to go and tell the other people, just because they think you have got a mental problem or something, and treat you stupid, you are thick.
(Patient group 1, par. 646)

This reflected another observation patients shared concerning the nature of the work of staff on the wards. One patient had the feeling that nursing staff are not engaging in therapeutic work, but rather performing reactive, crisis management functions:

> Nurses are working more on the basis of crisis management, um… in that […] you can see a lot of people aren't interested. But um… the nurses are doing little other than making sure the ward runs. They are not offering any kind of support services, or um…or chances to talk to them about personal issues or private issues, or issues that are bothering particular patients.
> (Patients group 1, par. 69)

This perspective related to concerns one patient had over the professional qualifications of nursing staff:

> In terms of saying 'what are the issues, what are your issues, record them and then we can look at making some progress on them'. But it's one thing recording them, it's another thing doing anything about those records. Um…and I mean, to be honest, I would argue whether my named nurse or any other nurse here is qualified to be able to do anything about them, so I don't know whether it's a process that is taking place at the right level really.
> (Patients group 1, par. 171)

The patient felt that the doctor was the one to make the decisions over medication, and questioned whether the nurses would be able to, or interested in, providing any significant therapeutic input:

> But then the ward round has got the doctor on it, so, you know, it seems to be largely based on what the consultant says in terms of the medication you are on, the day to day medical management by their registrar, and the nurses are just here to make… to make notes about your behaviour. But there is no active involvement in any kind of […] ongoing. I can't go and talk to a nurse about the things that I think would make my life better, because they are not interested.
> (Patients group 1, par. 83)

Later in the discussion, another patient in this group expressed the view that the only staff who could do something to help them was the psychiatrists and psychologists:

> People that can actually help you, like the psychologists or the psychiatrists and doctors, they are the only ones that can help us, but you never actually get to see them, so none of us are being helped. We are just in here for no reason really, being kept prisoners.
> (Patients group 1, par. 587)

In another group, a patient shared an experience of having been told by nursing staff that they could not help:

> [Staff said:] 'there is nothing we can do for you. We can't actually help you'. It's actually extremely frustrating, I am sitting here, they are saying 'we can't help you'. 'You can't go out', 'you can't do this', 'you can't do that', 'you can't […]', 'we can't help you'.
> (Patients group 3, par. 378)

The patient focus groups, then, conveyed a mixed picture of patients' relationships with nursing staff as, at their best, based on positive and caring personal support and, at their worst, involving an 'observing', crisis management approach that is disinterested, unhelpful and might even be experienced as bullying. In either case, patients did not experience therapeutic engagement placed at the centre of their relationships with nursing staff.

2.3. Nurses' relationships with patients

Nurses emphasised the importance of building good relationships with patients. It is seen as a delicate act of social interaction and requires of the nurse to follow the pace of the patients and meet them where they are, as this quote illustrates:

> **N 1**: What I try to do with some patients is to try to find a kind of focal point where we can sort of build a relationship from. For instance, some may like music, and so we build something from there. But at the same time you keep a boundary, a nurse/client boundary so that they don't

overstep that. And we also… we don't overstep the boundary as a nurse. We maintain professionalism at all times. However, saying that there are some clients that put up a wall, and you can't always penetrate their world, so to speak, so you give them that… a kind of… you kind of give them that respect. If they don't want you too close, then obviously you don't get too close. We don't try to get in their world unless they say 'come in'.
N 2: Yeah, 'come in'.
N 1: So we don't try to push ourselves in, saying 'you are here in my domain, you know, you have got to talk to me'.
N 2: Yes.
N 1: We kind of give them that respect, we say OK if you want to remain silent then I will be silent as well.
(Nurse group 1, par. 64-72)

The process takes place over time, and it is essential that the nurse is sensitive to the fact that the patients, at least initially, are, on top of the mental difficulties they are suffering, likely to feel insecure and uncomfortable in the unfamiliar environment:

When you look at a patient you have to understand that […] they are just coming to the hospital, and the hospital environment is quite different from your house environment, because you are meeting a lot of professionals coming in and out. And it's rather confusing and you feel so vulnerable, at the end of the day you cannot just trust somebody that you have met for two hours. It's a gradual thing, and that time you will notice that patients that relax with other patients. They would prefer to go to another patient just because they are telling people that can't them. I mean, when you try and go and ask the patient 'what is the matter' they will tell you 'I am not talking' or probably they don't want to do anything. Because trust is something that takes time to build so… I mean, in some cases, because they are here for a brief period, some patients come in for a week and a week for some people, it's really hard for them to get around people and tell them their problems, they can't. Some people take about three weeks to let out whatever they are feeling and that's where you find communication is really, really… you can't… you just can't get into people. Sometimes they will withhold information, the most important thing, or they will tell you what you want to hear. If you ask them 'are you OK?' – 'Yes I am fine'. [The patient thinks:] 'Why are they asking, what do they want to know?' They forget it is the job.
(Nurse group 1, par. 124)

The dimension of time has another direct bearing on the relationship issue, through the importance of being available for a conversation when needed by the patient. The discussion in one group of nurses showed that staff may take different approaches to prioritise patients' requests for conversations, and it highlights the importance of the nursing team supporting each other:

N 1: I think when they [patients] actually come to you that's when you get the most coming out of them, rather than when you are approaching them. I think one of the things we have […] it is some pressure to have a certain amount of one-to-ones done, […] and I think that is counterproductive to the whole thing. There are times when patients do come to you and it's then when you really think its OK, because they have a problem they want to discuss with you, and they are willing to do whatever at the time. And it's guided by them, and yes, we are there, but the whole idea is guided by them. I think that's when you get the most results, rather than… being put in a position 'do you want have a one-to-one, do you want?'… because we have patients here who have been refusing, right, and to me as a patient, if I was that patient, I would become annoyed after a while […] it could put me off for when I might need it. If you understand what I am saying?
Interviewer: Yeah. Yeah.
N 2: Because that patient has refused they tend to get asked even more often, because they have refused, which then exacerbates the problem even more.
N 3: […] that situation yesterday, the situation […] apparently I was busy doing the obs so […] straightaway, I said 'is it OK to see you after lunch?' […] when I came to see her she said 'no, I don't want to discuss anything' […] I don't know what discouraged her, […] people waiting for her to see me […] and she changed her mind and said 'no, I am OK now'.
N 1: That's what I'm saying, the Tidal Model… the patient, the patient is ready now and you have a duty…

[All talking at once]

N 4: We are a team, you should be able to say [to a colleague] 'look, do you mind taking over? This client has asked for some one-to-one.' Because that's what we are here for isn't it? It's no good saying 'I have a specific task, I can't do it.'
(Nurse group 1, par. 257-269)

Apart from the timing issue the actual physical space and the social situation it suggests is of critical importance to the types of relationships and conversations you can have.

I have always found at the end of the day, to get the best out of them [patients] is the environment, the setting and everything, take for instance [mentioned] Ward, I don't find there a place where I can sit down and talk to somebody openly and freely on a one-to-one, because there are people […]. I used to go upstairs, you used to be able to sit outside the smoking room and chat to people and you learnt a lot more that way. When you […] and the environment you can get as much as you want, because they will give it to you freely over a period of time, and help build up that trust. But if you don't have the environment and setting right, it can be difficult I think.
(Nurse group 2, par. 575)

The nurses emphasised the importance of not just having formal conversation rooms, but also informal places on the ward where conversations can happen naturally:

This is what I was saying about the environment, like up the stairs you were sitting in the corridor and you had that time and space. Because obviously you would see people walking up and down, and people would either talk, or not talk, or stop, and then continue. And you still had that physical presence, and you weren't locked behind a door or anything, where you are getting strangled or killed! [LAUGHTER] There should be a setting or an environment as such which promotes communication, not destroys it.
(Nurse group 2, par. 601)

In another group nurses discussed how it is also important for the staff to get a better understanding of the patients and their particular problems in order to know how best to approach the person, especially with some patients who might be hostile:

N 1: In some patients it is part of their illness you know, to distrust people. That is something we have to put aside, you know. …//…
N 2: […] paranoia plays a part and so, when we know what they are suffering from, the history, then I think that will affect our relationship with the clients as well. Rather than just going straight in there, and approaching everybody like you would approach everybody and not fully understanding their history. It's important, I think, first of all to understand their history, so if it's paranoia then you know there is a certain approach you have to take. You can't just rush in there like that.
(Nurse group 1, par. 128-134)

2.4.   *Helpful conversations: patient perspectives*

Patients had mixed experiences with and views on the type and quality of the conversations they had with nurses. Some pointed out that everyday informal conversations could be very helpful:

Pt: Helpful, quite basic is to […] general chit-chat about football, racing, sport, things that… things that you know… just to strike a chord […] straightforward level with the nursing staff. You know… that then either… I wouldn't say that brings them down to my level, but it makes you feel like […] closer to their level.
Interviewer: […] human beings?
Pt: Yeah. Yeah. It's helpful if you have got like interests with someone, but you are not going to have like interests with everyone, that's a fact of life. So I think just general… you know, a member of staff picking up a paper and […] what do you think? Not […] their opinion, 'what do you think about this story?' say. Just bringing you in on… all right, they might not want to talk at

the moment or whatever, […] just general things, or you when you are watching the telly, and they give a bit of feedback, […] you having banter together.
(Patient group 3, par. 235-239)

The importance of this informal conversation was for the patient to feel recognised and respected for their individuality, as this patient explained:

I know they [nurses] have got their jobs to do, but I don't like to feel as though I am just systematically slotted in, moving along on the conveyor belt and not…you know …//… Yeah. I am not treated as an individual […] communication, and if you can do it, then it's a kind of bonding, and that can only help them and the patient.
(Patient group 3, par. 255-255)

In another group the opinion was that conversations with the nursing staff in general was of very limited value, as this exchange illustrates:

Pt 1: We don't really have conversations with them [nurses].
Pt 2: No, you don't. [LAUGHTER] No response.
Pt 3: I mean, it hasn't happened very much on this occasion, but you get more meaningful discussions with other patients than you do with…
Interviewer: I was going to ask you about that, yeah. Do you…?
Pt 3: Not always, but I mean… you get… you can get an understanding about how the system works, their experiences of the system they are involved with. Um… about if you have a […] about their experience as opposed to your experience, about what you might or might not have done that helped you. Um… but, you know, as I said earlier, this is about… it seems to be about crisis management. They are more prison guards than they are nursing; I mean, it's something I don't understand about psychiatric nursing maybe.
(Patient group 1: par. 238-246)

And later, in the same group:

Pt 3: The staff nurses, the qualified nurses and the senior nurses aren't contributing to the individual patients in anyway that I have seen.
Pt 1: They are not.
Pt 2: They are just telling us what to do and to go to bed and everything.
Pt 1: Yeah, and 'take your tablets'. They come in and turn the lights on at all hours, telling you to take tablets.
Pt 2: And waking you up in the morning.
(Patient group 1: par. 295-303)

In contrast, participants in the group discussion emphasised the positive role of conversations between inpatients, and pointed out that nurses did not contribute to this:

Pt 1: There is camaraderie among different groups of patients.
Interviewer: And that's helpful?
Pt 1: Yeah, they can support each other in whatever way they want to and whatever way they can. But, you know, there is little or no nursing involvement in that process. There is no formalised session, weekly, monthly whenever, where you might sit down with your named nurse and talk about how you feel, or what your problems are, or what side effects the medication is having, or anything else.
(Patient group 1: par. 274-277)

The patients felt that the nurses do not provide therapeutic input, and that they in general do not offer opportunities for patients to talk about the problems and concerns they have:

Pt 2: …you would like to have some sort of evaluation, […] they don't. You are just left in the air. And you are just left, or ignored, aren't you, and then you get frustrated and angry then.
Interviewer: Right.
Pt 2: Because there is no evaluation and no opinion, and you have got these things inside you that you want to speak to someone about, and there is no one there that you can actually talk

to. And then you get frustrated then, and then you are not just arguing with one person, you are arguing possibly with about three staff, and none of them have got… have got the quality that they can actually answer your questions.

Interviewer: What […] is it that qualification?

Pt 2: Well I'd say it's the qualification, they haven't got the qualification that they can answer your questions, they haven't got it there.

Pt 1: They are going to have to be able to communicate effectively aren't they? You know, over all […] a very strong quality that they are offering, you know the ability to be able to come in here with one or two or three, whatever patients and say 'let's chat about the things you have got in common'. Or 'maybe you can help each other by discussing this'. Um… that's a possibility, um… I don't know. Some sort of level of support with the ability to be able to communicate at an acceptable level, really.

(Patient group 1: par. 333-343)

In another group, patients discussed the difference between doctors and nursing staff, and it was pointed out that nurses engage differently with patients because they spend more time together.

The doctors don't see you the like the nurses, […] the nursing care. He [the psychiatrist] only sees you in little pockets. Obviously he is highly skilled in… or she, and the nurses and the assistants, the nursing assistants, obviously have the opportunity like …//… they have got the opportunity to see your fluctuating moods. And hopefully they feed that back to the doctors. And I have seen them do feedback with each other, but I don't feel that gets fed back to me. I don't know what the others feel? I can see they are feeding back to each other.

(Patient group 2, par. 414-422)

The nurses are the ones observing the patients over time. The perception was that the nurses did not themselves act on the basis of this information, but passed it on to others: other nursing colleagues and the doctors who were seen as the people authorised to act. The patient was left with a feeling of giving away information, without getting any feedback. Similarly, in the first group, some patients feel frustrated by experiencing that the nursing staff are not engaging dialogically in a qualified way to address their concerns:

There is some element, when you approach a new member of staff, or somebody you haven't spoken to, or doesn't know you, about having to repeat your life story before you even get to stage one. Um… then during the process of repeating your life story it becomes quite clear that that person is not qualified in terms of asking the right questions, and making the right input, then, you know, you both give up don't you.

(Patient group 1: par. 386)

Two of the participants in group 1 had previously been inpatients on a better resourced ward, and felt that the staff here were better qualified – as this exchange illustrates:

Interviewer: Does it make any difference; I mean if we were having this conversation over there [on other ward] would there be a difference?

Pt 1: Yes. The staff on [mentioned ward] are more supportive and more active in terms of…

Pt 3: I think they are higher qualified as well don't you?

Pt 1: No. No they are not they are just…

Pt 3: You don't think they are?

Pt 1: No.

Pt 3: I think the staff on [mentioned] Ward were higher qualified staff, they seem […].

Pt 1: I think that's […] experience base rather than anything else. …//…

Pt 3: I think [mentioned ward] is higher, they are superior qualified staff there.

Interviewer: Right.

Pt 1: Last time I was in [mentioned ward] they offered something called one-to-one, which was you sat down with your named nurse and talked through what problems you had.

(Patient group 1: par. 296-419)

An interesting implication from this exchange is that the patients think that nursing staff that engage competently in therapeutic conversations are higher qualified.

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During a feedback validation meeting, one patient explained how being allowed the opportunity to talk about your difficult experiences and sensations when you are in the ward makes it easier to get to terms with them: it makes you feel more 'normal'. In contrast, if you do not have this opportunity, then you feel more strange, fearing that you wouldn't be able to cope in the 'normal world' outside the ward. Somewhat paradoxically, therefore, as a result of not being allowed to talk about their mental health problems, patients feel they need the 'safe' environment of the psychiatric ward.

2.5. Helpful conversations: nurse perspectives

In the earlier section it was described how nurses see the informal conversation as potentially very helpful in building a relationship and trust, but also as a less formalised and less threatening method of getting information and a better understanding of the patient's situation and concerns. Also discussed was the importance of both the timing of the conversation and being available to talk when the patient requests this.

Apart from the more informal relationship-building conversations, nurses mentioned other types of conversations that could be helpful in different ways. The following exchange illustrates the difficult and very sensitive balancing act of asking about issues that might be too difficult for the patient (and perhaps equally for the nurse) to deal with, and the importance of asking exactly about these sensitive issues in order to find out what is troubling the person:

> **N 1**: Sometimes when you are talking to them [patients] in general, like […] but when you try to ask them personal questions about say family health, […] then it stops, it can be maybe some violence or something […] we have got to know individual, each patient, where we should go, what we should talk about. [...] I am talking about women, if they have abuse, you don't talk about their fathers and if you don't know, if you haven't read the history or you don't know the history, then you go into the whole thing, how is their relationship with father? Because, it takes them back into the relationship with the father.   …//… like, 'who are your support?', 'my mum, my dad', then they are comfortable to talk about that […]. And talk about other things.
> **Interviewer**: So, what you are saying is that certain themes, for examples, family or… can be very sensitive?
> **N 1**: Very, very sensitive.
> **Interviewer**: So when you start talking about that…?
> **N 1**: Yeah, we should know where they are coming from, a little about them. Sometimes through no fault of ours we are not given a little, only a brief history, they don't tell us much and […].
> **Interviewer**: Yeah, has anyone had different or similar experiences with that kind of issue?
> **N 2**: Yeah […] they are talking about their families, their life, career, their background, where they come from. As well as it can also be unhelpful to them, because that may be the cause of why they are here. But saying that, the only way we can get the information in order to help them, we may have to ask some of these… it may be painful, but unfortunately it's the only way we can build a case history.
> (Nurse group 1, par. 322-334)

Interesting here, is the way in which the nurse (N 2) talks about the value of this information to 'build a case history', rather than as a starting point for engaging therapeutically with the traumatic issues mentioned. This reinforces the perception of nurses' role as being primarily information collectors – not therapists. However, some nurses *did* believe that sharing the information could be helpful to the patient by allowing an opportunity to reflect:

> It does work, I have seen it helps. It makes them kind of come to a place in their life whereby they can look at why they came in here. For instance, let's say it was a drug case. They can look at it and say 'all right, it was a bit silly', you know, talking about it now, they can take themselves back and place themselves where they first encountered that problem and now they can look back with hindsight and also with maybe a bit of maturity and say 'well right, yeah, this is why I am here right now. I don't like this. So I have got to make a change'. But before that, before coming in here, maybe they never had the chance to stop. So this is maybe

the place whereby they come to a stop in their life and they can look back. So in a sense, yeah, it is helpful to them.
(Nurse group 1, par. 344)

In another group, a nurse mentioned that even a hostile conversation can be helpful by providing nurses with a better understanding of the state of mind of the patient:

> **N**: Well I think in terms of not being helpful, I think there are interactions with patients that are helpful, be it the result, be it negative or… either way, you have an idea of how the patient is feeling at that time.
> **Interviewer**: Right.
> **N**: So […] the conversation, I don't if there are specific […] trying to get specific information and you are not getting it, […] the patient for some reason might be guarded about an issue or whatever, which helps tell you how the patient is feeling currently.
> (Nurse group 2, par. 291-295)

When discussing how helpful different types of conversations are, nurses started questioning the usefulness of the Tidal Model approach to collecting information. As expressed very clearly in this group:

> **N 1**: Well yeah, I don't want to sound as though I am totally anti the Tidal Model, but I mean, who does it actually serve? Does it serve the patient or does it serve the staff? Who is benefiting from it? I mean, to my mind you could replace the whole Tidal Model, most of the time with just one question: 'is there anything that you would like to talk about?' I mean, what use is it to know who his favourite relative is, or what religion, does he have any religious beliefs, you know, who was most important in his life? What does that serve? He knows that already, it doesn't serve his purposes at all, does it? And what do we do with the information? Not very much, because it's not of very much use to us, is it? So it doesn't actually serve anybody's purpose accept to fill out another form. You could replace the whole thing with just… 'is there anything you would like to talk about?'
> **N 2**: Or just give them a piece of paper and let them write down what they are feeling.
> (Nurse group 2, par. 343-345)

Nurses in the other two groups raised similar concerns, and in one it was suggested that other mental health professionals (doctors and psychologists) may have better interview skills and that the nurses have not had the same opportunities for training and development of these skills:

> Well, the thing about the doctors, they do years with consultants watching them interview people, they have to go and practice presentations. We [nurses] get a couple of placements where you might get a good preceptor or a bad preceptor watching you, or you might get the chance to watch […]. But you never really get a sort of… get a critique of your interview skills or feedback on how you do that, or how you get the patient to tell you the information that you need to help them.
> (Nurse group 3, par. 317)

2.6.   Patient perspectives on paperwork

Patients taking part in the focus group discussions generally were unaware of the concept of 'The Tidal Model'. Some made the obvious connection to tidal waves and one said 'it makes me think of Portsmouth'. When explained by the researcher, some recognised it as 'the purple paperwork' they had been filling in on admission.

> **Pt**: I had a purple paper and sometimes the nurses write down word for word exactly what I write, but sometimes I have to write it down.
> **Interviewer**: Right, so you have been through that, has that been helpful?
> **Pt**: Yeah, helpful and unhelpful because you see this one afternoon I said I needed a one-to-one. I felt really unsafe […] and I told her I would go and get out of here. I said I didn't feel very

safe and she said 'we will talk to the doctor in the morning'. Well… I ran out an hour after that because I […].
Interviewer: So in that instance what happened with the bit of paper, with the documentation?
Pt: It just went into the office I presume. I don't know… if they handed it over, but since I ran off you see, now they have changed, you know.
(Patient group 3, par. 452-460)

In another group the participants discussed whether they had seen the Tidal Model documentation:

Pt 1: Yeah, the bits of paper we filled in, but I […] and I never heard any feedback, it was just put in my file.
Interviewer: Right.
Pt 1: But it was filled in.
Pt 2: The whole system is guilty of that. I mean, I have asked questions about medication in the past. I am talking months in the past and never had any comeback [feedback] from it. I mean, you know… surely part of the process of making people better is giving them a great understanding of what their illness is. Because at the end of the day they are the best people to help themselves. And if they are asking questions of the professional and then getting no response, no answers, no clue, then, you know, they are walking around in the dark. So I think that is very relevant to the type of model […] that it has been utilised effectively, not just […] 'tick that box'.
(Patients group 1, par. 201-207)

A general concern was nursing staff not engaging with and following up on the experiences patients had shared, in those cases when they in fact had had this opportunity. This relates to the earlier mentioned perception of nurses as 'information collectors' and not as clinicians who act therapeutically on the information. The perception of a very limited, or non-existing, benefit from adopting the Tidal Model approach was directly related to patients' experience of the nursing staff's role:

Going back to the Tidal Model, my perception of it is that you know it's only… it has very limited use on the basis that the staff that are in this ward now are purely and simply crowd control really. Um… stopping you going out, giving you whatever toiletries and food you need.
(Patients group 1, par. 625)

In contrast, when discussing experiences of having used the Tidal Model approach on a previous admission to another ward, two patients explained that it had actually helped them to be filling in the documentation.

Well, I actually felt it helped me and I had… one of the nurses sat down with me, the first one I wrote, then I did one a week later and he wrote it. And I actually felt it helped me when I wrote it out.
(Patient group 1: par. 459)

Towards the end of the group discussion the patient again emphasised the value of being supported by the Tidal Model approach to write down her story:

When I wrote the letter I felt so good after writing it, and I typed it perfectly so I know that I have got my normality there. It's just being in here that is making me feel doubtful about how I am.
(Patient group 1: par. 696)

These benefits experienced by the patient were related to the earlier mentioned suggestion that the nursing staff on the ward who engaged competently in one-to-one conversations appeared better qualified.

2.7.   Nurse perspectives on paperwork

Nurses were quite dismissive of the documentation – or 'paperwork' – accompanying the Tidal Model approach. In general, it was felt to be overly structured, too detailed and repetitive.

> **N 1**: Some people don't like paperwork at all, so…
> **N 2**: Yeah, well I am focussing on the Tidal Model that we have in here, when we are doing admission. Because according to the model the patients should tell us their story for us to derive whatever from it, hopefully to help them, together to work both ways, we work with them. But what we… our experience of this Tidal Model we have at the moment, it's a bit of… a lot of paperwork. Some repetition, some, that's why we meet a lot of hostility [from patients], because you ask a question, some of the questions 'what do you mean?', I go: 'the meaning is something […]', then you meet this attitude, 'nothing, nothing, nothing', 'I won't sign anything.' 'What am I going to do with this?'
> **N 1**: After they have seen the doctor, then they have to see the nurse…
> **N 3**: Yes.
> **N 1**: […] paperwork.
> **N 3**: Yes, it's two assessments. […] sometimes they work together with the doctor […] some of them are good, these pink ones are really good. Some of these are not.
> [Background conversation here]
> **Interviewer**: Yeah. All right. Um… you were just saying about…?
> **N 3**: Yeah, some of the questions, they say 'why do you ask me this? You have asked me already, and the doctor…'
> (Nurse group 1, par. 254-272)

And, as explained by a nurse in another group:

> **N**: The patients they tell you, they tell you it [the Tidal Model paperwork] is too long, too lengthy.
> **Interviewer**: Right.
> **N**: Too painstaking.
> **Interviewer**: Yeah.
> **N**: 'Oh, I am getting tired now', 'this is so boring', you get all these remarks from them. And then, like 'rate how safe you feel', the nurse is going to score it […] 'yes, I am going to kill myself', and …//… but the nurses are thinking 'there is no way you are going to do that'. And you have to rate it with them, and I think that causes some sort of angst with them as well.
> (Nurse group 3, par. 199-207)

Similarly, in another group nurses discussed the problem of duplication of information and the need to streamline the assessment process:

> I don't see where the duplication helps anymore, because we already write… if we have a one-to-one we write it in the notes and we say what we have spoken about. And then we have another form that we fill out again. I don't see the point in duplicating the work so… as the nursing notes are a standard way of recording what happens, why not just have it recorded in the nurse's notes? We highlight the fact that we have had a one-to-one and at least people know where to go to get a continuous record of the patient's behaviour, progress, whatever. Um… I agree totally with having one-to-ones, I agree totally with communication, but I don't agree with making a nurse have to do twice as much paperwork as is necessary.
> (Nurse group 2, par. 457)

As mentioned in a section above, nurses were unsure of the therapeutic value of the information they were collecting, and some nurses requested further training to clarify these issues and improve their interviewing skills. Also, concerns were raised over the timing of using the paperwork, and felt that the requirement for it to be filled in could jeopardise the building of a positive therapeutic relationship:

> **N 1**: Well, for some it is like you were saying, you give them the paperwork and they will write everything, and afterwards they feel good. It's released all their hurts, their concerns, whatever. Others, they are suspicious, because they, the environment they are under section, they can't

do certain things, then you read their rights to them, and then you give them another piece of paper and tell them they need to write whatever. It's too much.

N 2: Too much.

N 1: And after a while it seems to… like she [other nurse] said, they have come from their home into a place that they don't trust, sharing a bedroom with maybe three or four other people, it's a new world and they haven't had time to really settle into it and then all of a sudden because we have to get the job done we are pushing people away. If we look at it from their angle and also on top of that they are not well mentally.

Interviewer: Yeah.

N 1: So it becomes a bit too much and it's like overload.

(Nurse group 1, par. 202-210)

And, later in the same group:

> I would say, yeah we do use paperwork during conversations with patients, personally I don't think it's a good idea at all. Because we are talking about building relationships, although we are not talking about building good friendships or anything like that, but a relationship for continuous care. And I am sitting down talking with a client and yeah, I am asking them questions that are personal and I am writing everything down. I think that is so impersonal, I think really, actually, any relationship that is to be build is being destroyed right there.
> (Nurse group 1, par. 454)

Nurses stressed the need to take consideration and be flexible to time the introduction of the Tidal Model approach to meet the needs and mental readiness of each individual patient. Nurses stressed the need for the patient first to be 'settled', and that the Tidal Model approach is not suitable for acutely ill and paranoid patients. This could be a particular concern when requesting that patients sign the document:

> Any time they [patients] see a piece of paper coming for them to sign, it is as if they are signing their life away. We have to be creative to see how we can work around that to kind of gain their trust in order that we bring that document again at some other stage, another time, when they are feeling a bit more settled, and they will trust you.
> (Nurse group 1, par. 172)

In one group it was suggested that whereas using the Tidal Model approach could be beneficial where there is already a good nurse-patient relationship, it would more likely be therapeutically damaging to a weaker relationship. In general, the documentation appeared to be of limited value as a source of information for the nurses, as indicated by this statement:

> You know, I would talk to patients directly or the medical notes. The nursing day to day stuff. But I don't think… because if you look comparatively, you have got somebody else doing the Tidal Model admission, you have got this teeny little box with the mental state, or you could have a two page, fully comprehensive text done by the doctor, I will look at the doctor's. There is going to be more pertinent stuff in there.
> (Nurse group 3, par. 363)

Others were less dismissive of the value of the information in the Tidal Model documentation, but a dominant concern was the way in which the paperwork was seen as evidence to document nursing activity that would then to be audited.

> It helps when we can read and see where they are coming from, that's all. But otherwise… they [the documentation] go against us, not able to fill in, [...] you just can't […]. And the following day there is an audit, 'oh, what have you been doing? Nothing? You don't do anything with your client, the patient?', because it is evidence. So it's like coming back to you, the information they will give you, you can use it all: 'this is what you need', 'this is what you said', you can put in. If I have that, nursing is right, so whatever they tell us we can put in the nursing notes...
> (Nurse group 1, par. 492)

Rather than forming a supportive framework for therapeutic engagement, the Tidal Model documentation was in risk of predominantly becoming a managerial tool. This was a view confirmed by discussions with staff during the feedback validation meeting.

3. Staff support groups for therapeutic engagement

Key findings from the focus group discussions and subsequent feedback validation meetings reported above were presented and discussed at managerial level within the Unit to develop a practice development plan. Two such meetings took place in January and February 2007, and involved the two researchers (JAL and KA), the modern matron, ward managers, a psychologist, a Trust-based Practice Development Facilitator and a representative from the Foundation of Nursing Studies.

The discussion focused on how staff best could be supported to achieve improved nursing engagement in therapeutic person-centred work with patients. The matron informed the group that new assessment documentation was being developed and that it would replace the existing Tidal Model documentation, although some elements might be incorporated.

It was agreed that the findings pointed to the need for staff to be provided with a practice development input focusing on fundamentals of engagement work. The Practice Development Facilitator (PDF) working within the trust had experience of setting up and running staff support groups on other wards in the trust, and this model was chosen to be implemented also here. One ward manager had previously had good experiences of similar groups where staff were provided with an opportunity to speak about clinical issues in a supportive and externally facilitated group.

The first group was arranged to start in April 2007, to be running on a monthly basis. Through word-of-mouth positive feedback a further group was set up on the second ward in the summer 2007; and in autumn 2007 the third ward planned to also initiate a group.

The groups were facilitated by the PDF who was supported by the University of Surrey in relation to a parallel project involving the evaluation of the Acute Care Partnership Project (Larsen et al n.d.). As part of this project, four PDFs across the South East produced ethnographic evidence to document their practice development work. Ethnographic methodology offers an opportunity to document detailed social and interpersonal processes while locating these in a framework of interpretive understanding (Larsen 2007). The ethnographer makes active use of her or his own role within a social setting to observe and reflect on the behaviour and interaction between people (Sharkey and Larsen 2005).

While traditionally marginal to healthcare research, ethnographic evidence is gaining increasing attention and prominence (Savage 2006). The type of data is of particular relevance to document and critically reflect on practice development. As pointed out by Nastasi and Berg (1999), ethnography is crucial in describing and monitoring the process of change, and can help to describe the evolution of an intervention and its effect both on individuals and their social context. Details on the methodology adopted by the PDFs to provide ethnographic evidence can be found in Larsen et al (n.d.).

The following is an edited extract from the first-person[1] narrated ethnographic evidence by the PDF who facilitated the support groups.

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[1] In accordance with the tradition of ethnographic writing the PDF has documented her observations and reflections in the first person form, and makes use of the ethnographic present as a stylistic devise.

3.1. Introducing staff support groups

The staff support groups were based on similar groups set up in other acute mental health services in the trust. In the first few months I was in post as PDF in the early summer 2006 I carried out a lot of networking and did a mapping exercise trust-wide of what the needs were regarding practice development in acute inpatient services. The main need that was highlighted was for each unit to have staff support to look at complex challenging client needs that needed knowledge and expertise to formulate a clear and consistent care plan and package of care. I carried out a series of focus groups with staff and the main theme repeatedly was about staff support. They felt that they needed to meet two-weekly or monthly to formalise some structure of support and have time to reflect on practice. The first group was set up in the summer 2006. It mushroomed through word of mouth to the other units: two further staff support groups were set up in autumn 2006 on the open wards. We then also set up particular groups for the managers and the senior nurses, in order to develop their leadership and practice skills. They felt that having this time to reflect on their practice was invaluable to their own growth and development, individually as well as collectively within the unit.

At one unit it took time to set up the group because staff were resistant to change. The thought of the group was 'oh no!' – it meant looking at change, which was challenging, and some people don't like it. I then worked on building trust, rapport, engaging staff in role-modelling – i.e. working through a care plan of a client with complex needs, utilising a new approach, or an intervention that would be helpful in reducing that client's distress. This received positive feedback and I was invited to attend some of the handovers at the unit to offer further expertise and look at positive practice developments, such as reorganising the physical environment and looking at ways to improve effective communication at patient reviews. It is important to have the ward manager on board. The manager needs to see the value of the approach and actively promote it.

The group session is an opportunity to reflect on and improve practice. You could say that I and the senior staff who help facilitate the group represent management, but this is not how we arrange it. It is an opportunity to have time to reflect. The topics are very much influenced by things going on at the ward. The process and content of the groups are illustrated in the following.

In the following an illustration of the group process is given by drawing specifically on experiences with setting up the first group in relation to the current project.

3.2. The group process

I normally arrive at 1.30 pm for the meeting, and we first meet in the office, and the ward manager and senior staff nurse start rally people up: they go down the ward and say 'it's the group' and people they start moving to the room. On the duty roster it is highlighted that there is going to be a group. On this ward the ward manager and senior staff nurse are good at advertising the group, putting posters on the ward, word of mouth, talking about the group to staff and managers. They encourage people to come together. The manager and staff get staff from one of the other wards to cover, two or three, depending on what is going on on the ward. In this way, staff from the other wards also learn about the group. In this way it is a bit of a domino effect. By worth of mouth the managers also hear about the groups – it gets 'on their radar' – and it feeds into the directorate.

The staff trickle in. Settle down. I say 'shall we make a start' and I then welcome the group and introduce the main purpose, a few minutes introduction. The senior staff nurse or I say that 'this is not a teaching session, but about reflecting and mentalising'. And I do reiterate that it is confidential, will not go to the management, which people are a bit paranoid about at the moment (at the time of writing, summer 2007, about five groups had been run on the ward),

and that I do not keep notes or records. The wards use the groups to talk about their feelings of uncertainty in the current climate of restructuring, where some staff risk being redeployed. Some are worried about not being able to pay the mortgage and supporting their children. The group allows staff to get these thoughts and emotions out in the open – knowing that it is confidential, that it will not go to senior management. Often we have a chance to reflect on the Trust policy and approach, often involving humour and joking, as a way to release tensions. The group has helped to build social relationships and comradeship among staff – peer support.

Then the group starts to settle a bit and we can talk about clinical and practice development issues. There will have been arranged a theme in advance. Between myself, the ward manager and the senior staff nurse we have made sure that there is a theme relating to a clinical issue, such as 'what is "bipolar"?', 'the unconscious'. The person who is going to talk about the theme then starts off. As it is no teaching session, it is purely the sharing of knowledge, with no use of teaching technology (laptop, board) – and people then start to chip in, adding with their understanding. We are not there to teach, but to share knowledge. Bringing different perspectives together. If people start talking on top of each other I will ask people to wait for each other, it's like a rolling process of allowing people to share. It is allowed to come to a natural end.

Holding the groups is demanding, and especially on you own it is very taxing. You are holding a lot of frustration – transference is the word – it is very demanding. It is important to have supervision available for the facilitator – and a wider support structure. In addition, support is offered through the co-facilitator during the group. Using mentalising you have to think ahead of yourself. When you have a co-worker you have someone to bounce off with. The co-facilitator is usually a psychologist. On this particular ward I mainly use the ward managers and sometimes a senior staff nurse. This arrangement has evolved naturally – it was not something we formally agreed. During the session we are making regular eye contact; looking at each other – using it as a 'cue' to step in. It is almost intuition, creating a flow to keep the group going. We are encouraging staff to expand and join in, feel involved. It is about valuing people's experiences. When facilitating the group it is important to bring in humour, to bring another perspective to potentially difficult issues. I am conscious to support the group by being inclusive, and bringing warmth to the group – it is important to be visible and for example remember the names of people.

Cases are brought into the discussion, but not in a fixed or narrowly structured way. One would say 'do you remember the other week we had Jim (a pseudonym for a patient) in and he was very distressed and pacing up and down the ward and the family was very distressed, and he felt very distressed?' - and the nurse described how he dealt with the situation by talking to the client and how he approached him. And then another nurse mentioned how she had seen him (the nurse) being very good at handling these situations. This led to a wider discussion of how people feel distressed and not valued, and how that might relate with earlier experiences and situations of neglect. And how it is important to recognise these wider situations of the client and make sure to develop a more positive relationship – being aware how we form attachment and how that is felt, and how distressing experiences are being re-enacted in people's lives. It makes the group reflect on how to help clients stop that process – of abandonment-rejection-anger, accepting it and developing strategies to cope with it. We discuss and explore techniques and strategies to defuse anger – like physical breathing techniques, or cognitive techniques like counting backwards, or psychological approaches, or taking time out – taking ownership.

We looked at how to change approaching clients. When people are angry we, as practitioners, sometimes respond in a negative and confrontational way: 'hands on hips' or 'calm down!' – not always realising that is what we are doing. Instead, we should adopt a more open and compassionate approach. Instead of adopting a 'child approach' telling clients what to do, we should adopt an 'adult approach', asking how they feel (to use the language of transactional

analysis). We should try to talk about it: 'I hear you are angry' and stay with it – trying to move away from the situation and talk about it. It is about finding a good time – 'pull the person back into their adult'. In the group we try to stop at 2.30 pm, but we usually go on to 3 o'clock, allowing things to finish; it depends on the demands on the ward and how staff feel. It is important 'not to overstep the mark' and 'wearing down the carpet'. Towards the end of the group I will highlight the positive contributions, validating what people have contributed and shared – to put it together as a 'gift' towards the end. I attempt to capture the session's richness and the comradeship of the group – 'sowing a seed at the end'. People at times say 'thank you' and there have been rounds of applause.

3.3.   Example of a group session

Last week we had a group with 17 people present, including me, the ward manager, the senior staff nurse and the two nursing students. They looked at 'bipolar', they wanted to talk about that. The senior staff nurse gave a synopsis of 'bipolar' – you could hear a pin drop. It was focused, all alert.

I invited the group to reflect on what the senior staff nurse had just shared – and it opened up a conversation about people, great leaders, who had also experienced 'bipolar'. This made us reflect on the fine line between sanity and madness, and how when the leaders were functioning well their functioning was amazing. This opened up a further reflection that this client group is very resourceful, as well as suffering mentally and emotionally. It made us think of our approach to treatment: to think about what makes the clients stressed, their mood go low. And the debts this particular client group can create for themselves, the highs and low. It makes it difficult for them to manage their lives. That it was difficult for them. Some of these people managed quite well, perhaps because of good support from a partner. And that made us reflect on the social support and how the ward works. To perhaps consider how to better slow down the stimuli and the amount of distraction. To avoid the brain working overtime. As practitioners, we tend to forget how the people feel on the ward, and that we need to consider this. And perhaps this is also why it is difficult for patients to manage their finances, to control all the things going on. It made us look at the person's quality of life. Everyone contributed.

One of the nurses shared that one of his friends had recently been diagnosed with 'bipolar', and feels very depressed. I then asked whether this person was creatively gifted, like Mozart. And he was, he played piano, but it was difficult for him to do this for a longer time. And then another nurse suggested that perhaps what is needed is to focus on the strength of the person, to support them to do the things they are good at. And that medication is not the only way to help. Another suggested that perhaps it was the experience of attachment in early life, a feeling of being abandoned, that could trigger the feeling of intensity, the feeling 'it must all be done now'. Staff gave examples of the patients on the ward pacing up and down, drawing frantically, like Van Gogh – always stressed, losing weight. It made the group consider the challenge to find ways to help the clients to pace down. To find also ways to break maladaptive thought/ behavioural patterns in their lives. We also reflected on the difficulty of doing this when you are working on the ward, and are perhaps having the chance to work with people over a longer period of time. We thought that it would be important to work with other people, like a sponsor, or the voluntary sector – to have someone to work with the person, perhaps supporting a person with a diary, or what is helpful to them. When people with 'bipolar' come on to the ward it is always a trail of mess, in terms of relationships, finances, furniture – that all need to be dealt with. We spoke about how the clients bring this trail of mess, and bring other people into it – like ward staff and other people.

And we spoke about how we don't know enough about the legal and social aspects of their lives, and that we need to include other people and sponsors. And the ward manager, pointed out that there is a gap, that the support workers are not around to help these situations. And we also discussed more political issues: how the trust is reorganising the workforce. We looked at a rolling programme in London. With emphasis being on targets, some staff were

concerned that there might only be a limited amount you can offer clients, especially for clients who are not well off financially. There is a need for further intervention. We looked at the different approaches (like CBT) – that these are needed skills to work with the people.

We ended by coming positively back to where we started – looking at the skills and positive aspects of patients, and that the staff are doing lots of important and good quality work. The ward manager mentioned that the next session will be arranged by the night staff, and they will be talking about sleep disturbance. Which made everyone laugh.

Sometimes when I leave I have a chat at the door with my co-facilitators: the ward manager and the senior staff nurse. It Is important with positive reinforcement and feedback, such as: 'We are having to keep on the bicycle and keep riding' and 'keep positive'."

4. Staff experiences with support groups

In order to assess the practice development work through staff support groups a series of focus group interviews were conducted during September 2007. Separate staff focus groups were arranged on each of the three wards.

At the time of the group discussions (September 2007) the three wards had had different levels of engagement with the staff support groups. As described in the sections above, one ward took the lead in introducing the staff support groups and had had monthly meetings over the proceeding 6-month period. Another ward had run the first staff support group in June and experienced three meetings at the time of the focus group discussion. The third ward had not yet had their first staff support group, but it was planned to introduce it when practically possible (a first meeting arranged for early September had been postponed due to activities on the ward).

This time, data collection solely focused on staff, as it was considered that interviews with patients would not be able to provide data that could be analysed to document changes in nursing engagement practice beginning to emerge as a result of the staff support groups conducted over the previous few months. As mentioned in the background section, practice development is a slow process dependent on sustained support and attention. Alternatively, data collection, presentation and analysis direct attention to the self-reported experience of staff with respect to improved skills and confidence regarding therapeutic engagement.

The group discussions focused on these three questions:
1) What is important to support you in the relationships and conversations you have with patients?
2) What are your experiences with (or expectations to) the staff support groups?
3) Is the Tidal Model approach now being used on the ward? (if so, how? and what do you think of it?)

A total of 14 nursing staff (qualified nurses and nursing assistants) took part in these focus group discussions, with different representation on the three wards: 3, 5 and 6. The focus group discussions were arranged at a convenient time around handover in consultation with ward managers and moderated by the external university-based researcher (JAL). The group interviews were audio-recorded and notes taken by the researcher.

The following presents key findings emerging from thematic interpretive analysis undertaken in dialogue between two researchers (JAL and KA). The above mentioned differences in the three wards' stages of adopting the staff support groups provide an empirical background for analytic comparison which is used along with the focused questions to structure the presentation of staff experiences and views.

4.1. Support for therapeutic engagement

Many of the same themes as discussed during the earlier staff focus groups were repeated in these groups (see section 2, above). In particular, staff emphasised the importance of a good physical environment where you have spaces – both informal and formal – for conversations with patients. On one ward staff were very satisfied with their physical environment and found it facilitative of patient engagement; on another ward, staff were highly critical and commented that there is not adequate access to rooms where it is possible for staff to conduct one-to-one conversations in a private and safe manner. On this latter ward staff explained that usually they have the best opportunity for 'catching-up' conversations with patients when they come for their 5-minute medication hand-out. Conversations are arranged on an emergency basis 'when they need to' and often in open and public spaces that are not conducive of therapeutic engagement.

All groups highlighted the staff-patient ratio as important in order to facilitate meaningful nurse-patient conversations. In the group where there was satisfaction with the physical environment, staff felt that the staff-patient ratio on the ward was adequate for one-to-one engagement with patients. In the group where staff were unhappy about the physical environment there was also a sense that the staff-patient ratio was inadequate on that ward. In the third group staff also mentioned staff-patient ratio as an important issue, but pointed out that structural and managerial issues are crucial by ensuring that the shift management allows for nurses engaging in one-to-one conversations with patients. In addition, as also highlighted in the earlier focus groups, it is important that staff support each other to allow for one-to-one conversations to happen:

> **N 1**: Sometimes, because of time constraints, we are under pressure to have a quick time with the patients because of demands on the ward. So we need more time so we can spend more time with patients.
> **Interviewer**: And how do you get that time, or what is a condition for having that time?
> **N 2**: Usually you tell your colleagues 'I am going to have an one-to-one' and they in turn, there might be some demands, like maybe on observation or environmental, if someone can take over that, or you have other jobs you have to do, if someone can take over that job while you have time with patients
> **N 1**: Yeah, that flexibility sometimes, because you get involved with the patient.
> (Nurse group 6)

The importance of the flexibility to be ready to talk *when patients are ready* is then crucially related to the support staff give each other.

> The patient could be ready at any time to have a one-to-one. So the patient could come 'could I have?...', it can happen any time. So at that time you are also supposed to be there. It is not easy, but maybe we need some more flexibility.
> (Nurse group 6)

The discussion demonstrated also the importance of staff being aware of the importance of using giving time to one-to-one conversations, and to support each other in making it happen. In relation to this, the staff discussions emphasised the value of staff training, and on one ward there the staff support groups had been running monthly for half a year these groups were mentioned as an important source of support for engagement with patients.

4.2. Views on staff support groups

Given the different stages at which the three wards had progressed in implementing the staff support groups the groups were in quite different positions to talk about their value. On one ward they had not yet been introduced and staff seemed to be generally unaware that this was being planned. Staff expectations in this group were that they might be useful by allowing an opportunity to talk about issues on the ward.

In the group where there at the time of the discussion had been three staff support groups nurses mentioned that they had found it useful to be allowed an opportunity to 'ventilate' concerns over the day to day work. However, some unease was mentioned in relation to potential problems of confidentiality and the risk that voices of criticism might come back to penalize individual members of staff.

A more substantive presentation and discussion of the content and benefit of the staff support groups emerged from participants in the group related to the ward where such meetings had been occurring monthly for the past half year. Nurses mentioned that the groups were both informative and enjoyable. It was felt to be useful that staff from different disciplines who are working together on a day to day basis have the opportunity to talk about issues facilitated by an external person (the PDF) which allows an outside perspective on the group dynamics, without being part of these herself. It is easy to get 'bogged down' in the day-to-day issues, but the external facilitator allows a bit of 'blue sky thinking' and the introduction of more theoretical concepts and discussions.

Nurses mentioned that the value of the group could also be related to the fact that they have been set up in direct response to their own request:

> I think because they came about from the findings of what we wanted in the first place it just worked well, because we all knew what we wanted and we got it!
> (Nurse group 4)

Staff mentioned that they have walked away from the groups with a better understanding and more curiosity about the patients' conditions and experiences. Nurses felt that the groups had made a real impact in terms of their clinical practice, encouraging further therapeutic engagement:

> **N 1**: The unconscious mind is a really interesting one if you are looking for a concrete example.
> **N 2**: Yea, definitely interesting.
> **N 1**: It made me think of my unconscious mind and the patients' unconscious minds, so when I saw speaking with them it made me think of 'am I thinking of them unconsciously here?' it just made me explore and think of the patients as well. Just about like, how [named staff member] talked about how patterns repeat themselves and behaviours have always deeper meanings, so that sometimes we… I got to the point where I just forgot why patients behave the way they do, and just be dealing with the actual behaviour and not the reason maybe, and exploring this.
> **Interviewer**: So did it then make you act differently when you were sitting with the patients, influenced about the discussions that you had?
> **N 1**: I think it made me listen to them a bit more. It made me ask different style questions.
> (Nurse group 4)

Nurses mentioned how they are actually looking forward to the next group and that on this ward even night staff come in specially in order to take part.

4.3.   What happened to the Tidal Model approach?

When asked whether the Tidal Model approach was still being used, the nurses immediately associated this with the related documentation or 'paperwork'. Again, the criticism voiced in the earlier staff focus groups was repeated concerning a feeling that the Tidal Model questions can feel like an 'interrogation', that there is too much paperwork to be filled in and that it is overly structured.

One nurse mentioned that the highly structured and directive nature of the paperwork takes away the autonomy of the nurses and undermines their clinical skills to conduct meaningful conversations in a more flexible manner:

I have major problems with the Tidal Model. It is just far too much paperwork, which allows for absolutely no targeting of nursing skills at all! I just think what's the point of us learning about how to assess patients and what's important to treatment plans and, you know, care plans. Basically, it is fool proof, right, if you didn't know anything about nursing you just have to ask these questions and they have the answers. But I think, you know, give us some credit, we are nurses, we know a bit more about nursing! And it doesn't reflect in the paperwork, the questions.
(Nurse group 4)

Issues of 'timing' and the importance of the patient being 'settled' was also mentioned again (see discussion in section 2); and it was suggested that this approach may not be suitable for patients on acute wards who, in most cases, are not likely to stay on the ward for a longer period to develop the therapeutic process. In addition, it is a significant problem that the Tidal Model paperwork is only being used on the wards and not elsewhere in the Trust, which makes referral and sharing of assessment between different mental health documentation difficult.

Although echoing concerns over the amount of paperwork associated with the Tidal Model approach nurses in one group did point out that some patients do enjoy having the opportunity to write their own story. Nonetheless, in this group also nurses did express a need for further knowledge about how to use this information in a therapeutic engagement with patients.

At the time of the group interviews new electronically-based assessment documentation was about to be introduced (on 1st October 2007) which had incorporated some individual components of the Tidal Model paperwork. Nurses pointed out the need to be fully involved in designing and introducing this new form of documentation and for it to be meeting their needs and requirements; they were somewhat sceptical about this actually happening.

5. Conclusion and recommendations

This report documents a prolonged effort of practice development work to improve inpatient care on acute mental health wards through nursing therapeutic engagement with patients. In particular, it reports on staff and patient experiences of introducing the Tidal Model of mental health nursing on three acute wards in South East England, and how an action research approach was used to support the practice development process.

Findings from interviews with patients and staff regarding the implementation of the Tidal Model approach pointed to key requirements in terms of supporting nursing engagement. The negotiation over how best to address these requirements coincided with the local managerial decision to adopt a revised nursing assessment approach, and the practice development intervention was directed towards providing a forum for staff to reflect on and share knowledge about best nursing engagement practice. As a result, monthly staff support groups facilitated by a Trust-wide Practice Development Facilitator (PDF) were introduced.

Findings from follow-up focus groups interviews with staff regarding their experiences with the **staff support groups** emphasise their value in terms of developing knowledge of mental health issues and stimulating staff interest in the experiences and perceptions of patients. This encourages staff curiosity in patient perceptions and engagement in understanding their perspectives. Furthermore, it provides an opportunity for the multi-professional staff team to share and exchange knowledge to the benefit of the team spirit.

Interviews with staff suggest that the process of **responsive practice development interventions** where the knowledge gathering brought about through the action research approach had a positive effect by enhancing staff's experience of 'ownership'. Equally, the project findings suggest the key importance of active managerial involvement in driving and continuously supporting the intervention.

Negotiation and ownership is crucial to successful practice development. Perhaps not surprisingly, it has consistently been found that successful organisational change takes place when employees have a purpose, a plan for, and a part to play in that change (Bridges 2003). To ensure this, practice development interventions need to engage at all levels – Trust, ward manager and different groups of staff – in personal conversations and negotiations to **listen to people's concerns and suggestions** and to develop an approach to service improvement and practice development that fits the needs and requests **on the ground** (Larsen et al 2007). Successful practice development depends crucially on engaging in a change process where different stakeholders are given due consideration and actively, and repeatedly, invited in to take part in making change happen.

Staff provided evidence to suggest that the staff support groups have had direct benefits in terms of improving inpatient care, by heightening nurses' interest in engaging with patients, trying to understand their experiences and perspectives. The group format appears to stimulate a 'clinical curiosity' that places engagement work with patients high on the agenda among day-to-day tasks, and is supportive of staff affording themselves and their colleagues the flexibility to respond to patient needs for personal engagement work when required.

In order to continue the essential work of these groups they need continued support from an external facilitator. This needs the backing from senior Trust management. One way to ensure this is to have regular meetings with senior managers to ensure that work progression is monitored and valued. This means utilising the Modern Matrons group and the Acute Care Forum so that consistency, coordination and effective communication is ensured.

Recommendations:

The experiences from the project highlight the importance of the process and *ownership* in implementing these recommendations:

- 'Front-line' staff and service users must take a key role in driving the design of explicit and concrete action plans to address each of the above recommendations.

Managers, clinicians and service users need to work together to:

- Establish ongoing training, support and supervision in the use of focused, collaborative interview skills for Acute Inpatient Nurses.

- Ensure meaningful structural changes – in terms of time, space and reprioritising of nursing roles – in order to enhance interpersonal skills, and ensure available space and time for patients and staff to 'tell their stories' and to collaborate in 'reauthoring' existing stories.

- Actively explore ways to reduce unnecessary documentation, perceived by staff as 'irrelevant' and 'repetitive' paperwork.

- Develop new approaches – through training, discussion and ongoing supervision – to 'paperwork', incorporating into the process of care as an essential tool for adding meaning, depth and enrichment to stories, rather than as mechanised dictator of the story.

- Develop regular, externally-facilitated and story-focused supervision engaging with staff development needs and current priorities.

- Follow-up and re-evaluate therapeutic engagement patterns, strengths and challenges in the end of 2008.

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