Original article

A qualitative study exploring the patients' perspective from the 'Reserved Therapeutic Space' nursing intervention in acute mental health units

Abstract:

This study aimed to explore the perspective of people who had experienced treatment as patients at acute mental health units, regarding an intervention model to improve therapeutic relationships in the units, which had been previously designed by the nurses. The study participants were people linked to collectives for social activism in mental health. Six focus groups were held. The results were classified into three themes: a) the meaning of a space to enable the establishment of a therapeutic relationship, b) the procedures to implement the space and c) the difficulties to overcome to establish the space. For the participants, the Reserved Therapeutic Space intervention was perceived as a space where they could share expectations and needs with the nurses, considering it as both valid and useful to improve the therapeutic relationship in acute units. For the participants, the intervention should be structured in three stages: orientation, follow up, and discharge. The content of the intervention should be proposed by the patients based on their needs and concerns. The barriers identified for carrying out the intervention were the lack of relational competence, the violation of rights and the lack of accessibility of nurses. The facilitating elements were the availability of nurses, active listening and empathy. The resulting intervention model includes realities of both groups, providing insights for nurses to initiate a space with patients and improve their therapeutic relationship. This intervention model could be used by managers to test its effectiveness.

Key words: mental health nursing, nurse patient relationships, nursing intervention, psychiatric inpatient care, Reserved Therapeutic Space.

INTRODUCTION

The Therapeutic Relationship (TR) is accepted as the backbone of nursing care and a vehicle for improving the health of people with mental health problems (Zugai, Stein-Parbury, & Roche, 2015). In fact, the proper establishment of the TR increases the effectiveness of any nursing intervention in the clinical practice of acute mental health units (McAndrew et al., 2014), improving health outcomes for hospitalized people (Kelley et al., 2014).

Background

The concept of the TR has progressively developed, in parallel with the growth and professionalization of mental health nursing (Gabrielsson et al., 2016; McAndrew et al., 2014; Zugai et al., 2015). From an empirical point of view, for both mental health nurses and patients, the TR is conceived as an interpersonal interaction between the nurse and the patient; a relationship based on trust with a humanistic approach focused on therapeutic assistance, in which respect, individuality and empowerment prevails (Moreno-Poyato et al., 2016). From the theoretical perspective, in 1950, Peplau conceptualized the therapeutic objective of the nurse-patient relationship, identifying a process comprised of three phases: orientation, working and termination. During the orientation phase, the nurse helps the patient to recognize, understand and evaluate his/her problem and situation. Subsequently, the working phase represents most of the time that the nurse spends with the patient, in which the nurse facilitates the exploration of feelings to help the patient cope with the illness and to be able to move on to the last phase, the termination phase, which marks the satisfaction of old needs and the appearance of new needs that must be satisfied (Peplau, 1997; Peplau, 1988).

Nonetheless, the correct development and maintenance of the TR is complex, even more so in mental health hospitalization units and in involuntary contexts (Moreno-Poyato et al., 2016). Thus, in recent years, certain barriers to the establishment of therapeutic relationships have been identified, such as the lack of time among nurses due to administrative tasks and the nurse-patient ratio (Kingston & Greenwood, 2020), the decrease in the average hospital stay, the lack of leadership and support from supervisors (Moreno-Poyato et al., 2016), the regulations and the structure of the units (Adler, 2020). Patients expect high-quality relationships, where they are treated with respect and empathy, so that they develop a sense of trust in the professional. (Staniszewska et al., 2019) and a space for shared decision making is created (Beyene et al., 2019). However, the main perceived barrier is a lack of communication, since, sometimes, they feel they are not listened to due to the inaccessibility of nurses and their limited availability, perceiving that they do not have the opportunity to collaborate in their care (Rio et al., 2020; Staniszewska et al., 2019).

Likewise, in recent years, from the perspective of different theoretical and methodological approaches, there have been attempts to implement certain interventions to improve the TR in mental health nursing (Hartley et al., 2020). Thus, in the context of acute units, group strategies have been used in the form of clinical sessions addressed to the staff to discuss patient cases and improve the understanding of the factors that influence patient behavior (Berry et al., 2016). Also, the creation of spaces for joint activities on the unit, either in individual or group sessions, facilitating meaningful engagement between nurses and patients (Molin et al., 2018) and the use of daily individual interactions with patients combined with staff focus groups (Moreno-Poyato et al., 2018). In any case, although to date no intervention has demonstrated acceptable effectiveness (Hartley et al., 2020), according to the literature, it is necessary to

establish optimal conditions that guarantee protected spaces that promote high quality therapeutic interactions between nurses and patients (Gerace, Oster, O'Kane, Hayman, & Muir-Cochrane, 2018; Gerace & Muir-Cochrane, 2018; Molin, Graneheim, Ringnér, & Lindgren, 2018; Moreno-Poyato et al., 2018). Consequently, it seems evident that interventions based on solid theoretical foundations should be evaluated, with the participation of service users and professionals, as well as considering methodologically consistent designs where information is collected from both nurses and users (Hartley et al., 2019).

In this sense, as a specific nursing intervention to improve the TR, the nurses of two mental health acute units used a Participatory Action Research approach to design, implement and evaluate, both qualitatively and quantitatively, an intervention aimed at enhancing individualized encounters with patients, obtaining acceptable results (Moreno-Poyato et al., 2018; Moreno-Poyato, Delgado-Hito, Leyva-Moral, Casanova-Garrigós, & Montesó-Curto, 2019). In order to design a valid and applicable intervention in all units of the Catalan mental health network, the study design was replicated at the level of 18 acute units and with the participation of 198 nurses. (Moreno-Poyato & Rodríguez-Nogueira, 2020; Roviralta-Vilella, Moreno-Poyato, Rodríguez-Nogueira, Duran-Jordà, & Roldán-Merino, 2019). In the line of a previous study (Moreno-Poyato et al., 2019), the nurses began with self-observation and reflection on their clinical practice regarding the TR, although, on this occasion they reached a consensus at the unit level and later at the whole unit level on an intervention called Reserved Therapeutic Space (RTS) and emerged as part of one of the evidence-based strategies to improve the therapeutic relationship of nurses with their patients. Specifically, the RTS intervention consisted of creating a space following-up on the patient's hospitalization process, focused on the expectations and needs of the person

and carried out via encounters of a specific duration, aimed at working with the patient in a personalized manner. The nurses designed it as a regulated and programmed space, in a comfortable, intimate and uninterrupted environment (Table 1) (Tolosa-Merlos et al., 2019).

[Table 1]

However, considering the recommendation that prior to implementing and evaluating interventions in clinical practice, these should be designed and validated with the people who will subsequently be relevant to the intervention (Hartley et al., 2020), it is necessary to incorporate the patients' perspective, as key actors in the intervention.

With this in mind, this study aimed to explore the perspective of people with experiences in acute mental health units in relation to the nurse intervention model Reserved Therapeutic Space.

In this regard, the three principal aims were: (1) To explore the meaning of the RTS in the context of the nurse-patient TR in acute mental health units from the patients' perspective; (2) To explore the patients' perspective in relation to the content and procedure of the RTS intervention model; and (3) To identify the facilitating and limiting elements for the development of the RTS intervention model from the patients' perspective.

METHODS

Design

A qualitative descriptive study design was used. The use of focus groups was chosen as a commonly used method for exploring views on health issues, programs, and interventions (Tong et al., 2007). Focus groups are not limited to exploring what

participants have to say, rather they provide information about the sources of complex behaviors and motivations, as in the present study (Jayasekara, 2012).

This study was carried out with the collaboration of ActivaMent, an activist collective of people with their own experience in mental health problems, and Obertament, another activist group aimed at fighting against the stigma and discrimination that people suffer as a result of a mental health problem. Both entities are formally recognized by the government of Catalonia and are important agents in improving mental health in the social sector. The study data was collected between December 2019 and June 2020.

Participants

The study participants were people over 18 years old with experience as patients who underwent hospitalization processes in mental health units during the last two years. The only exclusion criterion was people who were hospitalized in the month prior to data collection. In order to recruit participants with first-person experience, the collaborating collectives disseminated the information among the activists linked to their social networks. In this manner, those interested in participating contacted the first author (ARMP) directly by e-mail or telephone, who were then explained the study objectives and the activities to be carried out. By means of convenience and snowball sampling, participants were selected until it was considered that the number of people was sufficient to meet the requirements of the data collection technique (Liamputtong, 2013).

Data collection

Six focus groups were held with four to eight participants. The focus groups were conducted by the first author, a mental health nurse specialist (ARMP), with the collaboration of the second author as an observer (KE). The groups were held at a space

set up at the headquarters of the ActivaMent group, to support greater trust by means of a known environment as well as the necessary intimacy to be able to discuss the subject of study. The focus groups lasted between 1.5 and 2 hours. These sessions were audio recorded to facilitate subsequent transcription. A field diary was used to monitor the research process from both a descriptive and methodological point of view and to help integrate theory and practice (Taylor & Bogdan, 1987). At the beginning of each session, participants were provided with an explanation of the group's purpose, along with informed consent, informing them how the extracted information would be used. In addition, each group was given a working document with a specific script that included the contents to be discussed concerning the intervention.

Ethical considerations

Ethical approval for this study was provided by the Bioethics Committee of the Universitat de Barcelona (IRB00003099). Written and verbal informed consent was obtained from all persons before participation in the study. Also, the authorization for the public release of the data was requested, while strictly preserving the anonymity and confidentiality of the participants. It was noted that the subject of study had the potential to generate strong emotions in the participants by recalling sensitive moments of their experience during their hospitalization. In this regard, the clinical experience of the group leader helped to manage risk during the sessions, providing space for participants for emotional support or offering the possibility to voluntarily leave the session. No such events took place.

Data analysis

For the analysis of the data, the content analysis method was used (Mayring, 2000). The data gathered was transcribed verbatim. Later, the text was fragmented into descriptive codes assigned exclusively according to their semantic content. In a second stage, these

initial codes were grouped into more analytical subcategories, which classified the codes according to the meaning of the linguistic units and their combinations. Thereafter, a third hierarchical stage was reached in which, taking into account the semantic analysis of the previous subcategories, the codes were classified deductively according to the study aims. The first author (ARMP) was responsible for the analysis of the data. The first and second stage followed an iterative process until a more specific understanding of the subcategories was achieved. These steps were mainly carried out by the first author and continuously and critically discussed and reflected upon with the second author (KE). The third and final step was critically discussed and reflected upon with the entire research team. No computer software was used in the data analysis process. After the sixth focus group, the research team decided not to conduct any more focus groups, since no new meanings were found and they considered that data saturation had been achieved (Jayasekara, 2012; Lincoln & Guba, 1985).

Rigor

Reflexivity was continuous throughout the process. The fact that the research team included researchers with an academic background and others involved in clinical practice enabled the establishment of a reflective and equidistant position in the process of both data collection and analysis. The groups were led by the first author, with qualitative doctoral training and with extensive experience as a nurse in acute units, although without a contractual relationship with mental health services, which facilitated the establishment of a peer-to-peer relationship with the participants, creating an atmosphere of trust among the group. Similarly, the credibility and confirmability of the data should be highlighted, given the triangulation of the researchers in the analysis process and the constant auditing of the results by the participants group after group. In relation to the transferability of the results, the fact that the participants were people linked to groups with ample territorial representation and with an activist and critical

approach to the health system, can contribute to the fact that the results can be used in any hospitalization unit throughout the territory.

FINDINGS

This study included 11 people, 3 men and 8 women, aged 28-53 years. The psychiatric diagnoses that participants reported receiving included depressive disorder, schizophrenic disorder, bipolar disorder, or eating disorders. All of the individuals had experienced a minimum of three-weeks hospitalization and almost half of them had experienced an involuntary hospital admission and a mechanical restraint episode during their hospitalization.

Three main topics were the main focus of the study: a) the meaning of a space in order to establish the therapeutic relationship for the person who is hospitalized, b) the procedure to implement the Reserved Therapeutic Space and c) the difficulties to overcome in order to establish the Reserved Therapeutic Space.

Figure 1 shows an overview of the Reserved Therapeutic Space intervention model based on the analysis of the findings.

[Figure 1]

The meaning of a space in order to establish a therapeutic relationship

The RTS was contemplated by the participants as a space to share their expectations and needs with the nurses while hospitalized at the unit and while preparing for their potential discharge. The participants stated that, in their opinion, it was essential to consider that during the process of hospitalization the way in which the therapeutic spaces take place and the attitude of listening and availability of the nurse is more important than the content of the spaces themselves.

"As long as I am listened to and respected... I don't care where and what" FG3P6

"The space doesn't matter if there is a dialogue. It's not so much where so much as how" FG4P6

Thus, the participants expressed that the content of the spaces should be constructed individually, due to the concerns and worries that patients have at each moment of the process.

"She should ask us about our topics of interest and concerns.... What's important to me, not what's important to her" FG4P9

The procedure to implement the *Reserved Therapeutic Space*

The participants verbalized that the intervention should be carried out through individual encounters between the nurse and the patient in a comfortable and intimate space, where there are no interruptions, and which is also chosen by the person who is hospitalized.

"I prefer to meet in the room alone with the nurse... as it is a more intimate place" FG6P5

"Maybe the person should be asked where he or she would like it to take place" FG4P10

In addition, the participants expressed that there could not be a minimum or maximum number of encounters, however, it would be appropriate to have a minimum of one of these encounters each week, which could vary according to the patient's needs.

"Meeting once a week is enough... then, if I need something, I will go to her" FG2P5

The participants identified three stages in this procedure: a first stage or orientation encounter, a second stage with follow-up encounter and a third stage in which a closing session is held.

The participants indicated that the first encounter or orientation meeting should take place within the first 24 to 72 hours of hospitalization and that it should be at the request of the nurse who referred them to the unit. In this first encounter, the participants emphasized that the purpose should be to establish contact and to generate a bond of trust.

"I would have liked to receive a welcome from the first moment and an introduction by the nurse ... an open door for me to ask questions and talk to her" FG1P4

"The nurse has to generate trust and, to do so, she has to convey confidence, be affectionate, give patients the option to express themselves and talk about their concerns" FG3P6

In order to generate the bond and to truly explore what their experience of hospitalization was at that time, participants stated that as a starting point, nurses could use open-ended questions designed to truly know what their needs and expectations were.

"Ask me how I want to be treated and what I need" FG3P6

"Each person will need different things... a key manner to start is to ask: can I help you with something?" FG4P9

In relation to possible topics to be dealt with in that first encounter, aspects such as the regulations of the unit (permits, visits, objects...), the violation of rights, the experience of involuntary admission or even the feelings of guilt in relation to what is happening to the person may be relevant topics.

"Talking to the nurse and letting her know more about why I am here, what I need, and my concerns will be better for both of us... it is important to talk about the reasons for admission, why it is involuntary, medication changes…" FG2P5

"To talk about taking care of my needs, of where I am hospitalized and the fact that I don't want to be hospitalized, how I feel" FG4P9

Therefore, for people with experience in hospitalization, in this first encounter they should detect what the patient's main concerns are and establish as much as possible an agreement for the subsequent individualized encounters or work meetings and what their topics of interest may be.

For the subsequent follow-up encounters, the participants indicated that the nurse should demonstrate availability, so that each day the nurse should greet and invite the patient to meet up during the course of their workday. Similarly, at the end of each shift, the nurse should say goodbye and invite the patient to meet at the next day's work.

> *"The nurse has to keep reminding us and leave the door open to meet with her" FG2P5*
>
> *"The nurse must be available and willing so that the patient can tell her that he or she needs to talk to her" FG4P.*

Regarding the content of the encounters in this follow-up stage, the participants stated that a possible way to start these encounters could be to reinforce the aspects to be improved detected by the nurse in relation to the patient's health status, thus facilitating spontaneous discussion of the subsequent topics that may arise directed at the patient's concerns.

> *"If there are more talks later on, may these be because they see that I am improving... because they see a change. One way to come and talk to me by saying: you seem better, do you feel like talking?" FG2P5*

The key issues identified by the participants were: the side effects of medication, length of stay, extra medication or incidents on the unit. To conclude the encounters, it was stressed that it was important to show availability.

> *"…What worried me the most was finding out how long I was going to be at the hospital" FG2P5*

"Talking about the side effects of medication, dealing with how side effects can affect the patient's personal life" FG3P7

"We have to talk about incidents during the admission... why there were incidents" FG3P6

Finally, the participants expressed the need to have a farewell or closing meeting before discharge. In this last encounter they considered it important for the nurse to positively reinforce the patient's evolution throughout the hospitalization process in order to empower, and also to help situate the person at the time of discharge from the unit. During this encounter, they indicated that it might be particularly important to provide information on resources and continuity of care outside the acute care unit, to resolve doubts and concerns about future plans and to recommend strategies for the prevention of relapses.

"It has to prepare us for discharge and teach us that life goes on after the mental disorder we have" FG5P9

"It's important to discuss how to reconcile the disorder with daily life and talk about the evolution once out of the hospital... also tools on how to avoid readmissions" FG3P7

The difficulties to overcome to establish the Reserved Therapeutic Space

Participants identified difficulties that needed to be overcome so that a RTS could be implemented among nurses and patients in mental health units. Within this theme, participants pointed out the violation of rights and experiences of coercion, along with the relational competency of the nurses and the use of the spaces within the unit.

The first aspect they highlighted was that, especially in cases of involuntary hospitalization, nurses should recognize the feeling of the violation of people's rights. It is difficult for hospitalized persons to establish a therapeutic relationship with

professionals who actively participate in interventions of a coercive nature such as mechanical restraint, pharmacological restraint or isolation.

"We assume that involuntary admission is a violation of rights ... it is difficult to maintain a therapeutic relationship …" FG1P2.

"From the moment a person's job is to chemically contain another person without generating a debate as to whether this is ethical or not ... there is already one thing that is easily broken ... the relationship will make a difference" FG1P1

This is because, according to the participants' perceptions, this type of intervention is experienced as a punishment by the people who suffer it.

"I have always seen hospitalization as a punishment... it's like a prison" FG1P2

"I self-harmed, so they didn't let me out as a punishment... I kept on self-harming, they didn't help me" FG1P3

That is why, according to their experience, the awareness and recognition of this situation of violation of rights by the nurses equals an improvement in the construction of the therapeutic relationship.

"A key measure of the therapeutic relationship is the absence of chemical and mechanical containment" FG1P1

"Nurses needs to be aware that mechanical and pharmacological restraint violates rights." FG1P2

"When there is awareness that involuntary hospitalization violates rights, the restraints decrease" FG1P1

Another category identified was the relational competency of the nurses. The participants perceived that, both the attitudes of some nurses in relation to the lack of interest and empathic attitude towards the hospitalized person, and the solely biological approach to the problem could hinder the generation of the Reserved Therapeutic Space.

"The multifactorial processes of a mental illness are not addressed, only the biological aspects." FG1P1

"There has to be a sincere and genuine concern and trust must be instilled... There has to be a relationship with continuous feedback in which the nurse has to expose herself so that the patients also expose themselves and explain their life" FG1P1

Likewise, participants expressed that the use of certain spaces for relating with patients such as the nurse station or the fact that the nurses remained in the nurse station for a large part of the day or that the encounter took place while the nurse was carrying out other activities, represented a barrier for hospitalized people and generated a feeling of distance between the nurses and themselves.

"... while preparing the medication... I explained everything I was feeling... and I would go to sleep more peacefully... but actually, he wasn't there for me, he was doing his job and didn't have time for me nor was it the right space" FG1P3

"You can't stay all day long at the "sentry box" and then come and ask me if I want to talk" FG6P11

[Figure 1]

DISCUSSION

The main purpose of this study was to explore the patients' perspective on the Reserved Therapeutic Space intervention model that had been previously designed by nurses to improve the nurse-patient therapeutic relationship in mental health inpatient units. Our findings show that patients considered the RTS intervention model as a space where they could share their expectations and needs with the nurses during hospitalization at the unit and while preparing for their potential discharge. The participants confirmed the importance and usefulness of the intervention for the improvement of the therapeutic relationship between nurses and patients in hospitalization units. Similarly, in terms of

structure and content, the results confirm that the structure and spaces for carrying out the intervention are similar to those proposed by the nurses. However, the content was clarified, together with the manner in which the encounters proposed by the nurses should take place. Likewise, facilitating elements and possible barriers were identified to enable a more effective intervention.

It should be noted that, in terms of the meaning given to the RTS by the patients, this coincided with the nurses' previous approach and with the current model of person-centered care (Håkansson Eklund et al., 2019), since the results highlighted that it should be a space to share the experiences of the hospitalization process, rather than directed at functionality aspects in relation to the mental health problem (McAllister et al., 2019; Staniszewska et al., 2019). In this sense, sharing experiences is highly relevant as it enables us to measure the bond between professionals and patients, an aspect based on trust and which allows us to take risks and develop a more profound relationship (Czypionka et al., 2020). These findings are in line with other studies that have explored patients' perspectives and the design of therapeutic spaces (McAllister, Robert, Tsianakas, & McCrae, 2019; Molin et al., 2019; Molin, Lindgren, Graneheim, & Ringnér, 2018; Moreno-Poyato, Delgado-Hito, Leyva-Moral, Casanova-Garrigós, & Montesó-Curto, 2019; Wyder, Bland, Blythe, Matarasso, & Crompton, 2015).

Our findings reveal that for the patients the content to be elaborated in each interaction was not as important as the manner in which the encounter took place (Harris & Panozzo, 2019; McAllister et al., 2019; Moreno-Poyato et al., 2016). Thus, a genuine attitude of listening and empathy, together with the availability of the nurse, are factors that enable the emergence of the issues that truly concern hospitalized people (Gerace et al., 2018; McAllister et al., 2019). As for the intervention procedure, the results show that for patients there should not be a certain fixed number of encounters, rather, the

process should be individualized for each case (Moreno-Poyato et al., 2019; Van Sant & Patterson, 2013). In this sense, the patients, along the line of the nurses in previous studies, observed that the spaces for interactions should be comfortable and ensure privacy (Staniszewska et al., 2019). However, patients also identified certain barriers to building such spaces, such as the lengthy periods of time nurses spend doing administrative work (McKeown et al., 2020; Reavey et al., 2019). Consequently, the characteristics that participants highlighted as important are in line with the characteristics that previous studies assign to person-centered care (Byrne et al., 2020; Moreno-Poyato & Rodríguez-Nogueira, 2020). For the patients, as for the nurses, the encounters within the RTS could be divided into three stages depending on the moment of hospitalization: a first stage of contact and orientation, a second stage with follow-up encounters and, finally, a closing stage prior to discharge, coinciding with the theoretical postulates on the TR process (Peplau, 1997; Peplau, 1988). Likewise, the findings highlight that the patients request nurses to provide empowerment, availability and positive reinforcement throughout all three stages of the process. Specifically, the patients noted that the first stage should be focused on their needs, the second stage should enable the capacity to decide on the content and timing of the encounter, and, finally, the closing stage should be aimed at greater autonomy for discharge. Again, these results confirm the need for person-centered care (Håkansson Eklund et al., 2019), directly related to the autonomy paradigm and the recovery model, where a greater participation of the service users is proposed, a vision of the person beyond his/her illness and facilitating the selection of treatment (Newman, O'Reilly, Lee, & Kennedy, 2015; Smith & Williams, 2016).

Finally, these findings have enabled us to identify certain facilitating elements for enabling this space. According to the patients, the starting point for building the

relationship was the nurses' understanding of the situation of violation of rights that the hospitalized people often perceived (Akther et al., 2019; Cutler et al., 2020; Norvoll & Pedersen, 2018). In this sense, the nurses' self-awareness in the context of the TR was considered fundamental (Fitzpatrick, 2014; Peplau, 1988; Zugai et al., 2015). Another highlighted aspect was the nurse's interest and empathic attitude towards the relationship and knowledge of the patients' lived experience (Gerace et al., 2018; Håkansson Eklund et al., 2019; Moreno-Poyato & Rodríguez-Nogueira, 2020), an approach that is obviously far removed from biological care and focused on the clinical needs from the patients' perspective.

Limitations

This study has several limitations which must be considered. The first is the convenience sampling and snowball sampling method employed, as those who participated were motivated by the topic. However, it should be noted that all participants belonged to activist entities that are often critical of the health system and seek to improve it. In addition, the data collection and analysis supported the data saturation. The findings were confirmed in all the focus groups. Another limitation worth considering is the time lag between the participants' hospitalization experience and the performance of the focus group, as this may have affected their memory in relation to past events. However, the data collection was focused on the overall meaning of the patients' experiences rather than on the specific details that may have occurred.

CONCLUSION

The RTS intervention model is perceived by people affected by a mental health problem who have experienced hospitalization as a space to share expectations and needs with nurses. These findings confirm that it is a valid and useful intervention model for the

improvement of the nurse-patient TR in mental health units. From the patients' perspective, the RTS should respect the person-centered care approach and be structured in three stages: orientation, follow-up and a pre-discharge closing stage. The content of these encounters should be proposed by the patients themselves based on their needs and concerns. The barriers for carrying out these encounters are the lack of relational competence, coercive acts and violation of rights and the lack of accessibility of the nursing station, whereas the facilitating elements are the availability of nurses along with active listening and empathy.

Relevance for clinical practice.

An intervention model has been designed to share the expectations and needs of people hospitalized in mental health units based on the knowledge of nurses and the experiences of patients. The opinions of those who have had first-hand experience of hospitalization are of paramount importance in providing person-centered care. The resulting model includes realities of the two groups that must relate with each other, providing key insights to nurses for initiating a space with patients and to improve their therapeutic relationship, with the intention of increasing the quality of care. This model of intervention could be considered by managers to test its effectiveness in acute mental health units.

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Table 1. Reserved Therapeutic Space: nurses' version

Description	Follow-up of the hospitalization process focused on the expectations and needs of the user, in a personalized manner, carrying out individualized encounters.		
Aims	*1. Working on the therapeutic bond of trust.* *2. Joint agreement on shared objectives and interventions*		
Characteristics of the space	Comfortable, intimate and uninterrupted space. *a) Room* *b) Nurse station* *c) Office* *d) Communal room*		
Number of encounters	Number of encounters in this reserved space of intimacy that should be carried out ordinarily, regardless of the daily circumstances that require nursing care *a) 1 per week* *b) 2 per week* *c) 3 per week*		
Timeline of the encounters	First programmed encounter: *a) 48 hours after admission* *b) 72 hours after admission*	Second and subsequent programmed encounters: *a) Every 4 or 5 days* *b) Every week*	Last programmed encounter: *a) Pre discharge*
Content of the encounters	**<u>First encounter</u>** *a) First contact/getting to know each other* *b) Adaptation to the unit/involvement* *c) Detection of needs and general problems* *d) Reasons and objectives for admission* *e) Expectations and concerns regarding hospitalization*	**<u>Second and subsequent encounters</u>** *a) Open theme / Reinforcement of previous topics* *b) Reasons for admission* *c) Awareness/adherence to treatment* *d) Improvement/evolution* *e) Facilitate resources, well-being in the room* *f) Adaptation, experience of hospitalization* *g) Incidents during hospitalization and critical care* *h) Questions*	**<u>Last encounter</u>** *a) Discharge/Continuity Programming* *b) Satisfaction and proposals for improvement* *c) Confronting / reinforcing / feedback* *d) Awareness of the disorder and treatment* *e) Future plans, expectations, family.*

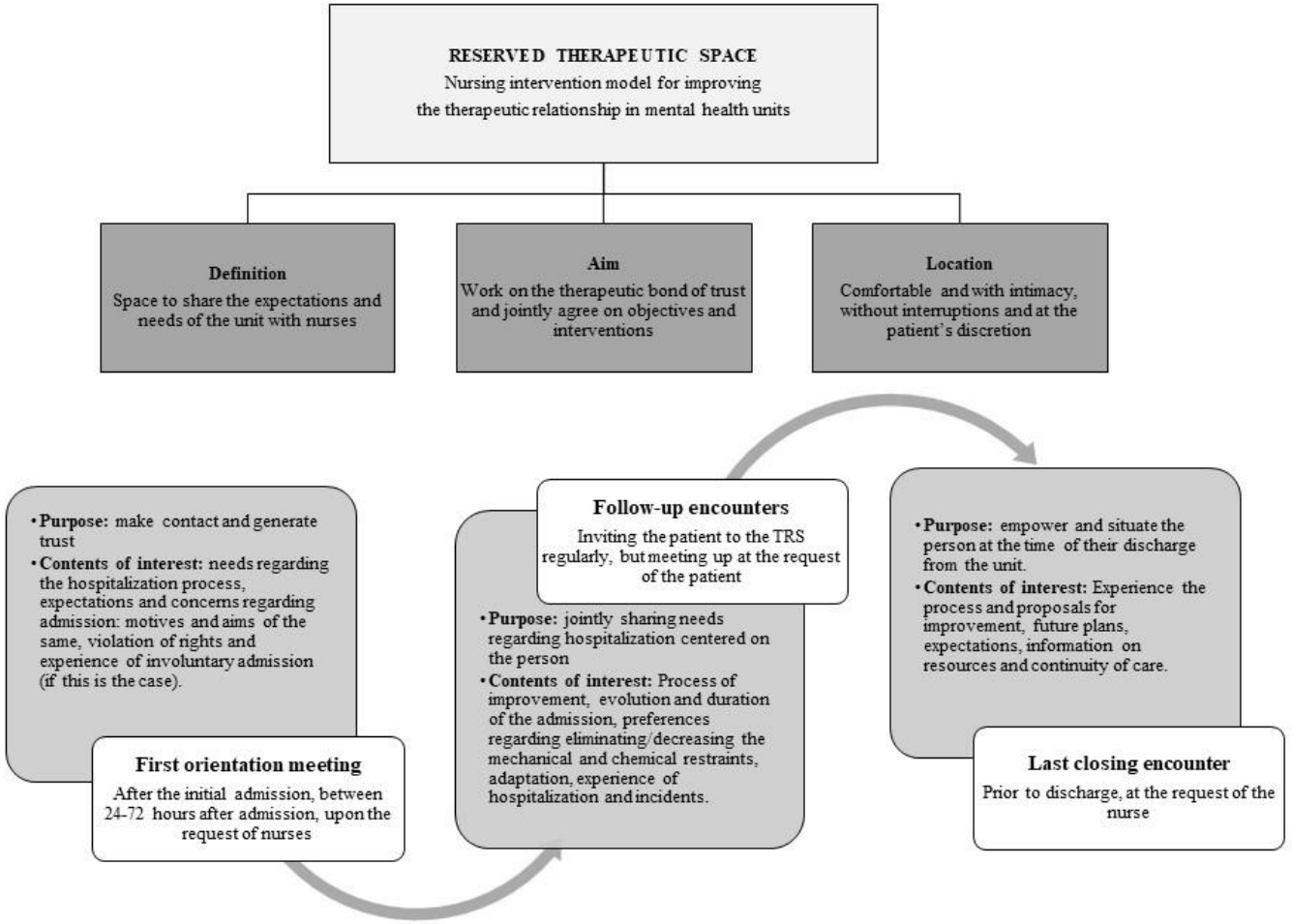

Figure 1. Reserved Therapeutic Space: patients' version