Title: Implementing Evidence-Based Practices in the Therapeutic Relationship in Inpatient Psychiatric Care: a Participatory Action Research

Abstract:

Aims and objectives: To produce changes in the therapeutic relationship between clinical practice nurses and patients in psychiatric units by implementing evidence-based practices through participatory action research.

Background: The therapeutic relationship is the cornerstone of nursing care in psychiatric units. The literature suggests that theoretical knowledge alone is insufficient to establish the therapeutic relationship in practice. Therefore, strategies are needed to adequately establish the therapeutic relationship in psychiatric units.

Design: Participatory action research.

Methods: Participants consisted of nurses from 2 psychiatric units of a university hospital. Data were collected through focus groups and reflective diaries, which were analysed using the content analysis method. The COREQ guidelines were followed to ensure rigour.

Results: Nurses conceptualised the therapeutic relationship in their practice, identifying facilitating elements and limitations. They were able to compare their clinical practice with the recommendations of scientific evidence and constructed 3 evidence-based proposals to improve the therapeutic relationship: i) a customised nurse intervention space, ii) knowledge updating, and iii) reflective groups, which they subsequently implemented and evaluated.

Conclusions: This study shows that nurses in psychiatric units can generate changes and improvements in the therapeutic relationship. The process of implementing evidence-based practice enhanced participants' awareness of their clinical practice and allowed them to make changes and improvements.

Relevance to clinical practice: The process confirmed that the implementation of evidence-based practice through participatory methods, such as participatory action research, is valid and produces lasting changes. This study also reveals the need to rethink nurses' functions and competencies in current psychiatric units.

Key words:

Evidence-based practice; psychiatric nursing; nurse-patient relationship; action research; qualitative study

1 INTRODUCTION

The therapeutic relationship (TR) is one of the most important tools for nurses in their clinical practice in general and for mental health nurses in particular. A rational framework for mental health nursing was mainly developed by Peplau, who conceptualised the therapeutic purpose of the relationship between nurse and patient (O'Brien, 2001). Effective establishment of the TR increases the effectiveness of any nurse intervention in clinical practice in psychiatric units (McAndrew, Chambers, Nolan, Thomas, & Watts, 2014).

1.1 Background

The TR is composed of a series of attributes that nurses must possess and integrate into their clinical practice. These essential elements are: a) understanding, b) interest and availability, c) individuality, d) authenticity, e) respect and f) self-knowledge (Moreno-Poyato et al., 2016). However, despite theoretical and empirical knowledge of the TR among nurses, the reality of practice is that the biomedical model is a strong influence in mental health nursing and is often imposed (Duxbury, Wright, Bradley, & Barnes, 2010). Work focused on tasks, as well as the time taken for their performance in mental health care, hinders individualisation and, therefore, the efficacy and quality of the TR (Hopkins, Loeb, & Fick, 2009).

In recent years, evidence-based practice (EBP) has become the axis for improving clinical practice, quality of care and excellence. However, over the past few years, there

have been some difficulties in integrating this empirical knowledge into the complex clinical reality of health services (Stevens, 2013). As with the TR, limitations have been identified for its use at both the individual and organisational levels. For nurses, the main difficulties are a lack of time and knowledge and the high workload, while the main organisational factors are a lack of human, material, support and leadership resources (Warren et al., 2016).

One of the possible strategies for implementing EBP in health services is participatory action research (PAR) (Abad-Corpa et al., 2012). Its use has had positive effects on the implementation of EBP, since it has had effects on nurses' knowledge, professional performance, structural context and patient outcomes (Munten, van den Bogaard, Cox, Garretsen, & Bongers, 2010).

PAR is a dynamic process, carried out on the basis of the unique needs, specific challenges and learning experiences of a particular group (Kidd & Kral, 2005). Therefore, the aim of PAR is to modify specific problems in communities. PAR is based on the view that participants' actions need to be filtered through experience and reflection before they can improve or change their practice. Knowledge generation in PAR is a collaborative process, in which the skills and experiences of each participant are essential to the project's results (Delgado-Hito, 2012). As shown in Figure 1, PAR is carried out through a sequence of steps involving a spiral of self-reflective cycles (Kemmis & Mctaggart, 2008): planning the desired change, action and observation of the process and consequences of change, reflection on these processes and their consequences, re-planning change, action and re-observation and reflection again. Throughout this process, participants act and reflect, simultaneously becoming aware of their practice and transforming it (Baum, MacDougall, & Smith, 2006).

Scientific evidence confirms that theoretical knowledge of the TR alone is insufficient to carry it out effectively and, as a result, it is difficult to provide high-quality care (Cleary, Hunt, Horsfall, & Deacon, 2012). Therefore, there is a need to propose EBP-based strategies that promote change and its adequate implementation. Exploring nurses' perceptions of the factors that hamper their clinical practice could help in the design of appropriate strategies for evidence-based change (Registered Nurses Association of Ontario, 2002).

The main purpose of this study was to generate changes in nurses' clinical practice through the implementation of EBP with respect to TR through PAR. The specific objectives of the study were: i) to describe the meaning assigned by nurses to establishing the TR with patients, ii) to identify the factors facilitating and limiting the establishment of the TR, iii) to identify strategies to improve the establishment of the TR by contrasting the evidence with real-world clinical practice, and iv) to qualitatively assess the effects of implementing the evidence.

2 METHODS

2.1 Design

A qualitative methodology was proposed and the PAR method was selected, within the framework of the constructivist paradigm and following the model of Kemmis and McTaggart (2008). The COREQ guidelines were followed to ensure rigour (Tong, Sainsbury, & Craig, 2007) (See Supplementary File).

2.2 Study Setting

The study was carried out in the 2 psychiatric units of a tertiary care hospital in Spain. These units cover an urban population of approximately 380,000 inhabitants and consist

of 39 beds for patients with acute decompensation of psychiatric pathology, mainly psychotic and affective disorders. There are 3 nurses in the morning shift, 2 nurses in the afternoon shift and 1 in the night shift.

2.3 Study Period

Data were collected from October 2014 to December 2015.

2.4 Study Participants

Study participants consisted of nurses working in the psychiatric units. The permanent and temporary workforce of these units consisted of 40 nurses. Participants were recruited through the director of nursing, those responsible for acute care units and through personalised written information and institutional e-mail to all nursing professionals about the project and its objectives. For the sample selection, the types of nurses' profiles in the units were identified and maximum variation sampling was carried out to ensure a variety representation of gender, age, work shift, years of experience and specialised training (Patton, 2002). The final sample was composed of 13 nurses.

2.5 Techniques, Procedure and Data Analysis

To generate a model of change in clinical practice and to implement EBP through PAR, 4 focus groups were held, lasting from 1.5 to 2 hours. In addition, 19 reflective diaries were collected throughout the process. To monitor the research process both descriptively and methodologically and to help integrate theory and practice (Taylor & Bogdan, 1987), we also used the investigators' field diaries as an indispensable tool in qualitative research. The study procedure was conducted in 2 phases, adapting the cycles' model of Kemmis and McTaggart (2008). The first phase consisted of an initial

stage (stage 0) in which we analysed the situation and the study context. In the next 4 stages, the participants designed guidelines to self-observe their practice, and then conducted and registered their self-observations. Next, they described the contrast between their observed practice and the scientific evidence. In the second phase, the nurses proposed strategies in relation to the evidence, and then implemented and evaluated them. Finally, they narrated aspects related to the PAR process. The process is described in Figure 2.

The content analysis method was used in this study (Mayring, 2000). All the data obtained were transcribed literally. Then, once the authenticity of the transcripts had been verified by the participants, we proceeded to fragment the text into descriptive codes assigned purely on the basis of 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. Thus, a third hierarchical stage was reached, in which, taking into account the semantic analysis of the previous subcategories, the codes were categorised deductively according to the study objective. The rigour of the results obtained was verified by triangulation of the researchers. The analysis process was assisted by QRS software NVivo version 10.

Other rigour-related factors guided the performance of the study. First, the participants were genuinely interested in the TR, leading to engaged participation and viable changes. Second, the detailed descriptions were considered in depth in the phases and stages of the study, allowing us to focus on the research process rather than on its results (Kidd & Kral, 2005). Third, both the principal researcher and the participants maintained reflexivity throughout the process. Participating nurses reflected on the self-observation of their clinical practice and noted their observations in their field notes, allowing us to obtain an Audit Trail of their reflective process. Moreover, at each stage

of the process, before each focus group took place, the principal investigator sent a document to the participants with the preliminary results of the information they had provided from their field notes in the prior stage. Thus, at the beginning of each group, the information obtained from each individual was validated and complemented by group discussion. Given his professional experience in contexts similar to that of the study, the principal investigator initially had some difficulty in holding himself back and not providing information, which would have worked against the aim of the study as a freely evolving process, hampering the growth of awareness among nurses and their empowerment during the process. Once the principal investigator had accepted his role as group facilitator and provocateur, a relationship of equals was established, with an atmosphere of trust among the group. This in turn encouraged participation and the generation of ideas by the nurses.

2.6 Ethical Aspects

The project was approved by the Ethics and Clinical Research Committee of our institution. Participation was voluntary and participants signed a consent form accepting the study conditions; at all times, they could withdraw from the study.

3 RESULTS

The study was initiated by 13 nurses but during the data collection process 4 nurses withdrew and therefore the final sample was composed of 9 nurses, who maintained representative criteria. The characteristics of the participants who completed the study are shown in Table 1.

Figure 3 shows how the process was conducted and the results were generated, and how the nurses generated knowledge, compared it with the evidence, proposed and implemented EBP, and then evaluated it.

3.1 Phase I

Stage 1: Plan

Through a focus group, the nurses decided how, when and where they would carry out the reflective self-observation of their clinical practice regarding the establishment of the TR with their patients.

Stages 2 and 3: Action and observation

In these stages, the nurses carried out the interactions in clinical practice, self-observed and noted their observations in their reflective diaries. Once the nurses had handed in their diaries, they were given a paper with scientific evidence on the establishment of the TR (Registered Nurses Association of Ontario, 2002). The nurses reviewed the guide and drafted reflections on its recommendations and on their observations of their own clinical practice.

Stage 4: Collective Reflection

Once the nurses had detected the limitations of the study objective in clinical practice, having contrasted it with the scientific evidence provided, it was time to collectively reflect on the results obtained. To do this, the second focus group was held.

The results of this stage were that nurses conceptualised the TR from their perspective. Thus, they identified the importance of establishing a bond with the patient and of setting objectives agreed with the patient, not only the nurses' goals. They also stressed the importance of the therapeutic environment. Among the barriers identified to

establishing the TR were the priority given to routine tasks in their practice and, only after these were completed, to the relationship. Other factors limiting the TR were a lack of time and professional motivation, workload, routines, and nurses' preconceptions about the patients.

3.2 Phase II

Stage 1. Re-planning

In this stage, the nurses planned 3 evidence-based improvement strategies for clinical practice through the third focus group:

1. *Customised nurse intervention space*: a strategy aimed at improving the TR through patient care interventions in a scheduled and systematised manner.
2. *Knowledge updating*: a strategy aiming to improve the TR through the training of professionals by regularly reading, describing and reflecting on scientific articles, in addition to the evidence already provided in the study process. To do this, the nurses decided that the principal investigator should select 4 articles of interest and send them by e-mail. To control variability in these articles, the principal investigator selected and sent 2 review articles and 2 original articles from indexed journals. After reading the abstracts of each article, the nurses voted on which 2 articles would be most useful for their practice. The participants agreed to read, describe and reflect on the 2 selected articles and make notes in their diaries.
3. *Reflective groups*: a strategy aimed at improving the TR by developing the nurses' self-knowledge and self-awareness through a space where they could verbalise the concerns affecting their clinical practice.

Stages 2 and 3: Action and observation

In these stages, the nurses individually implemented and evaluated the strategies they had designed to improve their clinical practice.

From the evaluation of the *Customised nurse intervention space*, the nurses emphasised the improvement in the effectiveness of the TR with their patients and the continuity of care. In addition, the strategy enhanced trust and bonding with patients. The strategy required nurses to carry out more individualised care planning, improving the achievement of goals and enhancing patient empowerment.

> *Developing this activity has improved (...) everything in general. The patients wait for the space to make their demands, resolve doubts (...) there hasn't been a continual drip of small conversations, demands, questions, doubts, (...) This way of working is infinitely more productive (...) (Achilles)*

Evaluation of the strategy of *Knowledge updating* revealed that the nurses emphasised that self-training had increased their knowledge and skills, which had facilitated the evaluation, reflection and application of these elements in clinical practice. Self-training was a stimulus for nurses to confirm and reinforce the quality of the care provided.

> *The scientific method contributes "mastery and reflection". (...) It implies a re-evaluation, self-correction and personal and group effort to improve. (...) It increases knowledge and skills. (...) It gives me strategies to try to develop human potential to the maximum (open mind) and the professional (which are closely connected). (Idalia)*

Evaluation of the *Reflective groups* showed that the nurses emphasised that the groups should be neutral and protect spaces where they could discuss emotionally draining activities and the coexistence between professional and other circumstances of clinical practice; the space allowed them to express their feelings and increased motivation among participants.

> *It would be beneficial if these groups were held together with the unit supervisor. That would allow a consensus among everyone, possible solutions or conclusions to day-to-day problems, and would also be a place where people could express their feelings (...) Criticism should always be constructive, with aspects to be solved or improved, and not destructive, well, otherwise, it wouldn´t solve anything, help to improve the dynamics or the atmosphere of the room and the workers. (...). (Jason)*

Stage 4: Final reflection and conclusions

This stage was the culmination of the process, and included the group's final collective reflection. In it, the nurses indicated that the process had empowered them to change their practice and produced changes at 5 levels:

1. *Improvements in the establishment of the TR*: participants believed that the change in practice had enhanced the effectiveness of interventions with patients. In fact, the nurses became aware of the theory in practice and the need to plan and structure their interventions more specifically.

> *Unlike a year ago, I now realise that I am going to do this. Until now, perhaps I was doing it, but I was not aware of a pattern or a beginning, a development and a termination of this therapeutic relationship, and now that´s how it is (...). (Nymph)*

2. *Improvements for the patient*: the change in practice enhanced patient empowerment, involving them in the treatment goals and in the tasks to be carried out.

Unlike before, maybe in the objectives I included the patient's goals, which (...) yes they are there, I know they were there, but they were not my priority. And then, now it's a way of working not with "my" priorities, but (...) (Valentina)

3. *Improvement for the team*: the process motivated the rest of the team members to introduce improvements agreed on by the PAR group and also allowed improvement and unification of the objectives for the whole team.

(...) there´s a ripple effect, because even if that partner is not with you, because of the shift or whatever, when it´s known that an intervention is being carried out, as a general rule, the change produced spreads to your colleagues who continue with the intervention (...) (Idalia)

4. *Improvements for the nurses themselves*: the process increased nurses' security in their clinical practice. In fact, the process of change allowed the nurses to become more aware of clinical practice and thus be able to change and improve it.

(...) it helped me to be a little more organised, a little more structured, because you often do things on the fly, when you can, how you can and where you can. (...) (Remus)

5. *Improvement for the profession and organisation*: needs and opportunities for change in psychiatric units were detected, such as finding therapeutic spaces, the need to regulate and provide training in the TR and to restructure the functions of mental health nurses.

(...)Someone should incorporate it into our workloads and developing the therapeutic relationship should the main task of nursing rather than automatically going for the pills and putting them into a glass (...) (Achilles)

4 DISCUSSION

Participants in this study were able to improve their daily care activity by implementing EBP through the PAR process. The nurses conceptualised the TR in their practice in a very similar way to that described in the literature (Hawandeh & Fakhry, 2014; Stenhouse, 2011). They reported that the TR was fundamental to their clinical practice, but that daily activity regarding the TR was not included in the protocols and clinical pathways, and consequently it was not always a priority in their daily work (Pazargadi, Fereidooni Moghadam, Fallahi Khoshknab, Alijani Renani, & Molazem, 2015). This finding is in agreement with that of Cutcliffe, Santos, Kozel, Taylor, and Lees (2015), who noted that there was increasing evidence that the importance and value of the TR was not recognised in clinical practice.

Likewise, the nurses identified barriers to establishing the TR. Some of them were related to the organisation and lack of time, since they reported that the excessive time devoted to completing registries and the high pressure of care prevented them from devoting sufficient time to establishing an appropriate TR (Hawamdeh & Fakhry, 2014; Pazargadi et al., 2015). Another barrier was lack of motivation and job dissatisfaction among some nurses, who were dissatisfied with their role in the team (Roche, Duffield, & White, 2011) and sometimes reported a lack of support from supervisors (Bowers, Nijman, Simpson, & Jones, 2011).

The participants' proposals regarding the design and implementation of EBP were related to the limitations detected. The nurses created a space where they could attend to their patients in their day-to-day practice in a scheduled and systematised way. This space was free from interference, where patients could feel welcome, listened to and, above all, understood (Borille, Paes, & Beusamarello, 2013; Wyder, Bland, Blythe, Matarasso, & Crompton, 2015), unlike what usually happens in routine practice in

psychiatric units (Stewart et al., 2015). Importantly, these types of spaces have already been introduced in other countries such as the United Kingdom (Mental Health Act Commission, 2008). Although evidence has not yet been obtained of their success, there are indications that they increase patient satisfaction in terms of coverage of their needs (Sweeney et al., 2014).

Following EBP, reflective groups were conducted. The nurses had detected that they needed to pool their experiences and be able to make constructive criticisms. No doubt, this commitment to fostering reflexive practice is inherent in the research method used (Dawber, 2013; Kemmis & Mctaggart, 2008; Oelofsen, 2012). When nurses proposed the purpose of these groups, it was evident that they needed these spaces to gain confidence and security and feel protected and understood by the rest of the team (Bowers et al., 2011; Dawber, 2013).

The last strategy implemented was updating of knowledge. After reading the evidence, the participants detected that, to improve their practice, they needed to have more training and to be able to transfer that knowledge to their day-to-day work (Oelke, da Silva Lima, & Acosta, 2015). This proposal again confirmed the high level of the nurses' involvement in the project, demonstrating a strong capacity for self-awareness and self-knowledge (Munten et al., 2010; Oelofsen, 2012).

When reporting the effects of the EBP implementation process, the participants emphasised that the change in practice gave them greater self-confidence and also allowed them to reflect, present ideas and gain knowledge (Dawber, 2013; Munten et al. 2010; Oelofsen, 2012). The process of change therefore allowed them to become aware of their clinical practice and thus generate improvements. Professional satisfaction and motivation increased because the nurses felt they participated in improving the

organisation (Abad-Corpa et al., 2012; Dawber, 2013; Munten et al., 2010; Oelofsen, 2012).

In their evaluation, the nurses reported that patients' trust and confidence in them had increased. This is an important desire and expectation among patients in the framework of the TR because it increases patient empowerment (Borille et al., 2013; Duxbury et al., 2010; Hopkins et al., 2009; Schroeder, 2013; Wyder et al., 2015). As well as observing improvements in the nursing team, participants also noted that the changes increased motivation in other colleagues (Dawber, 2013; Kemmis & Mctaggart, 2008; Oelofsen, 2012). In addition, the effects of the implementation of evidence enhanced and unified the objectives of the whole team (Abad-Corpa et al., 2012; Dawber, 2013).

Similar to other studies with the same design, one of the most important findings of this study was that the implementation of EBP through PAR identified the need to propose organisational and professionals changes (Munten et al., 2010). The results showed the need to restructure activities to facilitate the establishment of the TR, since its operationalisation is currently affected by organisational policies and the prevailing biomedical model (McAndrew et al., 2014; McCrae, 2014).

Limitations

First, the results of this study cannot be generalised. However, they can be extrapolated to settings and participants with similar characteristics to our own.

Second, the study was carried out in a relatively short time period. The initial evaluation suggests that improvements have been integrated into clinical practice. New evaluations are needed in the mid- and long-term.

5 CONCLUSIONS

Nurses in psychiatric units can improve how they establish the TR with their patients. The nurses were able to conceptualise the TR in their practice, discovering facilitating and limiting elements. They were also been able to contrast their usual clinical practice with the recommendations provided by the scientific evidence. In view of 3 evidence-based recommendations on the TR (Registered Nurses Association of Ontario, 2002), such as acquiring knowledge, following reflective practice and understanding how the TR works, the nurses formulated 3 critically constructed proposals to improve and implement practices for the establishment of a quality TR in their day-to-day care.

6 RELEVANCE TO CLINICAL PRACTICE

The results of this study show the importance of self-awareness and self-knowledge among nurses in order for them to improve their care. Once they were consciously aware of their practice, they were able to critique and propose improvements supported by scientific evidence. The effects of this reflective group process of the implementation of evidence enhanced and unified the objectives of the whole team. In addition, by discussing and building on their practice in the safety of the group, they gained confidence and security, especially regarding their care competencies. However, the need to rethink nurses' functions and competencies in current psychiatric units is also evident and recommended. This is confirmed by the gap between nurses' routine activities and those that they consider appropriate for the TR and for nursing care in psychiatric units.

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IMPACT STATEMENT:

What does this paper contribute to the wider global clinical community?

- Participatory action research helps nurses to become more aware of their clinical practice, the first step to change.
- The process identified the need for organisational and professional changes in clinical practice.
- The effects of the implementation of evidence through PAR improved and unified the objectives for the whole team.

Table 1

Overview of participants' sociodemographic and professional characteristics

Characteristics (n=9)	**n (%)**
Gender	
Male	4 (44.5)
Female	5 (55.5)
Age (years)	
28-38	6 (66.7)
39-49	2 (22.2)
>50	1 (11.1)
Mental health nursing specialty	
Yes	2 (22.2)
No	7 (77.8)
Work shift	
Morning	4 (44.4)
Afternoon	4 (44.4)
...Night	1 (11.1)
Working day (hours)	
40	6 (66.7)
21	3 (33.3)
Mental health experience (months)	
72-119	4 (44.4)
120-240	3 (33.3)
>240	2 (22.2)

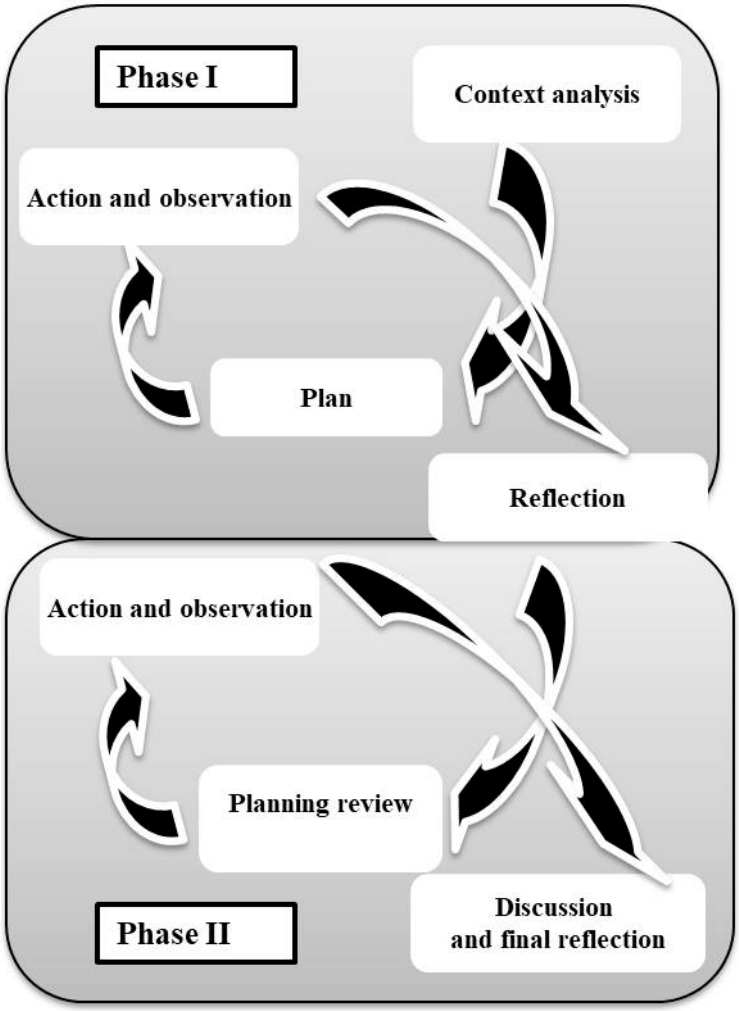

FIGURE 1 The participatory action research process

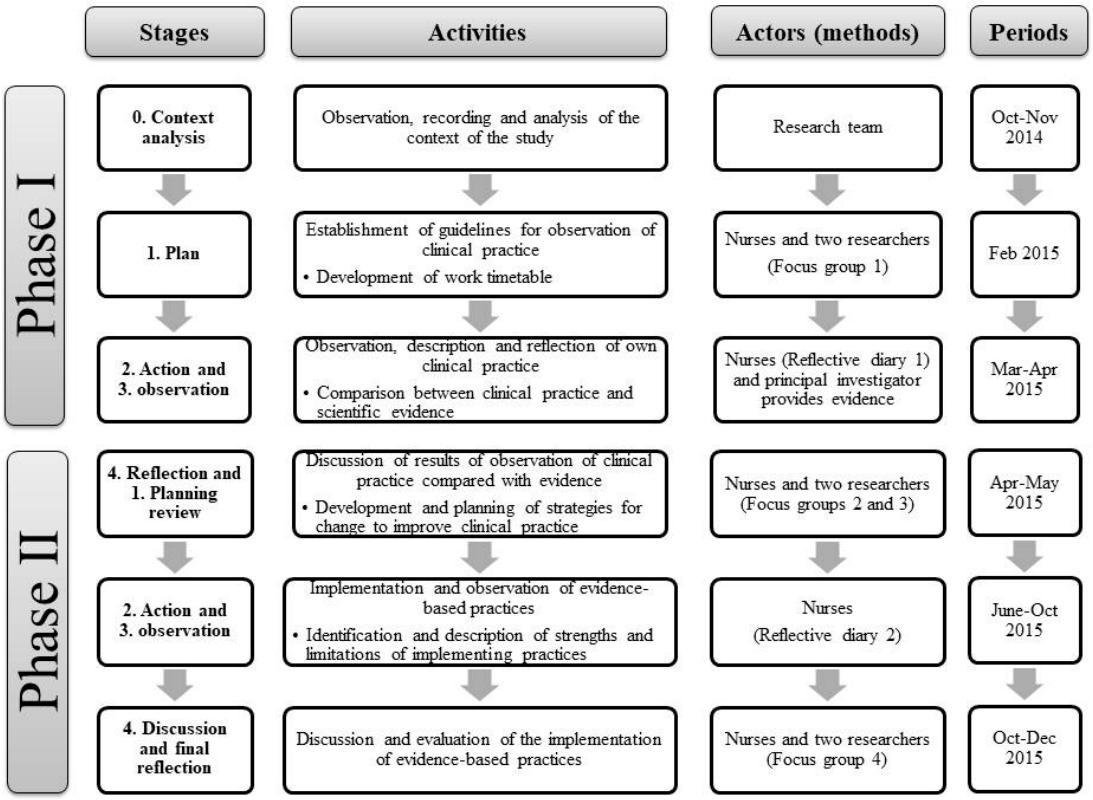

FIGURE 2 Procedure and methods used in the study

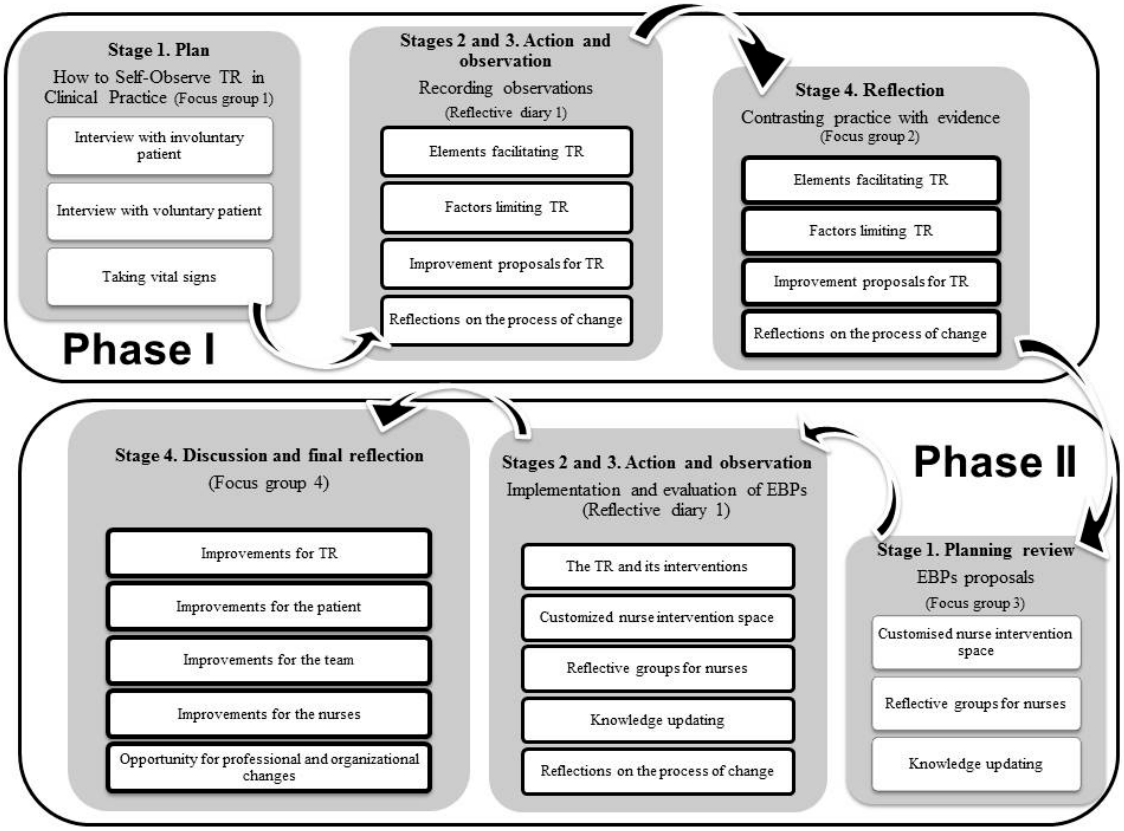

FIGURE 3 Process of generating and implementing evidence-based practice regarding the therapeutic relationship