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**Registered mental nurses' experiences  
of nurse-patient relationships in acute care**

Ian Taylor

Submitted to Swansea University in fulfilment of the  
requirements for the Degree of Doctor of Nursing Science

Swansea University

2012

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Ian Taylor

## SUMMARY

The changing context of mental health care provision in the United Kingdom in the last three decades has seen significant change in acute inpatient services. Service users have expressed dissatisfaction about current service provision and care. Nurses continue to represent the largest professional group providing care in these services. Comparatively little is known from nurses' perspectives about the present nature of the nurse-patient relationship in acute mental health inpatient settings. The purpose of this research study was to explore with a sample of 14 registered mental nurses, their experiences about the nature of the nurse-patient relationship. An interpretive, phenomenological approach was adopted. The principal research question asked 'What are registered mental nurses' experiences of the nature of the nurse-patient relationship in working age acute inpatient mental health care settings?'

Following ethical approval, unstructured, individual interviews were used as the primary method of data collection. Transcribed interview texts were analysed hermeneutically, supplemented with the researcher's field notes and reflective journal.

Key findings included the impact of poor ward environments, increased patients' acuity of illness, and multiple, competing demands placed on nursing time. Although nurses valued human interpersonal relationships with patients, they struggled to achieve their aspirations for the nurse-patient relationship, owing to a range of factors including organisational constraints, inexperience, and limited post-registration professional development. Nurses could experience stress and emotional fatigue, and their needs for support were not always met.

These factors may challenge possibilities for the development of therapeutic nurse-patient relationships. Whilst nurses appear to acknowledge the benefits of therapeutic nurse-patient relationships, they may be insufficiently prepared to achieve their ideals, given the challenges of working within an area of practice which provides for short term admissions focussed on acute risk management and containment.

## **DECLARATIONS AND STATEMENTS**

### **REGISTERED MENTAL NURSES' EXPERIENCES OF NURSE-PATIENT RELATIONSHIPS IN ACUTE CARE**

#### **DECLARATION**

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

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This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used, the extent and nature of the correction is clearly marked in a footnote(s).

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## LIST OF ABBREVIATIONS

AMED	Allied and Complementary Medicine
ASSIA	Applied Social Sciences Indexes and Abstracts
BNI	British Nursing Index
Caredata	Caredata Abstracts Social and Community Care
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CPA	Care Programme Approach
eCPA	Electronic Care Programme Approach
IESBS	International Encyclopaedia of Social and Behavioural Sciences
LREC	Local Research Ethics Committee
NHS	National Health Service
NMC	Nursing and Midwifery Council
PICU	Psychiatric Intensive Care Unit
RMN	Registered Mental Nurse. Registered Nurse – Mental Health.
SSCI	Social Sciences Citation Index
ZETOC	Z39.50-compliant access to the <u>British Library's</u> Electronic Table of Contents (ETOC).

## **CHAPTER ONE: INTRODUCTION**

This study seeks to explore registered mental nurses' reported experiences about the nature of the nurse-patient relationship in working age acute inpatient mental health settings. The purpose of this phenomenological study is to explore with a sample of registered mental nurses their reported experiences about the nature of the nurse-patient relationship in one working age acute inpatient mental health hospital setting. It was anticipated that the knowledge generated from this inquiry would afford new insights about the possible significance and current nature of nurses' perspectives on nurse-patient relationships there and so inform practice, education, future research, and patients.

This research employed a hermeneutic, phenomenological methodology to illustrate the phenomenon under investigation. Participants of this study consisted of 14 registered mental nurses who held a 'Registered Nurse – Mental Health' recordable professional qualification, and were registered with the United Kingdom Nursing and Midwifery Council. All participants were employed on a full-time basis within one NHS Trust, and worked in one working age acute inpatient mental health setting. Participants had at least six month's post-registration experience there.

This chapter begins with a brief discussion of the background and context of the study. Following this is the problem statement, a statement of purpose, research question and objectives. This chapter also includes a discussion around the research approach and the researcher's perspectives. The chapter concludes with a discussion of the proposed rationale and significance of this research study together with definitions and key terminology used. The structure of this and subsequent chapters follows guidance set out by Bloomberg and Volpe (2008).

### **1.1 BACKGROUND AND CONTEXT**

Mental health services in England have seen a major shift in focus of care delivery in the last three decades, from hospital care to community-based



care (Rogers and Pilgrim, 2003). The Care Programme Approach (Department of Health, 1990a) set out guidance for clinical practice which aimed to address and minimise the risks to, and from, people living with enduring mental health problems in the community. Following public safety concerns about the risks posed to them by people with serious mental illness in the community, the Government continued to invest in developing more acute inpatient services, with emphasis on risk management and security. During this period, mental health professionals and service users voiced their concerns and dissatisfaction about psychiatric inpatient services.

The late 1990s saw a continued shift in focus towards the further development of mental health services in the community, when the Government made mental health a key clinical priority in its National Service Framework for Mental Health (Department of Health, 1999b). Its guidance stated that people with mental health problems should receive care as close to home as possible, and in the least restrictive environment. It was recommended that 24 hour emergency home treatment services be developed for treatment as an alternative to hospital inpatient admissions.

Over the last 10 years, there has been a 24% reduction in short stay acute admission mental health beds in England (Department of Health, 2010). In the same 10 year period, there has been a 25% reduction in patient admissions to acute inpatient admission units in England. However, there has been a 7.4% increase in formal patient admissions under the Mental Health Act 1983 (amended 2007) (Department of Health, 2007a). Of these, the number of patients with complex mental health problems and challenging behaviours increased by 4% to 26% of all patient admissions.

Empirical research studies focussing on the realities of everyday working practices in acute psychiatric inpatient care often cite poor ward environments; increased patients' acuity of illness; and multiple, competing demands placed on nurses' time; as factors which may challenge possibilities for therapeutic nurse-patient relationships (Clarke and Flanagan, 2003; Cleary and Edwards, 1999; Fourie et al., 2005; Higgins et al., 1999b). Many service users appear to want to develop therapeutic nurse-patient

relationships within the adult acute inpatient healthcare setting. This is not always possible, and significant levels of dissatisfaction of their overall inpatient experiences are reported (Coatsworth-Puspoky et al., 2006; Goodwin et al., 1999; Shattell et al., 2007).

Empirical research studies have shown that essential role features of the mental nurse in the acute inpatient setting include prioritising risk assessment and management; maintaining safety; shift and care coordination; and administration (Barker et al., 1999; Clarke and Flanagan, 2003; Scanlon, 2006). These competing, often urgent demands placed on nurses, are always prioritised over direct one-to-one contact with patients which is time limited.

Given that the therapeutic nurse-patient relationship is claimed to be central to best mental health nursing practice (Barker, 1999), nurses' perceived vision of mental health nursing may conflict with the realities of their everyday practice in acute inpatient hospital settings. It appears that nurses there face considerable challenges in developing therapeutic relationships with patients with complex mental health problems. Although recent studies offer some evidence about the everyday realities of the roles and skills of the mental nurses, remarkably little is known about the present nature of the nurse-patient relationship in the adult acute psychiatric inpatient setting, from a nursing perspective. Given the present day context that the development of effective services for people with severe mental illness is a national priority, it is timely to explore the present nature of nurses' perspectives on the nurse-patient relationship in these settings. Therefore, this study seeks to shed light on registered mental nurses' reported experiences about the nature of nurse-patient relationships in acute working age inpatient mental health settings.

## **1.2 PROBLEM STATEMENT**

Research shows that nurses' realities of everyday working practices in acute psychiatric inpatient care may include poor ward environments, increased

patients' acuity of illness, and multiple, competing demands placed on their time. These factors may challenge possibilities for the development of therapeutic nurse-patient relationships. Many service users appear to want to experience therapeutic nurse-patient relationships, but this may not always be possible, and significant levels of dissatisfaction are reported of their overall inpatient experiences. Remarkably little is known from a nursing perspective about the present nature of the nurse-patient relationship in the adult acute psychiatric inpatient setting.

### **1.3 STATEMENT OF PURPOSE, RESEARCH QUESTION AND OBJECTIVES**

The purpose of this research study was to explore with a sample of registered mental nurses, their reported experiences about the nature of the nurse-patient relationship in working age acute inpatient mental health settings. This focus has arisen from established theory and research summarised in the literature review which follows later, and holds out the prospect of making an original, significant contribution to the academic literature and nursing practice. I believe that a better understanding of this phenomenon would allow practitioners, educators, researchers and patients to proceed from a more informed perspective in terms of promoting good nursing practice. I believe that the development of genuine nurse-patient relationships is fundamental to good nursing practice, and to nurses' and patients' wellbeing.

In seeking to understand this phenomenon, the principal research question asked 'What are registered mental nurses' reported experiences of the nature of the nurse-patient relationship in working age acute inpatient mental health care settings?' The study addressed six key objectives:

1. To review relevant literature relating to the nurse-patient relationship in acute inpatient care;
2. To explore nurse participants' reported lived experiences of the nurse-patient relationship;

3. To describe the essential components of nurse participants' experiences of the nurse-patient relationship emerging from these reports;
4. To interpret and understand the meanings of the relational themes and constitutive patterns of nurse participants' reported experiences of the nurse-patient relationship;
5. To provide a hermeneutical analysis of nurse participants' experiences of the nurse-patient relationship, as provided by them in the study; and
6. To generate new knowledge, making an original contribution to the field, with relevance for clinical practice, education and research.

#### **1.4 RESEARCH APPROACH**

Following approval of the Local Research Ethics Committee and research governance approval from the local NHS Trust Research Consortium, as researcher, I studied 14 registered mental nurses' reported experiences of the nature of the nurse-patient relationship in one working age acute inpatient mental health care setting.

This investigation used an interpretive, phenomenological approach which provided a means of interpretation of the everyday experiences and practices of the participants, to more fully understand their richness and complexity.

Unstructured, audio-recorded, face-to-face, individual interviews were conducted once with each participant, as the primary method of data collection. Field notes and a reflective journal were maintained by me throughout the research process. Transcribed interview texts, field notes and entries in my reflective journal were considered as data, which formed the basis for the overall findings for this study.

Participants' stories were analysed hermeneutically using Diekelmann and Allen's (1989) multiple stages of interpretation process. Participants' common experiences, practices and meanings were identified through the

development of relational themes and constitutive patterns. Findings were produced and supported using participants' anonymised direct quotes. Data were interpreted and discussed in relation to existing relevant literature.

Ethical considerations using an 'ethics-as-process' approach (Cutcliffe and Ramcharan, 2002) were considered throughout the research process. The trustworthiness of the study was provided through a detailed trail of the theoretical, philosophical and methodological decisions taken during the research process.

## **1.5 THE RESEARCHER**

This section provides relevant background information about me as the researcher, to locate myself within the context of the study. This is relevant to the collection, analysis and interpretation of the data. Drawing from Heidegger (1962), temporality or time provides the context for understanding all *being*, in other words, living in the world. Understanding is never without presupposition. The concept of a hermeneutic circle allows for reciprocal activity between pre-understanding and understanding (Moran, 2000). Pre-understanding relates to the knowledge brought through our own personal experiences of being in the world. In the hermeneutic circle, the researcher seeks to understand participants' accounts of lived experiences by first examining their own pre-understandings, moving to participants' accounts, from the whole to the parts, then back, in a reciprocal way. We make sense of our social world and come to understand what it is through our pre-understandings of phenomena, enabling interpretation, new meanings and insights to be gained. This cyclical process moves our pre-existing knowledge and understandings to new and different levels. We can only understand something by comparing it to something we already know (Palmer, 1969).

My own pre-existing knowledge and understandings of nurse-patient relationships in hospital and community mental health care have been developed through a range of clinical and educational experiences which have enabled me to interpret and gain new meanings and insights into

participants' accounts of their experiences the present study. This section provides the reader with relevant details of my own professional nursing and higher education backgrounds, to contextualise these interpretations.

I became a registered mental nurse in the mid-1980s, and soon after gained a registered general nurse qualification. I worked as a registered mental nurse in the National Health Service in inpatient and community settings for 10 years before becoming a nurse lecturer in 1996. I completed a part-time Masters degree in Nursing and Health Studies in 1993. It was at this time that I first became aware of qualitative research methodologies, and I was fascinated with phenomenology as a means to access meaningful insights into others' experiences. I gained a lecturer/practice educator qualification in 1997 and became a nurse senior lecturer in my current post in 1998.

Studies on the Doctor of Nursing Science programme have challenged my thinking, further expanded my nursing and research knowledge, and have afforded me this opportunity to undertake this research study.

I have been fortunate in my personal life to have developed a strong sense of 'connectedness' through close relationships with family, friends, educators, and colleagues. These relationships have been fundamental for me in developing a real sense of personal confidence, and a belief of high aspirations for the future. I am also aware that some close friends and family members were less fortunate, having faced stigma and discrimination in their lives, relating to their mental health and sexual orientation. There are parallels here with my experiences of working with patients, who too experienced stigma and discrimination. It is fundamental for me to recognise and acknowledge the process of 'being human' in the nurse-patient relationship, treating fellow human beings who happen to find themselves in different circumstances on an equal footing, with dignity and respect.

During my 10 year's nursing practice, I experienced the development of many therapeutic nurse-patient relationships. These relationships appeared to be valuable, and I believe they promoted service user well-being. For me, the development of genuine nurse-patient relationships is fundamental to

good nursing practice, and to nurses' own professional development and well-being.

In my present role as a nurse senior lecturer, I teach pre- and post-registration mental health nurses, some of whom are employed in working age acute inpatient mental health settings. Discussions with them and my partner, who also works as a senior mental health inpatient nurse, raised some concerns about the nature and quality of nurse-patient relationships in these settings. It seemed to me to be a paradox that whilst I believe that registered mental nurses shared similar aspirations to develop therapeutic nurse-patient relationships, that this may be challenging for them in practice, given the competing demands that they are exposed to in their nursing roles. Further concerns were raised as many inexperienced, newly qualified nurses are first employed in working age acute inpatient mental health settings, where they may not be sufficiently prepared to meet the complex needs of patients with serious mental health problems.

Whilst my own experiences provide valuable insights, I acknowledge that they may also serve as a hindrance as they may bias my judgement regarding the research design and the interpretation of findings. I therefore took steps to maintain rigour as a process throughout the study. These steps are discussed in depth in the research design chapter which follows later.

## **1.6 RATIONALE AND SIGNIFICANCE**

The rationale for this study arose from my aspiration to make explicit registered mental nurses' holistic philosophy of care, and willingness to meet the complex challenges of working with people with serious mental health problems in working age acute inpatient mental health settings. Central to this is that I believe that registered mental nurses inherently want to develop therapeutic relationships with patients, to best meet their holistic needs.

These nurses may be prospective senior nurses and nurse managers in acute inpatient settings in the future, but this may be threatened if nurses do

not value their professional contribution there, and choose to leave to work elsewhere. Patients in working age acute inpatient mental health settings are arguably at their most vulnerable, and deserve to receive high quality care from experienced, knowledgeable, skilled nurses; who themselves should be appropriately equipped and supported in this demanding role.

It is intended that this study will offer meaningful insights into nurses' reported experiences of the nurse-patient relationship when working in working age acute inpatient mental health settings, so that practitioners, educators, researchers, and patients themselves, may better understand nurses' contribution in meeting patients' needs, and how best to support them in this task.

## **1.7 DEFINITIONS OF KEY TERMINOLOGY USED IN THIS STUDY**

*Client* – People with mental health problems who receive care and treatment in the community.

*Patient / inpatient* – People with mental health problems who receive care and treatment during their stay in a hospital setting.

*Registered general nurse* – A nurse recorded as 'Registered Nurse – Adult' in the Nursing and Midwifery Council register.

*Registered mental nurse* – A nurse recorded as 'Registered Nurse – Mental Health' in the Nursing and Midwifery Council register.

*Service user* – People with mental health problems who receive care and treatment from a range of hospital and community-based mental health services.

A full list of abbreviations is provided in the front pages of the thesis.



## CHAPTER TWO: LITERATURE REVIEW

The purpose of this research study was to explore the subjective experiences of registered mental nurses of their nurse-patient relationships in the adult acute inpatient mental health setting. Specifically, as researcher, I sought to understand how participants' experiences may have influenced the development of nurse-patient relationships there. To carry out this study, it was necessary to complete a critical review of the current literature.

Decision-making about the process and structure of this review was informed by relevant guidance (see Bloomberg and Volpe (2008) and Hart (1998)).

Critical review of the literature was ongoing throughout the data collection, data analysis and synthesis phases of the study, exploring the issues arising from previous research studies and other relevant sources about the nature of the nurse-patient relationship in the adult acute inpatient mental health setting. This exploration was used to formulate an argument to justify undertaking this research. Related specialist literature is considered later within the findings and discussion chapters, relating to key themes emerging from the participant interviews.

In conducting this critical review of the literature, multiple information sources were used, including peer-reviewed journals, internet sources, reports, books and theses. The review begins with an account of the search strategy used to identify and select the relevant evidence from these sources, to inform my discussion of the key themes arising.

There follows a critical appraisal of the literature within three broad, interconnected sections. These are key theorists relating to mental health nursing; mental health policy and service provision; and the nurse-patient relationship in the adult acute inpatient mental health setting.

Throughout this review, I have sought to highlight important gaps and omissions in the literature as they became apparent within each section, placing this study in a broader context, supporting identification of the research question to be explored, and to inform development of an appropriate research methodology. The chapter closes with a conceptual

framework illustrating how the empirical literature has informed my understanding of its content, and how this contributes to the ongoing development of the study's conceptual framework.

## **2.1 SEARCH STRATEGY**

An outline of my search strategy is presented here to provide an audit trail describing the methods of searching undertaken, together with reasons for changes and amendments. Electronic databases were identified using three key service information providers: Swansea University electronic library resources; University of Brighton electronic library resources; and the National Health Service National Library for Health healthcare resources. The following databases were initially selected owing to their broad coverage of health and social sciences literature: Allied and Complementary Medicine (AMED); Applied Social Sciences Indexes and Abstracts (ASSIA); British Nursing Index (BNI); Caredata Abstracts Social and Community Care (Caredata); Cumulative Index to Nursing and Allied Health Literature (CINAHL); International Encyclopaedia of Social and Behavioural Sciences (IESBS); PsycINFO; Pubmed; Social Sciences Citation Index (SSCI); and ZETOC.

Keywords used to undertake an initial, extensive search within each database were 'nurs\*', 'patient', 'nurse-patient', 'inpatient', 'in-patient', 'client', 'relationship', 'mental' and 'psychiatric'. These were intentionally broad to enhance the sensitivity of the initial search which produced several thousand hits. Each search was then refined by combining search terms, and limiting searches to English language and empirical publications from 1990 onwards. Empirical literature was limited from 1990 onwards to identify relevant research studies which likely reflected nurses' experiences of nurse-patient relationships in an appropriate clinical, policy, and political context, to promote transferability of their findings to current mental health practice contexts elsewhere.

Electronic records of the retrieved references were stored in Endnote, a bibliographic database, to later facilitate the production of a reference list using its 'cite as you write' facility.

Later, a search for key theorists was added using the search terms 'nurs\*', 'theor\*', 'mental' and 'psychiatric'. Specific searches for key theorists Hildegard Peplau, Annie Altschul, Sidney Jourard, Carl Rogers, Gerard Egan, Carl Jung, and Sigmund Freud were undertaken. Finally, a search for relevant mental health policy sources was undertaken using the terms 'policy', 'mental' and 'psych\*'.

References identified were sifted in order to exclude irrelevant material, enhancing the specificity of the initial search. Papers and studies of relevance were identified by scanning their titles, those falling outside the review focus being excluded. Finally, abstracts of the remaining studies were scrutinised in order to select the most relevant material. Although material not specifically applicable to the adult acute inpatient mental health setting was initially excluded, their broader mental health focus was often of relevance to the broader context of the thesis, and therefore these were retained for possible inclusion elsewhere. The initial search was supplemented by hand searching of reference lists from the selected relevant studies, and perusal of nursing journal contents pages.

Further searches were undertaken using high quality relevant mental health websites identified via the electronic bibliographic resources provided by Swansea University, University of Brighton and the NHS National Library for Health. These included the Department of Health (<http://www.dh.gov.uk>); Intute (<http://www.intute.ac.uk>); Mental Health Foundation (<http://www.mentalhealth.org.uk>); MIND (<http://www.mind.org.uk>); National Electronic Library for Health – Mental Health (<http://www.nelmh.org>); National Institute for Mental Health in England (<http://www.nimhe.org.uk>); and Sainsbury Centre for Mental Health (<http://www.scmh.org.uk>). Finally, relevant books were identified by searching the online library catalogues of Swansea University and the University of Brighton, as well as the British Library (<http://www.bl.uk/>).

Selected literature was sorted into themes in order to facilitate their critical appraisal for quality. Empirical studies were evaluated through an assessment of methods, methodologies used, and their methodological rigour, using standardised checklists for consistency of approach. Extracted data were summarised and an evidence table produced to facilitate the comparison of each study.

Searches were updated periodically, at intervals of three to six months, identifying newly published appropriate references, until the final drafting of the thesis was completed. Choice of databases was rationalised to include AMED, BNI, CINAHL, PsycINFO and Pubmed, which yielded the most appropriate hits, and which could all be searched simultaneously via the National Health Service National Library for Health healthcare databases. Further individual searches were updated on the same basis using ASSIA and ZETOC databases. Searches using Caredata, IESBS and SSCI databases yielded minimal hits appropriate to the focus of the review, so were discontinued after the initial extensive search was completed. Finally, search alerts were set up with database providers for automatic electronic notification via email of possible appropriate references as they were added to each database.

In summary, searching for appropriate literature was a complex process. The initial extensive search produced several thousand hits, many of which were either directly or indirectly relevant to the focus of this review. Those information sources finally selected for inclusion reflect what I consider to be the most appropriate to inform myself and the reader about key themes arising in this study about nurses' experiences of the nurse-patient relationship in the adult acute inpatient mental health setting. The literature review places this study in its broader context, to help to identify the research question to be explored, and to develop an appropriate research methodology.

## **2.2 KEY THEORISTS RELATING TO MENTAL HEALTH NURSING**

This section considers key theorists which may influence the nature and quality of current mental health nursing practice in acute mental health inpatient settings. As Barker et al (1997) discuss, the development of effective relationships with patients has special relevance in psychiatric nursing. Within psychiatric inpatient services, nursing fulfils a broad range of functions and activities which support the safety, well-being and daily living needs of patients (Higgins et al., 1999b). Whilst these broad responsibilities are important, Peplau (1994) suggested that it is the interpersonal interactions which nurses have with patients that is of greater significance and therapeutic benefit. This view is widely supported in the literature (Bowles, 2000; Chambers, 1998; Forchuk, 1995; Gastmans, 1998; Jones, 1996; O'Brien, 2001). Service users too value their dialogue with nurses, particularly when engaged in seemingly genuine empathic relationships (Repper, 2000).

Peplau's theory of interpersonal relations in nursing (Peplau, 1988) is discussed as a possible suitable theoretical framework which provides a model that might guide nursing practice development. The model is described and critiqued in relation to four evaluative criteria: simplicity, generality, empirical precision, and derivable consequences. Further theorists which may influence mental health nursing practice are considered in brief. The relevance of these for nursing practice in acute mental health inpatient settings is discussed later in the discussion chapter of the thesis.

### **Nature of mental health nursing**

The Royal College of Nursing (2003) concluded that the ability of nurses to respond to individual nursing needs of patients fundamentally depends on the way in which nursing itself is defined. Among its defining characteristics, nursing is said to have a particular focus on the whole person and the human response rather than isolated aspects of the person or particular conditions. Nursing should be based on ethical values, respecting the uniqueness of individuals and the privileged nurse-patient relationship.

Throughout the thesis, I have used the term 'therapeutic relationship' to describe how nurses may engage in specific techniques to assist and help the patient. Henderson (1967: x) states this involves '...the practice of those nursing activities which have a healing effect or those which result in movement towards health or wellness'.

It is widely recognised that the therapeutic climate in inpatient mental health services has changed dramatically (Bowles, 2000). The Government's drive towards care in the community (Department of Health, 1990b) led to long-stay hospital closures and a reduction in hospital beds. Insufficient investment in community services, together with an increase in acute hospital admissions for people with serious mental health problems, led to overcrowding in acute hospital wards (Clarke and Flanagan, 2003; Higgins et al., 1999b). During this period, there has been a marked decrease in direct nurse-patient care, and an increase in time spent by nurses in administrative duties. These factors have contributed to service users' and nurses' general dissatisfaction with the inpatient environment and its negative impact on quality of care (Clarke and Flanagan, 2003; Goodwin et al., 1999). These factors are discussed in more depth later.

### **Peplau's model of interpersonal relations in nursing**

Models are conceptual tools that may be used to understand and place more complex phenomena in perspective (Wright, 1990). They help individuals to organise their thinking about everyday events, enabling effective transfer of their thinking into practice. Peplau's theory of interpersonal relations in nursing (Peplau, 1988) is a model which may have relevance to guiding the work of mental health nurses in acute inpatient settings, and may go some way to informing the decisions and actions that nurses make which contribute to the quality of care. This is further discussed in the discussion chapter of the thesis.

#### *Origins*

Peplau's theory of interpersonal relations in nursing was first published in 1952, and reissued in 1988 and 1991 (Forchuk, 1993). Her theory development arose in the late 1940's as a response to develop psychiatric

nursing literature for North American university-based graduate nursing education programmes, and to convey her ideas to improve practice. Her theory was influenced by her studies in interpersonal relations theory in the 1930s-1940s, and later she incorporated Sullivan's (1952) interpersonal development model into her work.

Peplau defined nursing as '... a significant therapeutic interactional process which functions cooperatively with other human processes that make health possible for individuals in communities' (Peplau, 1988: 16). Peplau viewed illness as a potential learning experience for both nurse and patient.

Through the development of a meaningful nurse-patient relationship, each would grow and develop themselves further as individuals (Simpson, 1991). In order to achieve effective care, Peplau claimed that nurses would need to develop and mature themselves, leading to greater patient opportunities for learning from the nurse about their illness, so gaining greater insights into their situation. Such insights would afford opportunities for the patient to manage their feelings and actions in relation to their health needs. Whilst Peplau's model has most commonly been applied in mental health nursing, she believed that her nursing theory transcended all nursing specialties, as nursing is based on an interpersonal process within the nurse-patient relationship (Peplau, 1988).

#### *Theoretical assumptions*

Peplau identified two guiding assumptions in her theory. The first states:

*'The kind of nurse each person becomes makes a substantial difference in what each client will learn as she or he is nursed throughout her or his experience with illness.'*

*(Peplau, 1988: x)*

This assumption relates to psychodynamic nursing, which involves recognising, clarifying, and building an understanding of the process when a nurse helpfully relates to a patient. Both nurse and patient grow as a result of the learning occurring in the nursing situation. The second assumption states:

*'Fostering personality development in the direction of maturity is a function of nursing and nursing education; it requires the use of principles and methods that permit and guide the process of grappling with everyday interpersonal problems or difficulties.'*

*(Peplau, 1988: x)*

For Peplau, concepts, principles, skills and abilities may be learned when new behaviour follows the exploration of problems that require particular principles and skills to find solutions. She states:

*'Nursing is a significant, therapeutic, interpersonal process. It functions co-operatively with other human processes that make health possible for individuals in communities. ... Nursing is an educative instrument, a maturing force that aims to promote forward movement of personality in the direction of creative, constructive, productive, personal, and community living.'*

*(Peplau, 1988: 16)*

This statement indicates the potential complexities of nursing, and what is required of nurses to effectively utilise this theory in practice. Peplau's focus on the interpersonal processes between nurse and patient are in sharp contrast to many nursing theories, which focus on the patient as the unit of care. Peplau developed her model by describing the structural concepts of the interpersonal processes between nurse and patient: the nurse-patient relationship, communication, pattern integration, and the roles of the nurse (Forchuk, 1993). These are discussed next.

#### *Nurse-patient relationship*

Peplau described four phases of the nurse-patient relationship: orientation, identification, exploitation and resolution (Peplau, 1988). Each phase is characterised by overlapping roles and functions, the nurse and patient learning to work co-operatively to resolve difficulties in relation to health problems arising.

During the orientation phase, the patient experiences 'felt needs' in relation to health, for which professional assistance is sought (Peplau, 1988). The emerging health problem may be more or less clear to the individual. Professional assistance that is thought to be helpful is sought. The nurse helps the patient to recognise and understand their health problems, and



determines the patient's need for help, whether immediate or planned ahead. Orientation phase is about strangers meeting and coming together, setting the scene for the nurse-patient relationship to begin to develop (Simpson, 1991).

When the patient's first impression is clarified, and a sense of knowing what the situation can offer emerges, they selectively respond to people who appear to offer the help needed. Trust is developed in nurses who are perceived as useful, and who do the things they say they will do. This occurs in the identification phase (Peplau, 1988). The nurse facilitates exploration of the patient's feelings in relation to their illness experience, to reorient these feelings and to strengthen positive forces in their personality. This provides needed satisfaction (Howk, 2002). The nature of these problems may be diverse, including psychological, physical, social and spiritual issues. In this phase, the nurse-patient relationship may take different paths (Simpson, 1991). The patient may become more involved in their care along productive lines; involvement may be avoided; or they may become passive, letting the nurse attend to their needs. The nurse should look for patterns in behaviour change, to understand what the patient is thinking and feeling.

When the patient has identified with a nurse who recognises and understands the interpersonal relations in the situation, the patient proceeds through exploitation phase, where full use of the nursing services offered is attempted. All services will be exploited by the patient on the basis of self-interest and need, to derive full value from the relationship, from the patient's perspective (Peplau, 1988). Simultaneously, the patient begins to identify and orientate himself toward still other new goals to be achieved through personal effort and power shifts from nurse to patient. As initial problems are worked through, new goals are identified. The nurse does not solve problems for the patient, but provides opportunities to explore options and possibilities within the context of their relationship (Forchuk, 1993). Advice giving is resisted, as this undermines the roles and responsibilities of the patient.

Finally, the patient gradually resolves original problems, putting them willingly aside, and adopts new goals, freeing them from identification with the nurse. This occurs in the resolution phase, when the relationship between nurse and patient ends (Peplau, 1988). Old ties and dependencies are relinquished. Resolution is a freeing process, nursing helping the patient to organise their actions towards more productive social activities, and relationships of their own choosing.

According to Simpson (1991), nurses who are observant and aware of the current phase of the nurse-patient relationship, tend to be more effective than those nurses who are unaware. Patients are also said to have greater insight into their health conditions using these phases of nursing care.

### *Communication*

According to Peplau (1988), communication is an essential component of the nurse-patient relationship. She stated:

*'The development of consciousness of tools used in nursing includes an awareness of means of communication; spoken language, rational and non-rational expression of wishes, needs and desires, and the body gesture.'*

*(Peplau, 1988: 289)*

Communication includes verbal communication expressed through language, and non-verbal communication, expressed through empathic linkages, gestures, postures and patterns (Forchuk, 1993). Verbal communication may include facts, conversations about everyday events, and interpretation of these events occurring during patient care. Peplau states that the concepts, words and symbols chosen to express ideas, thoughts or feelings, will be helpful in the reshaping of the patient experience. Each concept or word has both a reference and a referent; Peplau suggested that ...

*'The aim in communication is the selection of symbols or concepts that convey both the reference, or meaning in the mind of the individual, and the referent, the object or actions symbolised in the concept.'*

*(Peplau, 1988: 290)*

Communication is described as movement toward the development of common understanding between the nurse and the patient. Two key principles involve clarity, when words and sentences are used to clarify events as they occur within the frame of reference of all participants; and continuity in communication, when language is used as a tool to promote connections of expressed ideas, the feelings, themes or events conveyed in these ideas, leading to the discrimination of relationships.

Non-verbal communication is more subtle than verbal language, and may contradict the verbal message (Forchuk, 1993). For example, a patient may state 'I am not upset', yet may be tearful. The non-verbal message tends to be believed in such instances. Forchuk highlights that congruence of verbal and non-verbal communication should be carefully considered in the nurse-patient relationship, the nurse monitoring this in their own communication, as empathy and caring may be transmitted on a non-verbal level, as can the nurse's feelings of indifference or hostility. An awareness of the influence of possible cultural differences between nurse and patient is required as non-verbal communication may be interpreted differently when providing care to different patients.

#### *Pattern integration*

Peplau (1987) identified four common pattern integrations which may occur within the nurse-patient relationship: complementary, mutual, antagonistic and mixed. These pattern integrations represent customary patterns of interacting with others.

A complementary pattern integration exists when different patterns exist between nurse and patient, which 'fit' one another like parts of a jigsaw. An example is the nurse who insists on 'helping' a dependent patient with daily living activities such as preparing meals for them, arranging shopping and so on, when the patient is able to undertake these activities for themselves, but prefers that others make all their decisions for them. A comfortable partnership is formed, making it difficult for either party to change.

A mutual pattern integration occurs when two or more individuals display a similar pattern. Examples include mutual respect, mutual concern, mutual anger and mutual disrespect (Forchuk, 1993). It should be recognised that the nurse should only employ mutual pattern integrations that both nurse and patient would want to perpetuate.

An antagonistic pattern integration may arise at individual or larger systems levels (Forchuk, 1993). For example, the 'dependent' patient who is comfortable having things done for them may develop an antagonistic pattern if placed in a therapeutic environment that promoted the participation and decision-making of all individuals. In such an environment, it would be uncomfortable for the patient to maintain dependent behaviours.

Finally, mixed (or changing) pattern integrations may occur, which include a combination of earlier pattern integrations (Forchuk, 1993). For example, a person may respond to another's anger by first getting angry themselves (mutual pattern integration), and then withdrawing (complimentary pattern integration).

#### *Roles of the nurse*

Many roles are demanded of nurses, that may be influenced by the views of nurses themselves and by society, taking account of different community and economic groupings (Peplau, 1988). The roles adopted depend on patient needs and on the skills and creativity of the nurse. Peplau identified six nursing roles that may emerge within the nurse-patient relationship: role of stranger; role of resource person; teaching role; leadership role; surrogate role; and counselling role.

Within the role as stranger, Peplau states that the nurse should treat the patient with common courtesy, accepting the patient as he is, and treating him as an emotionally able stranger, relating to him on this basis until evidence shows otherwise. In other words, the nurse should not prejudge the patient.

Within the role as resource person, the nurse provides specific answers to questions usually formulated in relation to part of a larger problem. The

nurse determines what kind of response is most appropriate for constructive learning, and may either provide direct, straightforward factual answers, or provide counselling, for example, for questions involving feelings.

Peplau states that the teaching role is a combination of all roles, and should develop from what the patient knows, and around their interest in wanting and being able to use additional information. The teaching role was expanded later into two categories: instructional, consisting of giving information such as educational literature; and experiential, using the experience of the patient as a basis from which generalisations and appraisals are made (Howk, 2002).

According to Peplau (1988), nursing, as a human endeavour, must portray leadership as a characteristic of democratic living. These may arise for nurses in local, national and international situations. In clinical situations, patients often expect the nurse to offer direction during their current difficulties, and cast them in a leadership role. The nurse should help the patient meet the tasks at hand, within a cooperative relationship of active participation.

Peplau suggests that nurses are frequently cast into surrogate roles by patients. Peplau explains that, outside the patient's awareness, the patient views the nurse as someone else, for example, a parent or a sibling. Instead of relating to the nurse in terms of the current relationship, the patient relates to the nurse in terms of the older relationship. The role of the nurse here is to help the patient recognise likenesses recalled by the patient, between the nurse and the recalled person, before differences between them are highlighted. Areas of dependence, independence and interdependence are defined as the nurse-patient relationship moves on a continuum from a dependently functioning adult-child relationship to an independently functioning adult-adult relationship.

In the role of counsellor, the nurse responds to patients' demands, to help them remember and fully understand what is happening to them, in their current situation. The aim is to help the patient to integrate current

experiences and make sense of them within the context of other experiences in their life. Within the counselling role, Peplau (1988) explains how anxiety may be used productively by the patient. Anxiety is described as an energy that arises in response to perceived threats. Anxiety develops in a sequence of steps including holding expectations, expectations not met, discomfort felt, relief behaviours used, and relief behaviours justified (Peplau cited by Forchuk, 1993). Expectations include beliefs, goals, needs, wishes, and feelings. Relief behaviours may include: aggression, withdrawal, compulsive behaviour, psychosomatic complaints, hallucinations, delusions, sexual activity, risk-taking behaviour, denial, intellectualising, drug use, humour, self-reflection, discussion with others, validation, and problem solving, to identify the sources of difficulty. Relief behaviour patterns are developed by individuals, which tend to be used over and over again. Peplau (1988: 124-125) suggested that the nurse may develop '... skill in aiding the patient to undergo the discomfort and to utilise the energy provided by the anxiety in identifying and assessing the difficulties in the situation.'

Anxiety is described as existing along a continuum, including mild, moderate, severe, and panic. Peplau suggested that when anxiety is held within tolerable limits, it can be a functionally effective element in interpersonal relations.

Peplau emphasised the significance of the counselling role in mental health nursing, stating that this should be the primary role to be undertaken by these nurses. Peplau cited by Forchuk (1993: 16) stated:

*'If (nurses) are unable to contribute in a truly corrective manner to the care of mental patients, the traditional nurse-patient relationship will be usurped by those who can; and nurses will be shunted into glorified custodian or superclerk.'*

The counselling role, whether individual counselling, group work, community development or family systems nursing; must be valued as the prime vehicle for the development of the nurse-patient relationship. Within each of these modes, the nurse-patient relationship develops in overlapping phases, and

the concepts of verbal and non-verbal communication, pattern integrations and nursing roles apply.

To summarise, Peplau's theory of interpersonal relations consists of many interrelated constructs, formulated to explain the complex nature of the nurse-patient relationship. The theory claims to illuminate the work that nurses do with patients, assisting in personal growth and understanding in both nurse and patient (Peplau, 1992). But how does this claim stand up in current mental health nursing practice? And what relevance does the model have for research and education?

### *Critique of model*

Four criteria for evaluation are identified by Howk (2002): simplicity, generality, empirical precision and derivable consequences. Each is considered in brief.

A key strength of Peplau's theory is that its main focus, interpersonal relations between nurse and patient, is easily understood (Howk, 2002). Key concepts and basic assumptions are clearly defined in simple terms. Relationships of the interpersonal process, nurse, and patient are developed and explained in an understandable way, and meet the evaluative criterion of simplicity. The four phases of the interpersonal process depict a logical progression of the nurse-patient relationship (Reed, 1996). These are consistent with basic individual learning principles such as learning to trust, setting realistic limits, gaining self-identity, validating oneself, and participating in a community. To what extent these may be applied in the context of acute mental health inpatient setting is debatable, and this is discussed later in the discussion chapter of the thesis.

A second evaluative criterion is generality (Howk, 2002). Whilst Peplau believed that her theory of interpersonal relations met this criterion, Howk highlights that a nurse-patient interpersonal relationship must exist for this to be so. This may not always be the case in nursing, for example when working with a challenging patient who does not wish to form a relationship with the nurse. Here, the nurse-patient relationship is often one-sided, the

nurse and patient being unable to work together to become more knowledgeable, develop goals and mature. As understanding of the meaning of the experience to the patient is necessary for nursing to function as an educative, therapeutic, maturing force, Peplau's theory may not be applied to all patients, therefore the evaluative criterion of generality cannot always be met.

A third evaluative criterion is empirical precision (Howk, 2002). Peplau's theory is based on reality, based on observations in practice. She operationally defined the four phases of the interpersonal process, and nursing and patient roles. Behaviours are related to theory by naming and categorising, operationalising definitions of these behaviours, and diagnosing problems and principles that guide nursing actions. Howk suggests that Peplau's theory can therefore be considered empirically precise, though the degree of precision will increase with further research and development. The extent to which the four phases of the interpersonal process, and nursing and patient roles are relevant for current nursing practice in the context of acute mental health inpatient setting is debatable, and this is considered later in the discussion chapter of the thesis.

Finally, the fourth criterion, of derivable consequences, requires attention. Peplau's theory of nursing was one of the first to be developed since Nightingale (Howk, 2002). Her work is considered pioneering, particularly in the mental health nursing field, where a meaningful method of self-directed practice is provided at a time when the health care field is medically dominated. Peplau was committed to theory-based nursing practice at a time when theory development was relatively unknown, and reductionist conceptualisations were commonplace (Reed, 1996). The model was developed at a time when people seeking health care were viewed in terms of illness, rather than their inherent potentialities. Peplau's model offers an open, interactive view of the person, whose nursing focus is on transformation of the individual rather than reduction to specific problems. She advocated treating patients as participants, and appealed for dynamic rather than mechanistic approaches to patients. This is a major strength of



the model. Since its publication some six decades ago in 1952, it continues to provide direction for nursing practice, and has provided a significant contribution to nursing's knowledge base. The evaluative criterion of derivable consequences is therefore met.

Further key theorists who may influence the nature and quality of current mental health nursing practice in acute mental health inpatient settings are discussed next.

### **Annie Altschul**

Altschul was regarded by many as British psychiatric nursing's first leader (Barker, 2002). She advocated for nurses to care, to bond emotionally with patients in distress in acute psychiatric care. She was critical of the general care and treatment received by patients in the acute inpatient setting, rather than specialist interventions afforded to some people with mental health problems in the community.

Altschul's (1972) text on British psychiatric nursing, based on empirical research undertaken in a Scottish psychiatric hospital, cited Peplau in proposing that the therapeutic relationship lay at the core of psychiatric nursing. Altschul constructed the distinction between 'common sense' and an 'identifiable perspective' in nurse-patient interactions. The latter was concerned with an apparent lack of a recognisable body of knowledge to support accountable British nursing practice. Altschul concluded that nurses' practice was '... essentially a nonprofessional kind of practice; depending on personal aptitude rather than on application of a body of knowledge by reference to explicit principles' (Altschul, 1972: 139). Later, Altschul (1997) articulated that the aim of psychiatric nursing was to try to get to know the patient. She highlighted the knowledge base which may be useful for practice:

*'It seems important that psychiatric nurses should be familiar with the symptomatology of psychiatric disorder, with psychopathology and with medical views about treatment of psychiatric disorder. Some knowledge about mental health nursing is also necessary. Without such knowledge, psychiatric nurses would fail to understand psychiatrists and other workers, would be unable to report to them*

*and to contribute constructively to multidisciplinary therapeutic teamwork. It is particularly important that they should understand the medical model of mental illness, as they are responsible for administering drugs, monitoring their effect, reporting to medical staff, and influencing prescribing.'*

*(Altschul, 1997: 8-9)*

Altschul suggested that it may not be useful for nurses to base their own approach on the medical model, as they are not primarily concerned, as psychiatrists are, with medical diagnosis and treatment. Rather, nurses should focus on the patient experience, with a view to understanding their mental health problems, to assist them to cope and restructure their lives. This appears to parallel Peplau's theory, but contributes further concepts regarding multidisciplinary team working, which are relevant to the roles of nurses in acute inpatient care.

Nolan (1999) asserts that many mental health nurses no longer feel that theirs is a caring role, but a policing role to manage people deemed 'at risk'. This lends weight to the argument that Peplau's model may remain of central relevance today in the acute inpatient setting. Whilst some may argue that Altschul's caring focus in nurse-patient relationships belongs to a bygone age, Nolan supports the view that mental health nursing should remain the compassionate face of science, its practitioners living in the real world, helping real patients with their problems.

### **Sidney Jourard**

Canadian psychologist Jourard, developed a Self-Disclosure Theory (Jourard, 1971); a therapeutic model of humanistic treatment where total disclosure was encouraged between the client and the therapist. Drawing upon psychological theories, the therapist discloses self to the client who is encouraged to reciprocate. Such disclosure is aimed at promoting openness and enthusiasm to the client, to develop their personal and social growth.

Jourard regarded an individual's healthy personality as an authentic self, open to change, relaxed and self-aware (Jourard and Landsman, 1980). In contrast, an individual with an unhealthy personality is someone who lacks

self-awareness and struggles to become truly known to at least one other person, and may actively avoid doing so. Jourard believed that self-disclosure was an important means of growth for the individual, and that it lay on a continuum. Those with a healthy personality are able to discern appropriate actions and behaviours, whilst those with an unhealthy personality characterised by self-concealment, led to general malaise and disease. Participation in self-disclosure is said to create conscious awareness, which helps the individual and the therapist begin to understand the concerns of the individual and the contributing factors to their circumstances.

Jourard promoted dialogue between people as an appropriate way to be between human beings, to facilitate growth in competence, self-sufficiency and self-esteem (Jourard, 1971). People need to be heard to validate their voice and themselves as a person, and language is a means to share and experience other perspectives of the world, which may alter one's own experience.

Jourard (Jourard and Landsman, 1980) claimed that we feel comfortable staying within our roles, but these may be characterised by a false self to which the individual may not be self-aware. Individual roles are often influenced by wider societal roles into which we may be locked at the expense of self-experience and awareness. The therapist seeks to challenge these societal roles, raising the individual's level of consciousness, in an attempt to open them to consider their potential and other possibilities. Therapy is focussed on helping the individual to find their voice, to become more self-aware, to become an authentic self, liberated from the rules and roles which do not reflect who they are as an individual.

In a mental health nursing context, self-disclosure on the part of the nurse needs to be appropriate for each specific patient. To self-disclose too much personal information may lead to the nurse appearing selfish and self-centred. Appropriate self-disclosure may enable the nurse to be seen as a human being, with faults, strengths and emotions; and open communication may help relationships improve. This appears to echo Peplau's view about

reciprocity. Jourard (1971) asked the question as to how the professional helper should grow beyond mastery of technical aspects of their nursing profession. He believed that professional training encouraged dehumanisation of the individual, to wear a professional mask, limiting their behaviours to a range that proclaimed professional status. Patients are exposed to dehumanised, dehumanising 'experts' who may not relate to them on a human level. Jourard believed that illness occurs when a person's life begins to lose meaning, a sense of future and love. When relationships are impersonal, people lose hope and sickness develops.

Jourard (1971) suggested ways in which the nurse may become 're-humanised' to interact in a helping manner with patients. He suggested that nurses may inspire faith and hope by direct contact with patients, to demonstrate a conviction of caring towards them. If true, the quality of the nurse-patient relationship may be a significant factor in the patient's recovery. Direct patient contact may foster a sense of hope that the patient is a worthwhile person, and sincere attempts on the part of the nurse to come to know and understand the patient may enhance their sense of identity and integrity. Contempt, indifference, insincerity and impersonal relationships on the other hand may lead to patients feeling dehumanised and devalued.

Jourard (1971) recommends that nurses strive to learn each patient's 'self' through skilled use of self-disclosure and effective evaluation of patients' self-disclosure to them. He asks to what extent nurses and other health professionals are competent and capable of behaving at an authentic 'real self' level with one another, as well as with patients in their care. Finally, he asks to what extent disclosure data is valued and recorded as a basis for future helpful actions. The extent to which nurses in acute mental health inpatient settings may achieve these actions is discussed later in the findings and discussion chapters.

### **Carl Rogers**

Rogers was an American psychologist who developed person-centred therapy (Thorne, 2003). His theory (Rogers, 1951) suggested that all people

exist in a continually changing world of experience to which they react. The structure of the self is formed as a result of interaction with the environment, particularly with others. In developing self concept, Rogers believed that those experiencing unconditional positive regard had opportunity to fully self-actualise, fulfilling their potential, whilst those who experience conditional positive regard feel worthy only when the conditions laid down by others are met. The 'ideal self' founded in the actualising tendency requires positive regard, whilst the 'real self' develops as a consequence of living with conditions of worth imposed by individuals and society. Rogers believed that individuals must be in a state of congruence if they are to achieve self-actualisation. He maintained that the main determinant of an individual's potential to self-actualise is childhood experience.

The humanistic approach suggests that self-concept comprises three components: self-worth, self-image and ideal self (Vincent, 2005). Rogers believed that feelings of self-worth, what we think about ourselves, developed in early childhood during interactions between the child and the parent(s). Interactions with significant others in adult life later may also influence our feelings of self-worth. Self-image, how we see ourselves, involves the influence of our body image on our inner personality, and affects how we feel and behave in the world. Ideal self, who the individual would like to be, consists of the individual's goals and ambitions, which are dynamic and ever changing throughout childhood and adulthood.

Rogers referred to the gap between 'real self' (who the individual is) and 'ideal self' (who the individual would like to be) as incongruity. Incongruent individuals are unable to realise their potential, and lead their lives according to conditions imposed around them (Thorne, 2003). Rogers maintained that incongruent individuals are unable to function ideally, and may feel under constant threat, causing them to employ defence mechanisms, as they strive to maintain and protect their self-concept. If the individual's situation worsens, their defence mechanisms may become ineffective, leading to a disorganised and bizarre personality and irrational behaviour.

Rogarian counselling involves a process of helping the client take responsibility for themselves, to remove barriers experienced in their life, to promote growth and development. The client is then able to become more independent and self-directed in their life. Rogers identified three core conditions that promote therapeutic growth: congruence, acceptance, and empathy (Thorne, 2003). The counselling process requires the counsellor to be congruent, demonstrating an ability to be completely genuine with the client within the counselling relationship. This involves unconditional positive regard (acceptance) and empathic understanding (being listened to and understood) for the client.

Rogers believed that all people have the inner resources to improve their situation, once they accept and respect themselves. The approach focuses on the individual as they experience the world, placing attention on the concept of self, to address issues inflicted in childhood (Thorne, 2003). The theory suggests that all people have potential to achieve full functioning, but on a practical level, this may not be realistic for many. Specifically, in people who experience enduring mental health problems, Rogers theory does not acknowledge that other major biological factors are likely to impact on the individual (Gournay, 1996), which may not be readily addressed using this approach. The clinical applicability of this approach in the acute inpatient mental health setting may be limited, as patients there may not have the cognitive ability to engage in counselling during an acute mental health crisis. Time constraints placed on nurses for one-to-one time with patients, together with increasingly short length of inpatient stay, are factors which may challenge the application of this approach. These factors are considered in the discussion chapter. Person-centred counselling approaches may be more suited to understanding personality and human relationships in counselling and psychotherapy with clients with the cognitive ability to engage in the process.

Howard (2001) argues that Rogarian counselling is flawed in that the focus on humans as childlike beings does not acknowledge the impact of the realities of society on the individual. Howard suggests that humanistic

approaches are naive as society is materialistic and individualistic, focussing on 'survival of the fittest', rather than serving the best interests of humanity. Bach and Grant (2011) caution us against a simplistic understanding and practice of Rogerian principles. Instead, they argue for interpersonal communication in context, reflecting the differences in organisational power and status between the communicators. Whilst Roger's core conditions are necessary for good psychotherapeutic relationships, they are not in themselves sufficient to help individuals with mental health problems make changes in themselves and in their lives (Thwaites and Bennett-Levy, 2007). Whilst the formal practice of Rogerian counselling may not be appropriate or practicable in the acute inpatient setting, the core principles of congruence, acceptance and empathy may be relevant for the purpose of developing effective relationships with patients there. Again, these principles fit well with both Peplau's and Altschul's contributions to nursing theory.

### **Gerard Egan**

Egan (2007) developed the Skilled Helper Model, providing a structured, solution-focussed basis for counsellors to help clients solve problems and develop opportunities. This three stage model consists of specific skills the counsellor uses to help the client move forward. This approach assists the counsellor to adopt a structured, consistent approach to their work. The goal is to help the client to manage their problems more effectively, to help them help themselves in their everyday lives. It is most suited to working on current or recent past issues.

The values that drive the helping relationship include genuineness, respect, and empathy, which closely relate to Roger's core conditions (Rogers, 1967). The Skilled Helper Model encourages clients to become active interpreters of their world, giving meaning to events, situations, and challenges they are facing, with a view to developing problem-solving strategies, new goals and opportunities. This involves the development of skills and knowledge on the part of the client to address current and future problems, learned through the development of a therapeutic alliance between counsellor and client, based on collaboration, warmth and acceptance. This approach aims to develop in

clients problem-solving skills, building on their inner strengths, utilising external resources and support (Egan, 2007). Again, this appears to reflect elements of Peplau's theory discussed previously.

Egan's model aims to help the client address three key questions in three key stages:

1. *Exploring the client's existing situation - What is going on?* The client is able to tell their story in their own way, to be heard and understood by the counsellor. They are helped to see the wider picture, and to find a point from which to move forward with hope.
2. *Helping the client establish aims and goals - What do I want instead?* This question focuses on where the client would like to be, turning their problems into possible opportunities. The counsellor focuses on motivating the client towards hopeful goals for the future.
3. *Helping the client to develop strategies - How might I get to what I want?* The client is encouraged to consider what might help and hinder them making changes to move towards these future goals, and to consider possible strategies and actions for getting started.

The focus of the model is to keep the client's agenda central to the discussion, to move towards producing an action plan to meet their goals.

Egan (2007) developed the acronym SOLER to promote active listening skills for visibly tuning in to clients. This framework should be applied sensitively, taking care to be sensitive to clients' cultural differences. SOLER stands for S: face the client *squarely*; O: adopt an *open* posture; L: remember it is possible at times to *lean* towards the other; E: maintain good eye contact; and R: try to be relatively *relaxed* or natural in these behaviours. These basic non-verbal communication skills are intended to convey a sense of caring, empathy and involvement when communicating with clients. This places emphasis on the power of non-verbal communication, which when incongruent with verbal communication, tends to be believed by the patient in such circumstances (Forchuk, 1993).

Egan's Skilled Helper Model is promoted as a helpful framework for nursing practice (Bach and Grant, 2011). Its application in the acute mental health inpatient setting will be considered in the findings and discussion chapters.



## **Carl Jung**

Swiss psychiatrist Jung, founded analytical psychology (Jung and Storr, 1983). He is known for his research in the field of dream analysis and symbolisation. A central concept to analytical psychology is individuation, a psychological process of integrating the opposites, including the conscious with the unconscious, whilst maintaining their relative autonomy. His theories included the concepts of introversion and extraversion, the complex, the collective unconsciousness, and synchronicity.

Jung advocated that self-knowledge was an essential component for personal and societal transformation (Jung and Storr, 1983). Jung considered that the human psyche was made up of three parts: the ego, the personal unconsciousness, and the collective unconsciousness. The ego is identified with the conscious mind. The personal unconscious includes anything not presently conscious. The collective unconscious is the reservoir of human experiences we are born with as a species. Jung asserted that the collective unconscious influences all human experiences and behaviours, particularly in respect of emotions, but that individuals can never be directly conscious of it.

From his troubled childhood experiences and his work as a psychiatrist with people diagnosed with schizophrenia, Jung developed his thinking about levels of consciousness and archetypal patterning of emotional life, the meaning of symptoms, and the effect of different personality types on the interpretation of experience (Dunne, 2000). Jung emphasised the importance of assisting patients within a therapeutic relationship to find their own solutions to contradictions of their nature and circumstances. Jung viewed the 'sick mind' as an expression of unconscious knowledge of what is needed in order to recover a healthy balance in the imagery of its symptoms and dreams. Jung described the generation of schizophrenia's hallucinations and delusional system as the intrusion of night-time dream states into the waking consciousness (Dixon, 2005). Strongly repressed aggressive impulses instate a tear in the ego, creating a dream-world for the patient as ego defences are overwhelmed. This theoretical stance closely

relates to Freud's work in *The Interpretation of Dreams* (Freud, 1976), where Freud distinguishes between primary and secondary process thinking (discussed briefly below).

Jung developed his work on psychological types, dividing people into two modes of reacting to circumstances, each with differing attitudes to life: introverts and extraverts (Fordham, 1966). The introverted attitude is characterised by one of withdrawal, an inward flowing of libido, lacking in confidence in relation to others, tending to be unsociable, preferring reflection to activity. The extraverted attitude is characterised by an interest in events, an outward flowing of libido, in people and relationships with them, and a dependence on them. This type is motivated by outside factors and is sociable and confident in unfamiliar surroundings.

The application of analytical psychology within a counselling context requires specialist knowledge and skills. Whilst nurses may reflect upon the key concepts of introversion and extraversion in their everyday working practices, most would not have undertaken specialist training, so application of analytical psychology would be limited in a typical acute inpatient nursing context, as found in this study.

### **Sigmund Freud**

Freud (1993) developed his ideas of psychoanalytic theory through working with people with mental health problems. He asserted that personality had three structures: the id, the ego, and the superego. The id consists of instincts, is totally unconscious, and has no contact with reality. The ego develops in childhood, a new structure of personality in response to the demands and constraints of reality. The ego uses reasoning to make decisions. Both the id and ego have no moral compass, and do not take account of what may be right or wrong. It is the superego, referred to as our conscience, which takes account of what is right or wrong.

Freud believed that most important personality processes occur below our level of conscious awareness. The ego and the superego are partly conscious and partly unconscious, but the id is always unconscious. Freud

believed that the conflicting demands of the personality structures may lead to anxiety. The individual's ego may develop defence mechanisms to resolve conflict arising between its demands of reality, the desires of the id, and the constraints of the superego.

In *The Interpretation of Dreams* (Freud, 1976), Freud discusses primary and secondary process thinking to explain changes in thought pattern and schizophrenia. Primary process thinking, occurring in childhood, is characterised as overgeneralisation and the dreaming (hallucination) of desired objects or states of gratification. Memory, attention and judgement were believed to develop from conflicts arising between the immediate desire for gratification and the demands imposed on an individual by their environment. Dreaming and hallucinations were believed to be a return to primary process thinking. Secondary process thinking was believed to involve all the heritage of hierarchical relationships and abstractions acquired in developing towards adulthood.

Freud believed that sexuality was the cornerstone of emotional problems, the conflict between a person's sexual desires and society's prohibitions regarding sexuality, causing profound emotional problems requiring therapy (Dallos, 1996). Freud suggested that problems relate to a person's inability to resolve sexual differences within their family. The central concept of the Oedipus and Electra triangle suggested that the ambivalent feelings of desire, guilt and anger may arise in a young child through antagonism towards the same sex parent and sexual feelings for their opposite parent.

The practice of therapy places emphasis on the therapeutic relationship and transference (Dallos, 1996). Feelings carried over from early relationships, particularly parents, were seen to be inevitably transferred to the therapist by the patient. The focus of therapy involved working through these feelings with the patient, strengthening their ego by raising their awareness, and sense of control of them.

Again, the application of psychodynamic theory within a counselling context requires specialist knowledge and skills, which most nurses working in the

acute inpatient setting would not have. Without having undertaken such specialist training, nurses' application of psychodynamic theory would be limited in an acute inpatient nursing practice setting.

The relevance of these theoretical contributions for nursing practice in acute mental health inpatient settings is discussed later in the discussion chapter of the thesis.

## **2.3 MENTAL HEALTH POLICY AND SERVICE PROVISION**

Contemporary mental health acute inpatient service provision has been shaped by the current and historical context of mental health policy. This study seeks to understand registered mental nurses' experiences of nurse-patient relationships from their own perspectives, generating multiple themes which need to be understood within the context of national policy development and models of service provision. This begins with a short review of the asylum era before considering the impact of the First World War, the dawn of the National Health Service, key policy developments relating to community care, and more recently, successive government priorities leading to the 1990s and to the present.

### **The rise of the asylums**

Throughout history, 'madness' tended to be seen as a domestic responsibility, for family and friends to intervene (Lester and Glasby, 2010). It was not until the end of the Middle Ages that people with mental illness began to be separated from society, to be managed and cared for away from their families. Reaching back to St Mary House of Bethlehem, known as Bethlam, established in London in 1377, rudimentary treatments including chaining patients in leg irons, ducking them in water, and whipping them, were treatments of the day. Inmates were seen as a source of amusement to the public, who could pay to view patients placed in cages on the hospital's galleries.

It was not until the late 18<sup>th</sup> Century that formal provision began to grow rapidly, through the provision of private madhouses. Responsibility for

licensing London's madhouses, by the Royal College of Physicians, was introduced through the 1774 Madhouses Act (Roberts, 2011). The number of establishments rose from 16 metropolitan licensed houses in 1774, to 40 in 1819 (Rogers and Pilgrim, 2001). By 1800, about 5000 people were housed in a mixed economy of private asylums, state run county asylums, and workhouses (Lester and Glasby, 2010). Thus began an era of the confinement of lunacy. People with mental illness were increasingly managed and segregated in centralised asylums.

The 19<sup>th</sup> Century saw a continued rise in the number of people admitted to the asylums, possibly reflecting increased state intervention generally in dealing with social problems through new legislation, including the 1834 Poor Law Act, the 1833/1844 Factory Acts, the Mines Act 1842, and the Public Health Act 1848 (Rogers and Pilgrim, 2001). The underlying reasons for the rapid rise of the asylums are complex. Murphy (1991) suggests that a new social conscience emerged at this time, in response to the human misery caused by an increasingly industrialised, urbanised society. This led to the development of charitable institutions, offering gentle but firm treatments to heal the mentally insane, as an alternative to their exploitation in the workhouses, which some regarded as a dumping ground for those unable to cope and contribute to the political economy (Scull, 2005). These social pressures may also support a widely held theory prevalent at the time, of an increased rate of mental illness, notably schizophrenia (Lester and Glasby, 2010).

The 1845 Lunatics Act required the construction of a network of publicly owned county asylums, aspiring to provide moral therapy and non-restraint, but as numbers of inpatients increased, they became warehouses for the unwanted (Lester and Glasby, 2010). By the end of the 19<sup>th</sup> Century, many asylums housed 1000 inmates, with some up to 2000 (Rogers and Pilgrim, 2001). Inmates in all public asylums were required to be legally certified. Poor quality, low paid attendant staff managed inmates through custodial rather than therapeutic practices, including regimentation, imposed routine, mechanical restraint and dependence. The legal certification of inmates was

seen to encourage early admission and prevent discharge, and caused public concern. The 1890 Lunacy Act was then introduced to protect the civil rights of the general public outside the asylum against wrongful certification and detention, but detention remained rife at the turn of the century (Rogers and Pilgrim, 2001).

### **Impact of the First World War**

The containment of pauper mentally ill and a biological emphasis dominated late Victorian psychiatry (Rogers and Pilgrim, 2001). Mental abnormality was assumed to arise through faulty brains, product of a faulty heredity, or criminality (Marshall, 1990). This view was challenged during and immediately after the First World War, when 7-10% of officers and 3-4% of other ranks suffered breakdowns through shellshock (Stone, 1985). During this time, industrial output at home doubled as a female labour workforce replaced men in the factories. This led to industrial fatigue and psychosomatic conditions in the workforce, including anxiety reactions, miscarriages and exhaustion (Hearnshaw 1964 cited by Rogers and Pilgrim 2001). These factors challenged the prevailing eugenic view of mental illness as illogical, and possibly treasonable (Stone, 1985). A relative boom in outpatient facilities followed, offering new psychological techniques, mainly dealing with thousands of ex-soldiers suffering the effects of shellshock (Coppock and Hopton, 2000).

A Royal Commission on Lunacy and Mental Disorder, the Macmillan Commission, was instigated in 1924, in response to growing public sensitivities about mental distress among all class backgrounds, and their concerns about wrongful detention (Rogers and Pilgrim, 2001). The Commission reported in 1926, and among its findings, it concluded that both mental illness and physical illness should be seen as overlapping, not distinct; that mental illness had physical concomitants, and vice versa; and that there were many cases where it was difficult to identify whether mental or physical symptoms predominated. This approach firmly placed the medical profession at centre stage, psychiatrists maintaining authority to

deprive individual liberty without trial, and the need to use force to treat mental illness.

The 1930 Mental Treatment Act legislated for local authorities to develop outpatient facilities for the voluntary treatment of those with mental illness, at a time when only 7% of admissions were voluntary (Leff, 1997). No new monies were centrally allocated to support implementation of these changes, and this became a common theme emerging in later developments in mental health care.

### **Dawn of the National Health Service**

Despite the dominance of hospital-based somatic psychiatry, the onset of the Second World War challenged this standpoint (Rogers and Pilgrim, 2001). Concerns over armed service selection, training, morale and rehabilitation from stress reactions, favoured psychological rather than somatic methods of treatment there. Structural changes in health care organisation took place in response to the Local Government Act 1929, ending the Poor Law, and leading to workhouses and infirmaries being placed under the administration of public assistance committees. This facilitated the development of local authority hospitals, to provide accommodation for sick people, a responsibility of the public assistance committees, and adding to existing provision through the asylums.

The National Insurance Act of 1911 entitled working men to free health care, and contributed to debates over possibilities for a free National Health Service for all (Lester and Glasby, 2010). This, together with the success of an Emergency Medical Service set up to coordinate the work of public and voluntary hospitals during the Second World War, highlighted uneven standards of care (Rogers and Pilgrim, 2001). The quality of care in hospitals was formally scrutinised in a series of regional surveys by the Nuffield Provincial Hospital Trust working closely with the Ministry of Health. Their findings revealed concerns over organisational inefficiencies, inadequate and inconsistent funding, and variable standards of care. The Beveridge Report (Beveridge, 1942) on Social Insurance and Allied Insurance, consolidated these concerns. The formation of a National Health

Service (NHS) was proposed, paid for mainly through taxation, and free to all at point of use (Webster, 2002).

The NHS came into being in July 1948, and assumed responsibility for mental health care from the county councils and boroughs. Interestingly, although shortcomings in mental health provision were acknowledged, their organisation was not scrutinised at the time of the Nuffield regional surveys (Rogers and Pilgrim, 2001). A case was made by the then Hospital Board of Control to exclude mental health provision in the asylums, on the basis that a more ambitious review would be required on the scale of a Royal Commission. Inequalities between mental health and non-mental health services were not addressed, and by the 1950s, mental health and mental deficiency hospital provision (the terminology of the day), remained overcrowded and underfunded. These facilities provided 40% of NHS inpatient beds but were allocated only 20% of the hospitals budget (Goodwin, 1997). This trend for underfunding of mental health services continued in later decades.

### **Community care policy developments**

By the late 1950s, some progress had been made in the development of community care services, rising from almost no outpatient clinic attendances in 1930 to 144,000 in 1959 (Lester and Glasby, 2010). The Royal Commission on Mental Illness and Mental Deficiency (1954-1957), known as the Percy Commission, highlighted the need to develop more community-based care and treatment, but hospital-based approaches still dominated. The report uncritically supported a medicalised approach to mental illness. Psychiatrists were given authority to identify cases of mental illness with a presumption of the need for treatment, even if individual loss of liberty followed (Rogers and Pilgrim, 2001). The integrity of the medical profession was beyond doubt, and the treatment offered was accepted as effective. This uncritical acceptance of the medicalisation of complex mental issues, and the loss of individual civil liberties, had already been seen in the 1926 Macmillan Commission, and was to follow in the 1983 Mental Health Act.



The Percy Commission recommended the development of local authority community services, including hostels, day care, social work support, and sheltered employment schemes (Lester and Glasby, 2010). These services were intended to provide support for people with mental illness, to receive treatment in the community, and to promote patient discharges from hospitals more quickly than in the past. The Mental Health Act 1959 did not fully support these recommendations, as local authorities were invited, rather than required, to produce community care plans. Again, no new money was made available for this purpose.

A Hospital Plan for England and Wales (1962) proposed the development of small scale psychiatric units within district general hospitals, which were envisaged to shift the provision of mental treatment from the institutions to the community (Lester and Glasby, 2010). Local authorities were to provide a full range of support for people with mental illness in their own homes, but financial pressures continued to undermine this aspiration. The shift in focus from the institutions to the community was successful to some extent, in that numbers of people in mental hospitals fell from 160,000 in 1954, to 100,000 in 1974. However, Grove (1994) highlights that whilst poor conditions in hospitals had been criticised, many patients may have experienced worse conditions in the community following mental hospital closures. This position was to be repeated in the 1990s, during further moves towards care in the community.

The factors contributing to mental hospital closures and increased care in the community were complex. These included the development of antipsychotic medications in the late 1950s and moves towards social psychiatry in the community (Goodwin, 1997). There may have been more readiness of the general public to adopt more tolerant attitudes towards people with mental illness, in the context of the emergence of anti-psychiatry and the civil rights movement. Scull (1977) argues that the need to contain financial pressures of the welfare state may have favoured community care over hospital care, as this was erroneously perceived as a less expensive option for mental health provision. The range of common mental health problems classified by

psychiatrists as mental illnesses throughout the 20<sup>th</sup> century also expanded, requiring medical treatment and increased demand for community services (Goodwin, 1997).

The need for the development of more community based services, supported with appropriate financial investment, was recognised in the 1975 White Paper Better Services for the Mentally Ill (Department of Health, 1975). Joint planning and partnership working between health and local authority services was advocated to address mental illness, which was acknowledged as a major health and social problem which required more day hospital services and treatment and support at home, from staff with better training to meet peoples' needs. The economic constraints of the country in the mid-1970s led to a lack of funds being made available by the Labour government to properly implement these community care proposals, a theme which was to emerge again in future years (Busfield, 1996).

#### **Government change: Conservatism**

May 1979 saw a change in government from Labour to Conservative, led by Prime Minister Margaret Thatcher, whose policies and principles became known as Thatcherism (Leach et al., 2011). Their ideals included financial discipline, firm control over financial expenditure, privatisation, free markets, and tax cuts. The National Health Service at this time saw increased demands from advances in medical technology and an aging population, together with growing patient expectations for increasingly advanced treatment (Bloor and Maynard, 1994).

In 1983, an NHS Management Inquiry Report, known as the Griffiths Report (Department of Health and Social Security, 1983), highlighted an absence of general management support, and recommended that consensus management should be replaced with general management at all levels. Throughout the 1980s, the government systematically challenged the authority and power of professionals, including psychiatrists and other mental health professionals in health and local government, and imposed strict local spending limits on them (Rogers and Pilgrim, 2001). Public services were systematically converted into business-like organisations. Tight financial

controls over public spending, and taxation reduction, contributed to a cumulative shortfall in NHS hospital and community health service spending by 1988 of £1.8 billion since 1981-82 (Lester and Glasby, 2010). In light of this, the government made a further £101 million funding available, and began a Ministerial Review on the future of the NHS. In the context of a developing NHS funding crisis and increasing medical disquiet, drawing upon the ideas of American economist Enthoven (1985), the review focussed on how NHS resources could be used more efficiently. They concluded that responsibility for purchasing and providing services should be split to create a competitive internal market. The Conservative government introduced a new funding system in 1990, the purchaser-provider split, which saw an end to direct payments to hospitals/providers directly from the government. Instead, funding was allocated to NHS agents or managers with responsibility to selectively purchase care from hospitals, establishing the internal market in the NHS (British Medical Association, 2011). This move created competition between providers to sell their services, to encourage more cost effective services and greater efficiency (Lester and Glasby, 2010).

Continuing pressures for community care reform in the 1980s were highlighted by the Audit Commission (1986), who criticised lack of joint working between health and social care services. In response, Griffiths was commissioned to review the funding and organisation of community care (Griffiths Report, 1988). Among his recommendations, local authorities were to be given a lead role in community care provision to reduce confusion among agencies, and increased provision from the private and voluntary sectors was suggested.

Working for Patients White Paper (Department of Health, 1989) brought the Griffiths Report (1988) and the Ministerial Review together within the NHS. Despite strong protests from the medical profession and others, the government's timetable for implementation was largely achieved (Lester and Glasby, 2010). The NHS and Community Care Act (Department of Health, 1990b) became law in 1990, and was fully implemented by 1993. The focus

of the Act aimed to provide community services to support people living at home and elsewhere in the community for as long as possible, and also prioritised support for carers. The Act made local authorities responsible for community care, but no guaranteed funding was made available to implement these changes (Rogers and Pilgrim, 2001). Market principles were also introduced to health and welfare services, including purchasing from public and voluntary agencies. Health authorities assumed responsibility for purchasing healthcare, with NHS Trusts taking responsibility for service provision (Lester and Glasby, 2010). General Practice fundholders provided primary healthcare services as well as purchasing care for individuals and families.

Whilst the vision for services was ambitious, inefficient interagency collaboration between the NHS, social services, and the voluntary and private sectors; together with inadequate funding mechanisms between hospitals and community care, led to difficulties in implementing the changes (Bean and Mounser, 1993). Role confusion between health and social services, operating parallel but different methods of implementation, contributed to these difficulties. For example, within the NHS, The Care Programme Approach (Department of Health, 1990a) duplicated effort, contributed to increased bureaucracy, and presented barriers to joint working with the parallel social services led Care Management Approach (Department of Health, 1990a).

These difficulties were highlighted in the Richie Report (1994; Sharaf et al., 2009) following the tragic killing of Jonathan Zito by Christopher Clunis, who was known to services owing to severe mental health problems. The Report concluded that Clunis had no overall plan of care despite being known to health, social, and prison services over a period of five years. This and other high profile cases of people with severe mental health problems harming others, shifted the focus of the vision of mental health services from increased care provision in the community to fear of risk of harm to the general public by people with severe mental health problems (Lester and Glasby, 2010). The Richie Report (1994) concluded that public safety was

paramount over community service provision for people with serious mental health problems, despite evidence to the contrary that homicide rates among people with mental health problems was very small and was falling (Lester and Glasby, 2010). Supervised registers were introduced to identify and monitor people with serious mental health problems deemed to be a serious risk of committing serious harm to themselves or to others (NHS Executive, 1994). Supervised discharge orders were introduced, which gave clinicians power to specify where patients could live, what treatment they should receive, and the right of the clinician to enforce mental health assessment. These orders were rarely used in practice, and the requirement to maintain supervision registers was eventually removed in revised Care Programme Approach guidance (Department of Health, 1999a).

### **Government change: New Labour**

A change of government in 1997 saw New Labour vow to change and support the NHS. More emphasis was placed on partnership working between health and social care services (Department of Health, 1997; Department of Health, 1998b). Services were encouraged to focus on partnership across sectors, with consultation with service users, and the introduction of targets and performance monitoring to foster quality and continuous improvements in public services (Cabinet Office, 1999). A 'third way' philosophy of running the NHS, built on partnership working and driven by performance, was introduced (Department of Health, 1997). This new focus for the NHS gave a clear commitment to abolish the internal market, but retain the purchaser/provider split (Lester and Glasby, 2010).

Commissioning moved from health authorities and general practitioner fund holders to primary care groups, then later still to primary care trusts, with competition being replaced by partnership and collaboration between commissioners and providers.

## **Introduction of National Service Frameworks and monitoring**

Key monitoring mechanisms in health and social care were introduced to assess providers' performance against National Service Frameworks, the first being for mental health (Department of Health, 1999b). The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) were set up to develop and publish cost benefit analyses for specific technologies and pharmaceuticals, to identify best practice in health and social care services (Lester and Glasby, 2010). New bodies were created to monitor providers' performance: the Commission for Health Improvement (subsequently known as the Health Care Commission) and the Commission for Social Care Inspection. These were replaced in 2009 by the Care Quality Commission, which assumed responsibility for regulating health and social care in England.

Recommendations following publication of the Darzi Report (Department of Health, 2008) further developed this approach, emphasising a focus on health and well-being, personalised care and patient choice, within a broad context of improving quality, ensuring patient safety, and improving the effectiveness of care. Services were required by law to publish information about the quality of patient care, taking account of service users' views on success of treatment and quality of experiences. In parallel, the role of the independent sector in delivering services in the past decade was further strengthened by the government, to increase capacity, patient choice and service innovation (Department of Health, 2007b).

## **Modernising mental health services**

The White paper 'Modernising mental health services: safe, sound and supportive' (Department of Health, 1998a) provided a comprehensive statement of commitment to providing mental health services, including those for people with serious mental health problems. This identified the inclusion of access to services, and the development of assertive outreach and crisis intervention teams. A commitment of £700 million of new investment over three years was provided. The government pledged to recruit and train staff with the necessary skills and motivation to deliver modern mental health

services. Improved planning and commissioning of services was promised. Whilst this White paper was supportive of partnership working, there remained an underlying focus on public safety over the health needs of service users themselves (Lester and Glasby, 2010).

The National Service Framework for Mental Health (Department of Health, 1999b) set out a 10 year plan for the development and delivery of mental health services for working age adults. The plan included seven standards covering five areas of care: mental health promotion; primary care and access to services; effective services for people with severe mental illness; caring about carers; and prevention of suicide. This comprehensive mental health document was the first to set a common agenda for local agencies, its strengths including a mental health promotion focus, as well as addressing the needs of people with serious mental health problems including those in primary care. Its philosophy promoted social inclusion and access for people with mental health problems to the mainstream of health and social care services.

In its mid-term evaluation, mental health services for service users still reflected problems identified in previous decades, and services were acknowledged to have fallen short of expectations (Department of Health, 2004). Ten years on, assertive outreach and crisis resolution services had been developed (Care Services Improvement Partnership, 2008). However, inpatient mental health services were criticised for lack of individualised care provision to patients and poor support offered to families and carers (Healthcare Commission, 2008). Inpatient services maintained a focus on risk, protection and compulsion, at the expense of offering greater choice and control to service users themselves under the government's personalisation agenda.

Despite a plethora of reforms, the government's programme of reforms was initially unsupported with additional resources (Webster, 2002). Public criticism over the government's record on the NHS saw this change to allow 6.1% real terms growth from 2000 when the NHS Plan (Department of Health, 2000) re-launched the government's commitment to the NHS.

Mental health was announced as one of three clinical priorities. Additional funding to implement the National Service Framework for Mental Health (Department of Health, 1999b) was provided to deliver more services. These were to include additional mental health staff in primary and community care; the development of 50 early intervention teams; 335 crisis resolution teams; and an increase to 220 assertive outreach teams; among other changes. Whilst pledges were made for primary and community care developments, there was relatively little emphasis on acute inpatient services or mental health promotion (Lester and Glasby, 2010). Priebe et al (2005) argue that there was an overall emphasis on compulsion, even reinstitutionalisation, as funding was directed to forensic beds, involuntary hospital admissions, and proactive care for people traditionally seen to be difficult to engage in community services. The NHS Plan required a well-trained, motivated workforce to implement these changes, but this did not materialise (Lester and Glasby, 2010). Similarly, management expertise was insufficient to effectively lead and see these changes through (Department of Health, 2001) as mental health service provision moved to increased integration of health and social care and the creation of English specialist mental health Trusts. Later, it was acknowledged that there had been a 20% shortfall in funding required to fully deliver the National Service Framework for Mental Health (Parsonage, 2009).

Specific government guidance for adult acute inpatient care provision was published in 2002 (Department of Health, 2002a) to augment guidance already provided in the National Service Framework for Mental Health guidance (Department of Health, 1999b). The report was based on feedback from service users and carers, expert professional opinion, and recognised good practice. The report attempted to address criticisms of the physical, psychological and therapeutic care environment, and was intended to stimulate local service improvements. Whilst emphasis to date had been placed on the development of alternatives to admission, this report addressed opportunities to reduce pressure on inpatient wards, and to improve the physical environment with the specific funding already available. Key targets were to define the purpose and place of adult inpatient care



within the national policy context; to establish effective acute services coordination; to develop an effective service user centred focus; to address the need to enhance the role, status, training, support and career development of inpatient staff; to strengthen clinical leadership, organisation and management of inpatient services; to ensure adequate clinical and support inputs for staff therapeutic engagement with service users; and to promote more inclusive service user provision. Whilst these targets were well intentioned, their implementation was left as a matter for local services to consider.

### **Changes to Mental Health Act 1983**

Following concerns over public safety from people with serious mental health problems discussed above, an expert committee chaired by Richardson was set up to consider reform of the Mental Health Act 1983 (Department of Health, 1983). Richardson made recommendations on issues of capacity and reciprocity to safeguard patients' rights and appropriate service provision, but these were later overridden by the prevailing concerns of public safety in a first draft Mental Health Bill in 2002 (Lester and Glasby, 2010). Following considerable opposition to the proposed changes by a plethora of mental health organisations, the government decided not to proceed with the bill, but instead introduced amendments to the Mental Health Act 1983. The Mental Health Act 1983, as amended 2007 (Department of Health, 2007a) introduced key changes. These included introduction of a Responsible Clinician role, giving appropriately trained health professionals, including nurses and social workers, the right to assess and detain patients in hospital. The amended Act also made provision to place patients on compulsory community treatment orders on discharge from hospital, enabling supervised treatment in the community and the right for swift recall of patients to hospital without the need for formal recertification. Laurance (2003) argues that placing more emphasis on genuine engagement of service users with services, providing opportunities for them to take control of their care, would be more appropriate approach, given the government's agenda of partnership working, access and patient choice.

However, community treatment orders do require the agreement of the service user for their implementation.

### **Challenges of implementation of policy initiatives**

The development of mental health services, including acute inpatient services, has had mixed reviews (Lester and Glasby, 2010). A range of factors have contributed to this. Implementation is more likely to be successful when there are clear roles and responsibilities identified between services. However, in the preceding discussion, it is clear that there has been considerable overlap and role confusion among services in the statutory, voluntary and private sectors.

Manion et al (2003) suggest that strong organisational performance in the NHS requires strong leadership, clear lines of upward accountability, and a commitment to the development of staff; all of which appear to be lacking or insufficient. Leatherman and Sutherland (2003) argue that the extent to which policies may actually secure change in organisations in terms of their culture, role performance and quality, is relatively unknown and further research in this context is required. Difficulties in changing working practices may also be implemented within organisations and systems which themselves are in a constant state of change (Walshe et al., 2004).

Managers and staff working at a clinical level with patients may also struggle to keep pace with the ever changing demands and rapidity of new policy guidelines and initiatives (Means et al., 2008). In practice, policy directives filtered down from the Department of Health, through Strategic Health Authorities, Primary Care Trusts and Acute Trusts, may not lead to effective local change as relatively small failures in communication between organisations easily escalate, leading to implementation deficits (Lester and Glasby, 2010). That said, the modernisation agenda has and continues to exert a powerful influence within health and social care.

### **Summary**

Since the rise of the asylums in the 19<sup>th</sup> Century, a recurring theme in mental health care provision has been poor management and financial neglect.

Over the last two decades, there has been further movement towards the

development of mental health provision in the community. Whilst this has been welcomed, there have been tensions between meeting the needs of mental health service users in the community and the perceived risks they present to public safety; a consistent concern since the 1960s. Since 1998, with the introduction of the National Service Framework for Mental Health (Department of Health, 1999b), and later, the NHS Plan (Department of Health, 2000), there has been a definite change in political priorities towards mental health service provision and funding. However, confusion over roles and responsibilities between health and social care agencies, changing funding arrangements, poor management and limited staff preparation for new roles, and insufficient financial investment, have all challenged their successful implementation.

A central paradox remains between the promotion of service user involvement and partnership working, and better acute and community service provision, versus compulsory mental health treatment in hospitals (and now the community), coercion, and social exclusion by the community (Lester and Glasby, 2010). This presents challenges to policy makers, service providers, practitioners, and service users, to shape mental health services which truly reflect what is affordable, desirable, and practical for the workforce to deliver. Insights regarding the realities of inpatient service provision from both nursing and patient perspectives, drawn from empirical literature, follow.

## **2.4 THE NURSE-PATIENT RELATIONSHIP IN THE ADULT ACUTE INPATIENT MENTAL HEALTH SETTING**

This section reviews the literature concerning the nurse-patient relationship in the adult acute inpatient mental health setting. This provides a critical review of the realities of everyday working practices; patients' perspectives on the nurse patient relationship; and nurses' perspectives on the nurse-patient relationship.

## **Realities of everyday working practices**

Whittington and McLaughlin (2000) explored the proportion of work time psychiatric nurses spent in potentially psychotherapeutic one-to-one communication with patients. Using a specially developed observation instrument, the 'Nurses' Daily Recording System', a convenience sample of 20 staff nurses from three acute admission wards in a psychiatric hospital in Northern Ireland were observed. Less than half their working day (42.7%) was spent in patient contact, and the proportion of actual work time devoted to potential psychotherapeutic interaction was small (6.75%). Nurses spent about a third of their time either undertaking administrative tasks or talking to one another. Limitations of this study include the small sample size of psychiatric nurses working in one Northern Irish setting, and the possibility that the nurses' knowledge of being observed may have influenced their behaviour. The observation instrument requires validation in other facilities. In addition, this study does not reveal any of the nurses' own internal thoughts or concerns about their observed or recorded practices.

In an Australian study, Cleary et al (1999) undertook an exploratory investigation to consider what factors influenced nurse-patient interaction in the acute psychiatric setting. A random sample of 10 clinical nurses on one ward were interviewed through semi-structured interviews, to outline and describe the factors they perceived to facilitate and/or impede nurse-patient interaction. An interview guide, based on issues pertaining to nurse-patient interaction derived from the literature, was used. Issues included perceptions of both the quantity and quality of time spent interacting, factors likely to hinder interaction, and factors likely to facilitate interaction. Using thematic content analysis, six major themes emerged from interviews: environment, something always comes up, nurses' attributes, patient factors, instrumental support, and focus of nursing.

Positive aspects of the ward environment included quiet places to sit and talk. Ward programme activities were a major factor in encouraging nurse-patient interaction, but these were often sacrificed if the unit was busy, when admissions, close observations and unit safety were prioritised. Nurses 'kept

an eye out' for patients to maintain a safe environment, but the size of the unit could be problematic. Patients could get 'lost' or go unnoticed. Nurses could become frustrated when looking for patients, particularly when under close observation, and this was time consuming.

The unpredictable nature of acute inpatient care facilities was accepted by staff, 'something always comes up', and this led to a number of unplanned activities: admissions, discharges, transfers in, transfers out, assisting other staff, accompanying patients to appointments, providing assistance and support to other wards, and documentation requirements. High patient numbers cared for in each shift often resulted in less time being available for nurse-patient interactions.

Nurses' attributes were viewed as an important factor in influencing nurse-patient interactions. Being understanding and non-judgemental were positive attributes, when nurses were able to adopt a positive, fresh outlook, on each shift. This created a positive ward atmosphere. Nurses demonstrating supporting, helping, educating interactions towards colleagues facilitated positive nurse-patient interactions. Avoidance of patients sometimes occurred, possibly owing to nurses' lack of confidence, but positive interactions between colleagues was a useful way to support staff and address this.

Patient factors included acuity of illness. Patients with complex needs and newly admitted patients were perceived as having greatest need for nurse-patient interaction, to promote their wellbeing by offering encouragement, reassurance and education. All patients had a specified nurse to whom to direct their requests. This promoted continuity of care and opportunities for rapport building.

Instrumental support encompassed the unit's culture, nurses' competence and confidence, and was an important factor in influencing interactions. Emphasis was placed on promoting a positive shared team philosophy, valuing education, learning through colleagues, as well as attitudes of management which affected staff morale and motivation. Contact with

managers on a day-to-day basis was valued by staff, as they were seen to care and listen to staff's needs. There was a need to balance professional development activities with patient care, with emphasis on team work, reviewing clinical practice, and service delivery. It was noticed that attending education sessions as well as staff spending time together decreased opportunities for direct patient care, limiting nurse-patient interactions. However, these were seen as instrumental in building team morale and positively influencing nurse-patient interaction. Team working during morning meetings, handovers, and case review offered staff opportunities for sharing information, reviewing clinical practice and service delivery, and supervision. These too were seen as essential activities which positively influenced nurse-patient interactions.

Finally, the focus of nursing was an important factor. A primary/associate nurse allocation system implemented on the unit was enjoyed by staff as this helped nurses to 'get to know' their allocated patients and provided a sense of involvement and individual responsibility. Patients too knew to whom they should direct their concerns. Nurses acknowledged the importance of the interpersonal nurse-patient relationship, in terms of 'being there' for patients, and understanding, respecting, developing rapport, and building relationships with them. This could sometimes be difficult when staff were allocated patients with whom they had no rapport. Competing demands placed on staff could also inhibit nurse-patient interaction. These included answering phones, writing notes, administering medication, and writing documentation. Time constraints including short length of stay and the acute nature of the illness, impeded the development of therapeutic relationships and effective nurse-patient interactions.

Overall, Cleary et al conclude that their findings challenge existing models of nursing care delivery, in the unpredictable acute care environment. Mental health nursing faces numerous challenges in providing acute inpatient care. Nursing needs to be organised to be more responsive to the demands of the environment rather than be solely reactive. Whilst nurses are clearly working to promote positive nurse-patient interactions, the current structures which

may support this practice need to be reviewed. Limitations of this study include the small sample size of mental health nurses working in one Australian setting. Cleary et al's conclusion that their findings challenge existing models of nursing care could be strengthened through closer review of nursing theories.

In an Australian ethnographic study, Cleary (2004) subsequently explored how nurses constructed their practice within a 22-bed acute inpatient psychiatric unit. Fieldwork observations, discussion groups, and individual interviews, were conducted with 10 nurses over a five month period. Findings demonstrated how the current role of acute care services had led to nurses working in increasingly complex environments, characterised by competing priorities and new demands. Nurses struggled to fit traditional models of practice within the changing acute care environment. One central theme emerging was 'overwork'. Whilst nurses recognised their special contribution of coordinating 24 hour patient care, they expressed concerns about the workplace demands placed on them. This included accompanying patients for transfers, electroconvulsive therapy, and magistrate court hearings; managing challenging patient behaviours, including physical assault; communicating with the multidisciplinary team, and external agencies; and anticipating constant pressure to meet immediate, and/or unpredictable demands. Cleary found that whilst this left nurses feeling stressed and emotionally drained, nurses generally accepted the many additional non-nursing roles placed upon them, at the expense of time spent in direct patient contact. Findings are relevant to enhance the understanding of contemporary acute mental health nursing practice. Cleary concludes that the sense of challenge permeating mental health nursing is in part attributable to the complexities of changing acute inpatient mental health facilities, and that nurses may need to refocus their role within these environments. Limitations of this study include the small sample size of mental health nurses working in one Australian setting, and the possibility that the nurses' knowledge of being observed may have influenced their behaviour whilst the researcher 'buddied' nurses as they engaged in their usual daily practice activities. Cleary describes nurses struggling to spend

time in direct patient contact, which constitutes nursing, owing to the imposition of many additional 'non-nursing' roles. However, it could be argued that these 'non-nursing' roles are indeed legitimate roles for the nurse, and could be seen in this context.

In a large scale, mixed method study, commissioned by the Department of Health, Higgins et al (1999b), among their aims, investigated the activities undertaken by nurses whilst caring for patients across 11 participating fieldwork sites in Regional Health Authorities in England. Four rich and extensive data sets were collected: statistical profiles; qualified/unqualified staff (n=118) and patient (n=52) interviews; qualified/unqualified staff (n=110) and patient (n=51) questionnaires; and non-participant observations of three shifts across each fieldwork site. Non-participant observations of ward staff and patients were used to validate the interview findings to give an indication of what staff and patients might be involved in during a typical week.

Among their findings, Higgins et al (1999b) found that a significant number of staff had reported stress and had taken sick leave in response to work pressures. It was not uncommon for staff to come to work on their days off to cover for sick colleagues. There was a need for effective managerial and clinical supervision, but the latter appeared to be *ad hoc* and unplanned.

They reported that devolved management responsibilities to ward level was a particular problem for senior ward managers and charge nurses, whose work had shifted towards an administrative role. This has led to a marked decrease in senior nurses' direct involvement in patient care. Staff nurses reported difficulties in implementing coordinated, planned programmes of care for patients, responding instead to workplace demands and the most severely ill patients. Staff nurses also reported a marked increase in office duties at the expense of direct patient care. A culture of defensive practice was reported, further reinforcing the importance of maintaining accurate written records.

Nurses emphasised the importance of multidisciplinary working, and that they were central to care in acute settings. However, they reported spending



too much time 'chasing' other colleagues, particularly medical staff, whose presence on the ward was generally limited to the multidisciplinary team meeting. As a result, nurses reported insufficient time to spend in therapeutic engagement with patients. This further added to their pressures of work, their stress and sickness absence. This was a relatively large scale study, and the content of face-to-face interviews was limited in scope. Detailed interview schedules had been used by the researchers to focus discussions around staff activities which had a limiting and/or constraining effect. Nurses' knowledge of being observed by the researchers whilst engaging in their daily practice activities, may have influenced their behaviour. However, the close matching of 'observed' activities and those described at interview would suggest that any Hawthorne effect was probably small. Finally, postal surveys of Trust profiles, ward profiles and operational routines yielded a poor response, reducing the validity of the findings. This large scale study provides useful insights into the day-to-day realities of life in the acute inpatient adult psychiatric care setting. However, it does not allow space for nurses to tell their own stories about their experiences of their relationships with patients.

Clarke and Flanagan (2003) investigated nurse-patient interactions and the management of acute psychiatric inpatient wards across five NHS Trusts in South East England, reported a similar range of findings to Higgins et al (1999a). Data were gathered in 2000/2001 using semi-structured interviews, observations of nurse-patient interactions (n=40), and documentary analysis. Of the 40 interactions observed, 29 were recorded as crisis or reactive responses to unforeseen events, including patients presenting with 'nuisance' or disturbed behaviours. Whilst some nurses may become desensitised to such behaviours, so tolerating their negative impact on the ward environment and other patients, others were seen as needful of adopting avoidance behaviours by distancing themselves emotionally and physically from these patients expressing these behaviours, so as to maintain their own well-being.

Clarke and Flanagan reported that planned proactive interactions with patients were rare, suggesting that this was indicative of the pressures and demands placed on nurses to undertake other activities. Non-involvement with patients appeared almost characteristic of the wards for prolonged periods. Instead, nurses spent much of their time in the office, retrieving and communicating information, staff handovers, facilitating multidisciplinary team meetings, liaising with colleagues, and organising admissions and discharges. Staff reported general 'busyness', partly defined by levels of activity, including admissions, transfers, discharges, meetings, ward visitors, and routines; the acuity of the patient population, evidenced by patient numbers, noise, and disturbed behaviours; and administrative and housekeeping demands. 'Busyness' induced feelings of stress and pressure, contributing to staff sickness. Overall, the nursing focus seemed unclear in an often stressful, chaotic environment, prone to external pressures. A significant limitation of this study was that the researchers only reported the most consistently expressed views and concerns of the nurses involved at interview, stating that these needed to be represented fairly and comprehensively. Important views expressed by 'outliers' may therefore have been discounted. Interviews were semi-structured using seven questions, which further restricted the scope for exploration. Participant observations took place only on weekdays between nine and five o'clock, selected as the busiest times on the wards to capture when most professionals and ancillary staff were around. In doing so, the researchers may have excluded important 'quiet' periods during evenings and weekends, which would have likely offered opportunities for planned activities including nurse-patient interactions. Arguably, this could have contributed to different findings and conclusions drawn. As with Higgins et al (1999a), the Clarke and Flanagan (2003) study is not focussed on hearing the stories of nurses about their own experiences of their relationships with patients.

In a qualitative, descriptive, exploratory New Zealand study, Fourie et al (2005) explored 10 registered psychiatric nurses' perceptions of their roles within three selected wards in one acute inpatient unit of a large mental health service. Data were collected in two focus group interviews. Using

non-participant observation, the researchers compared these with the actual range of observed activities that these registered nurses engaged in over three rotating shifts. Using thematic analysis, key themes/roles were identified in which there was broad agreement between what was observed and what the nurses said they did. These were patient safety (observed)/risk management (described); therapeutic interventions (observed)/nurse-patient interaction (described); assessment (observed)/planning care (described); coordination (observed)/key facilitator (described); professional communications (observed) /advocacy (described); education (observed and described); staff supervision (observed)/ supervisor of standards of practice (described); and administrative tasks (observed)/administration and organisation (described). Interestingly, nurses were observed in many activities considered as therapeutic, including developing and maintaining supportive relationships, attending to patients' physical and emotional needs, and 'forced' contact, for example meal times and medication administration. Nurses themselves acknowledged that sustaining nurse-patient relationships was central to their daily practice, but that this was challenging in a busy inpatient unit. They perceived that patients often looked for increased contact time with nurses, seizing available opportunities such as 'forced' contact times. Nurses generally expressed their perceived inability to undertake their role adequately.

This study provides useful insights into nurses' roles in the acute inpatient setting, and suggests that nurses believe that organisational needs drive practice more so than do patients' needs. The researchers conclude that further research is required to inform practice that could explore how nurses remain patient-centred and therapeutic in this challenging environment. Study limitations include the small sample size of mental health nurses working in one New Zealand setting, and the possibility that the nurses' knowledge of being observed by the researcher whilst engaged in their daily practice activities, may have influenced their behaviour. However, the close matching of 'observed' and 'described' activities would suggest that any Hawthorne effect was probably small. This study focuses heavily on a broad

review of the nurse role, but does not reveal what nurses themselves think about their experiences of their relationships with patients.

In a British survey of inner city acute admission psychiatric nursing wards, Ryrie et al (1998) explored patient/non-patient contact activities with six qualified and two unqualified nursing staff. These participants were required to record their activities, for each 15 minute period whilst on morning or afternoon shifts, over seven days, according to four operationalised variables. These were specified as non-patient contact (handover, liaison, managerial responsibilities), reactive patient contact (unscheduled, unplanned), planned patient contact (admissions, group work, community meetings, patient meal times) and structured observations (special, close, continuous observations). Some qualitative detail was also recorded to specify activities.

Ryrie et al (1998) found that charge nurses spent 65% of their time in non-patient contact activities, mainly in management and liaison activities. They reported 15% of their time in reactive patient contact and 15% in planned patient contact activities. Charge nurses spent approximately 5% of their time in structured observations. Staff nurses spent 50% of their time in non-patient contact activities, mainly in management and liaison activities. They reported 15% of their time in reactive patient contact, and 30% in planned patient contact activities. As for charge nurses, staff nurses spent approximately 5% of their time in structured observations.

In contrast, unqualified nurses spent 34% of their time in non-patient contact activities. They reported 6% of their time in reactive patient contact, and 34% in planned patient contact activities. Unqualified nurses spent approximately 22% of their time in structured observations.

Whilst it is commendable that approximately 50% of staff time was available for direct patient contact, most of this care was delivered by junior staff. Senior ward staff had 20% or less time available for planned patient contact, as they were primarily engaged in non-patient contact activities, including coordination and administration which distanced them from patients. As

Gijbels (1995) argues, this seems to be at odds with a therapeutic focus to the role of nursing. Limitations of this study include the small sample size, possible insensitivity of the specified operational variables, and of each 15 minute interval, and the brief seven day survey period in which the study was conducted. There were also significant differences in time spent in some activities between wards which could be explored further. Findings may not be typical of ward practices and should therefore be interpreted cautiously. Reliability of the data cannot be assured.

Berg and Hallberg (2000) explored psychiatric nurses' lived experiences of working in inpatient care services, on a general team psychiatric ward in Sweden. Twenty-two nurses were interviewed using semi-structured questions, and transcribed texts analysed using latent content analysis. Three themes emerged: developing a working relationship with the patient in everyday caregiving; encountering and handling the unforeseeable in daily living; and struggling with professional independence and dependency.

Developing a working relationship with the patient in everyday caregiving meant that the nurse-patient relationship was seen as the foundation of caregiving. The most important thing in daily nursing care was said to be to establish and maintain meaningful nurse-patient relationships. Mutual trust and respect were said to be met by active listening and accessibility. This included being with, doing for, and doing with the patient. Four different approaches in everyday caregiving were identified: teaching, networking, containing and protecting. Teaching was characterised as instructing, training, structuring and encouraging patients to develop abilities to manage and cope with activities of daily living. Networking referred to arranging meetings and advocating for patients. Containing meant holding and carrying 'emotional tension' for patients, allowing the expression of feelings such as despair, anxiety, sorrow and anger. Protecting meant providing comfort and relief, including providing a peaceful environment and physical contact. Nurses' approaches alternated between being an 'expert' and a 'collaborator'. These findings resonate with Peplau's theory of interpersonal relations (Peplau, 1952), discussed previously.

Encountering and handling the unforeseeable in daily living meant that nurses were exposed to and had to be prepared for unpredictable situations on their own, handling sometimes strong emotional reactions and relying on their own abilities to decide how to react. Psychiatric nursing demanded a readiness to act, the nurse using their own skills as the main tool in everyday caregiving. Nurses had to meet challenging situations, acknowledging the uniqueness of each patient, and handle strong feelings including suicidal thoughts, powerlessness, sorrow and fear, emanating from themselves as well as patients. Patient encounters also meant encountering oneself, one's inner feelings and private, sometimes painful, experiences. This relates to Peplau's theory about the reciprocal nature of the nurse-patient relationship.

Struggling with professional independence and dependency involved nurses sometimes finding themselves in contradictory situations, with many professional responsibilities but limited opportunities to influence the overall care planning. Contextual aspects included organisational hindrance, unsatisfactory work environment, and cooperation difficulties. Study limitations include the small sample size of nurses working in one Swedish setting. Findings are therefore limited to the nurses studied, but may be transferable to contribute to the ongoing development and understanding of the nature of the nurse-patient relationship in acute psychiatric nursing care.

Findings may also contribute to the meaning of psychiatric nursing as well as the significance of the organisation of psychiatric care (Berg and Hallberg, 2000). Nursing care meant using different approaches to caring for the individual patient, whilst also dealing with acute and unpredictable situations with patients with a range of often complex mental health needs. The team organisation, as well as nurses' roles within teams, was unclear. The organisational structure and culture therefore influence the ways in which nurses function, and how the nature of the nurse-patient relationship should be interpreted within this context. Further research is needed to explore the context of adult, acute psychiatric inpatient services, multidisciplinary team organisation, nursing management and leadership, and nurse-patient collaboration within these contexts.

These studies provide some helping insights into the various roles of psychiatric nurses working in adult acute inpatient settings. Practice has shifted towards a more defensive mode of delivery (Fourie et al., 2005). Nurses have a key role to play in the development of psychotherapeutic ward environments, but such a role requires a system of ward management, appropriate skill mix, and a nursing resource which enables planned contact time between nurses and patients (Whittington and McLaughlin, 2000). From the studies reviewed, this seems to be a common challenge. Senior nurses' roles tend to focus on coordination and administration tasks, significantly reducing opportunities to undertake planned psychotherapeutic interventions with patients. This trend seems at odds with the espoused therapeutic role of nursing, but is a consequence of the current focus of the National Health Service which devolves managerial responsibilities to the lowest level. Increasing bed pressures, acuity of patients' needs, and pressure on nurses to meet demands for greater administrative duties appears to be shifting the nurse role away from direct patient care. Less experienced nurses may have more available time for planned patient contact, but may struggle to do so, given the emotional challenges they may face, which often arise. Ryrie et al (1998) argue that solutions should therefore be sought from within the nursing profession as well as the broader organisation. As Forchuk (1993) reminded us, Peplau cautioned against nurses allowing their professional roles to be usurped by non-nurses.

These studies are based on small samples in specific settings, and further research is therefore required to strengthen their findings, to enable confidence in transferring findings to similar contexts elsewhere.

The shift from hospital to community care has radically affected the nature of patient admissions to acute adult psychiatric care settings. High acuity and safety issues currently appear to be the main factors of acute admissions (Hummelvoll and Severinsson, 2001). Patients are admitted, often with complex needs, for shorter lengths of stay, yet planned time for therapeutic activities is often given second place to the immediate demands of managing the ward, and of the wider organisation (Whittington and McLaughlin, 2000).

The focus of mental health nursing in the acute inpatient care context requires further evaluation. Cleary (2004) suggests that a crisis-oriented model of care, focussing on patient need in the 'here and now' is required. Fortnash and Holoday-Worret (2008) argue that an additional focus on symptom stabilisation is required, within a crisis intervention context. Psychiatric nurses need to evaluate the importance of one-to-one planned activities with patients in this context, and work with senior managers to argue for a skill mix to facilitate this. Cleary (2004) suggests that the reconstruction of current work practices, supported by clear operational guidelines and clearly articulated nursing roles to reflect the challenges of recent reforms, would assist nurses to reinterpret their role and professional identity. By adopting such a model, Fourie et al (2005) suggest nurses could accept the realistic expectations of their roles, to value them and view their current practice in acute inpatient settings more positively. Nurses could become more responsive to the demands of the environment rather than its current reactive focus (Cleary et al., 1999).

Psychiatric nurses' knowledge and communication skills in working effectively and therapeutically with patients also requires re-examination, and the place for access to post-registration education and training should further be explored within a British context. Nurses' perceived vision of mental health nursing may conflict with the realities of everyday practice. The relevance of current post-registration nurse education curricula in remaining in step with expected nursing roles in acute mental health settings should be explored. It is therefore necessary to identify what is fundamental to acute inpatient nursing practice.

It would be helpful to explore nurses' and patients' perceptions of the nurse-patient relationship, and related interventions, during the planned time spent together. Whittington and McLaughlin (2000) argue that detailed observation is needed to begin to develop a theoretical construction of psychiatric nursing. Fourie et al (2005) argue for further research to uncover what may enable nurses to remain patient-focussed and therapeutic in these challenging environments. This would include consideration of the personal



characteristics of the nurse, and their clinical support which may help to maintain their standards of practice. If we accept the evidence that practice is driven more by organisational needs, then further research could usefully explore the effect this reality has on the role of nursing, and importantly how tensions between priorities may be affecting employee-employer relationships.

### **Patients' perspectives on the nurse-patient relationship**

Whilst my study focuses on what nurses think about their relationships with patients, it is important to understand the patient perspective. The following studies reveal insights into this.

Cleary and Edwards (1999) explored factors influencing nurse-patient interactions in an Australian acute psychiatric inpatient facility. Ten nurses and 10 patients were interviewed. Findings from nurses' interviews were published separately (Cleary et al., 1999) and were discussed above. Four themes from patient interviews were: nurses' attributes; role perceptions; clinical care; and time.

Using an ethnonursing method, Coatsworth-Puspoky et al (2006) explored nurse-client relationships, from 14 mental health care recipients' perspectives from Southern Ontario. Data were collected using three semi-structured interviews and field notes. Ten of the 14 participants had been hospitalised for psychiatric illness. Data analysis revealed two types of relationships: 'developed' and 'deteriorated'.

Developed relationships were characterised by nurses who were friendly and listened to clients. In the initial phase, clients felt unwell emotionally, and sought nurses who were genuine, caring and friendly. This led to a middle phase of clients feeling helped to explore and resolve problems. The development of trust and disclosure of problems led clients to feel validated as human beings. The relationship was friendly, yet the nurse maintained professionalism and did not develop a friendship. The end phase was characterised by saying 'goodbye', when the client felt well enough to leave

hospital, having addressed their needs, and no longer required the support of the hospital.

In contrast, deteriorated relationships were characterised by negative client experiences involving three phases: withholding; avoiding and ignoring; and struggling with and making sense of. In the initial phase, nurses were perceived as withholding nursing support. Nurses failed to recognise the patient as a person with an illness and needs. Relationships deteriorated as clients felt increasingly uncomfortable, anxious, frustrated and guilty when they failed to access support. In the middle phase, clients began avoiding nurses, and perceived nurses as avoiding them. Nurses were perceived as rude and condescending, leading to a perceived mutual avoidance. In the end phase of the deteriorating relationship, clients struggled to make sense of their relationships with nurses, stating that these caused more harm than good. This phase could have a profound effect on clients, continuing for months, even years, after their negative experience. Some clients were left feeling hopeless and frustrated, emotionally struggling to make sense of their experience, and in need of support. These negative experiences may impede the development of future relationships with nurses. Findings suggest that nurses should be cognisant of the impact of their actions on developing and deteriorating relationships with clients.

Participants in this study were recruited from two consumer satisfaction organisations. Participants' negative experiences of nurse-patient support may therefore be over-represented. Participants' level of wellness may also have influenced their perceptions of the nursing support relationship. Further explorations of the nurse-client relationship are therefore suggested. The descriptions of 'developed' relationships resonate with Peplau's interpersonal relations theory (Peplau, 1988).

Shattell et al (2007) explored mental health service recipients' experience of the therapeutic relationship. This study was a secondary analysis of 20 qualitative interviews with North American mental health service users living in the community. Data were analysed using an existential, phenomenological approach. Individuals experienced therapeutic

relationships with a range of health professionals including mental health nurses and psychiatrists, in the context of challenges including mental illness, domestic violence, substance misuse, and homelessness.

Experiences of therapeutic relationships fell into three themes: 'relate to me'; 'know me as a person'; and 'get to the solution.' Within 'relate to me' theme, the researchers found that that interpersonally connecting to the service user is especially important in the beginning of an emerging therapeutic relationship. Participants judged that health professionals connected with them through their personal attributes: being non-judgemental; patient; soft spoken; open; genuine; calm; and stable. Mutual investment, self-disclosure and good communication techniques including restating, summarising, clarifying, open ended questioning, reflection, reassurance, sympathy, eye contact, full attention, and the expression of emotion, were also important factors in facilitating therapeutic relationships. Service users perceived 'feeling special' in the context of a stigmatising society towards people with mental health problems. Physical contact such as a hand shake, a hug, or touch on the shoulder, was perceived as reassuring, and a method of staff reaching out to the patient.

In 'know me as a person', participants' perceptions of being valued as an individual with valid opinions, not solely as a diagnosis, were significant to the experience of a therapeutic relationship. The therapeutic relationship was evident when in-depth personal knowledge of the individual demonstrated their acceptance as a fellow human being. Part of getting to know the individual involved genuine concern, care, sincerity, and understanding on the part of the health professional. This in-depth personal knowledge required investing time, understanding, and skill to develop the therapeutic relationship. Without any one of these, the therapeutic relationship will not develop.

Finally, 'getting to the solution' to help solve problems through doing for or with the individual, offering advice, information, medications, diagnoses, suggestions, feedback, information and resources, was central to the therapeutic relationship. This required skill on the part of the health

professional to guide and focus interactions, as well as honesty to provide truthful, sometimes blunt feedback.

Limitations of this study are the small sample size, and that the sample is drawn from a North American population. The sample was also community based, so findings may not transfer to adult psychiatric inpatient settings.

A therapeutic relationship for people with mental health problems required in-depth personal knowledge, acquired only with time, understanding, and skill. The authors conclude that knowing the whole person, not solely as a service recipient, was key to enhancing the therapeutic potential of relationships. These findings can be related to nursing theories discussed previously.

Rogers and Pilgrim (1994) explored service user satisfaction and views of psychiatric nurses. In 1990, using a survey questionnaire, quantitative (240 fixed choice questions) and qualitative data (30 open-ended questions) were collected from service users who had at least one inpatient stay (n=516), of which 475 answered questions about nursing care.

Sixty percent of service users were either satisfied or very satisfied with nursing care, but 20% were unhappy with this. Nurses were said to be the most helpful professional group, and psychiatrists least helpful. Good nursing qualities included empathy, tolerance, respect, and physical caring. The most valued aspect of nursing care was listening and ordinary relating – talking and counselling in a helpful manner, and basic physical care interventions from nurses. Interestingly, student nurses were felt to provide particularly empathic relationships, possibly as they spent more time with patients. The study suggested that this may reflect students' caring, enthusiastic attitudes, which are 'cooled out' with experience. Patients valued nurses who promoted empathy, tolerance and respect; and ordinary, everyday civil liberties, including reading at night and making a drink. These all helped to create a therapeutic ambience.

Some patients experienced harsh treatment, for example, insisting medication was taken, and force-feeding, and this was regarded as punitive. Such coercion and punishment was seen by patients as bad nursing

practice, even when acknowledged that nurses sometimes were obliged to undertake specific activities under Mental Health Act 1983 legislation, since amended in 2007 (Department of Health, 2007a). Whilst coercive treatment as part of the nurse's role is sometimes necessary under the legislation, punishment is not permitted. Some patients reported unwitnessed physical assaults by nurses, among other perceived punishments. Rogers and Pilgrim state that these accounts may reflect some experiences of an older client group, referring to former custodial regimes in the old psychiatric hospitals, although some younger patients hospitalised in the 1980s reported similar accounts. A limitation of this study is that the superior, empathic quality of student relationships was not fully understood, but would provide a good focus for future research.

On the matter of poor treatment by nurses, the Nursing and Midwifery Council (NMC) received 2,178 allegations against nurses' and midwives' fitness to practise in 2008-09, of which 740 sanctions were made (Nursing and Midwifery Council, 2009b). Of these allegations, 8.37% involved patients concerning incidents of physical, sexual or verbal abuse; inappropriate relationships, or failure to communicate and respect the dignity of patients. In previous years, these allegations accounted for 14.30% (2007-08) and 17.09% (2006-07) of reported incidents, showing a downward trend. These statistics include all nurses and midwives across the United Kingdom, and 43.72% arose in National Health Service (NHS) settings (2008-09), amounting to approximately 62 incidents, of which 27 occurred in the NHS. These statistics suggest that the 'punishments' reported in Rogers and Pilgrim's (1994) study may still be relevant in today's acute psychiatric care setting.

Pilgrim's study found that given the constant 24 hour caring role of nurses in the acute psychiatric inpatient setting, the impact of nurses on patients is likely to be greater than those of other health professional groups. The impact of acting coercively in the interests of the patient, on the nurse-patient relationship, requires careful consideration through reflection on the part of

the nurse. Overall, in this study, psychiatric nurses received a positive vote of confidence from service users.

Limitations of this study are that data were collected in 1990, so may not be transferable to the psychiatric adult acute inpatient setting today. Although the sample size was relatively large, qualitative data will have limited transferability to similar contexts. A further issue of significance is that data were captured regarding prior experience, which appears to have yielded contrasting results. This may be a useful theme to explore in future studies.

Using a grounded theory approach, Goodwin et al (1999) explored the views of adult inpatient psychiatric patients in a large rural county in England. Over a four year period, 110 inpatients were surveyed, of which 99 came from acute wards in one hospital. Interviews were undertaken by trainee psychologists and psychology undergraduates. A service user satisfaction questionnaire was administered, then participants were interviewed using a semi-structured survey of patients' views. Using a content analysis approach, data were sifted for emergent themes and distilled into categories. Thirteen themes were identified.

Patients commented about the tangible environment. Refurbished wards were described as homely, and made patients feel good. In contrast, the dull physical appearance of some wards and communal hospital areas led to some patients feeling more depressed in themselves. Lack of appropriate facilities such as private quiet areas, were problematic.

The non-tangible environment referred to the ambience of the hospital. Some patients reported a positive sense of community and relaxed atmosphere, but others expressed a loss of privacy inherent in institutional life, for example, general ward noise.

Some patients expected the institution to provide entertainment, and to segregate patients according to degree and types of 'illness'. Some patients commented about power and control issues, stating that although they had been admitted on an informal basis to hospital, they believed that they would be placed under a section of the Mental Health Act 1983, since amended in

2007 (Department of Health, 2007a), to detain them in hospital against their wishes. Patients placed under a section expressed feelings of desperation, anger and dejection, about having their rights taken away from them. Patients generally felt a sense of powerlessness over their situation, stating that staff were very persuasive and suggestive as to what patients should do. Patients felt frustrated at how little control they had regarding their treatment, making drinks for visitors, and coming and going from the ward. Whilst patients accepted the need for rules and policies in a ward environment, these sometimes created tensions, as different patients expressed different needs and desires. This included rules about smoking. Patients appreciated being allowed to do things that were not usually permitted, such as taking a call on the telephone in the ward office. These ordinary, everyday activities, usually associated with basic courtesies and rights, were conceptualised as special acts in the institutionalised environment.

Talking, counselling, and listening were seen as helpful in promoting good staff-patient relationships, and this was supported by a key worker system where each patient had a named key worker. Patients placed a high value on feeling cared for by nurses, who were approachable, kind and sympathetic, treating them like they would a friend. This again recalls Peplau's roles for the nurse (Peplau, 1988). The key worker system was only as good as the people in it. Staff that made themselves available to talk to were praised, but many patients stated that the onus was placed on them to make the first approach to staff. Not all staff conveyed a willingness to hear what patients had to say, instead conveying disinterest, sometimes making patients feel worse.

Patients praised staff when treated with respect, but most patients complained of being infantilised, looked down upon, or treated with indifference. This may lead to patients' loss of sense of self, self-determination, power and freedom of action, seeing the hospital more like a prison. Lack of information regarding treatments, effects of medication, discharge and other aspects of patient care, were common concerns among patients.

Overall, Goodwin et al (1999) stated that service users' dissatisfaction easily outweighed the positive elements and experiences of the institution. The most valued aspects of the inpatient experience were positive relationships with staff, and having the freedom to leave the ward and hospital grounds. However, the overwhelming experience is that of institutional rules and power.

There is an inherent tension between nurses and patients, in that nurses' roles ask of them to be caring and concerned whilst simultaneously giving treatments which patients find aversive. The authors claim that although considerable efforts were made by ward staff and managers to guarantee more autonomy, freedom of choice, and informed consent for all patients through the establishment of systems, protocols, procedures; all these issues remained key concerns. More attention should therefore be paid on the actual practice in implementing these intentions.

A limitation of this study is the relatively small sample size, so transferability of qualitative findings to similar contexts elsewhere should be cautiously applied. As interviews used semi-structured interview questions, the process may have directed patients only to address particular concerns. Comparison with similar studies involving service users' views would therefore be helpful.

Rather than researching multiple patient experiences, MacCallum and Robertson (1999) described the care received by one patient in a Scottish acute psychiatric ward setting, analysing the patient's account with reference to the literature. Three types of evidence were gathered: the patient's voice, the undergraduate student's voice and the research literature. The student gathered data in a reflective learning log.

The authors claim that the primary role of psychiatric nurses was to form therapeutic relationships. Both nurse and patient come to the situation with their own meanings and perspectives, and the nurse sets out to engage with that person, to understand the meaning of their situation. A starting point can be generating accounts of practice, which captures meanings from individuals and the practice situation.



In their study, a 26 year old male patient was described as a 'new long stay patient', generally defined as patients who have been in hospital for more than six months. The main characteristics of such patients are that they are usually male, homeless, and not registered with a general practitioner. According to the student, there was minimal nurse-patient interaction. Control and containment, either by physical or chemical means, appeared to be the two main nursing activities. Drug treatment appeared to be the only therapeutic tool. The observed patient had little social contact, spent most of his time alone, and generally did not talk with others whilst in communal areas. Whilst the wider literature suggests that many patients found simply talking to nurses and doctors to be the most helpful aspect of patient care (McIntyre et al., 1989), this did not regularly occur for the MacCallum and Robertson patient.

In an observational study of patients' daily activities in acute psychiatric care, Lepola and Vanhanen (1997) reported that patients spent more than half their time alone, even when in the company of other patients and nurses, where there was little interaction.

Gradually, the student and patient established a relationship with some trust, and spent time in short social outings, during which the patient engaged in conversation. These were judged successful, and a befriending service was sought to continue with these activities. No such service could be found, but later, the patient was transferred to a rehabilitation ward. The authors concluded that new long stay patients faced a lack of appropriate provision to meet their needs in acute ward settings operating at crisis levels of occupancy. Mental health nursing is not only about the psychological relationship with patients, but should become an activity which seeks to address their needs, acknowledging the social, political, economic and institutional conditions which impact on their lives.

A major limitation of this paper is the small sample size, so transferability of findings may only be undertaken cautiously. The study was undertaken by a student nurse inexperienced in data collection methods, and this further reduces the rigour of the study. It is unclear as to whether the failure to

establish a therapeutic relationship was owing to the condition of the patient, or approach of the nurse.

In summary of the literature studying the views of patients regarding the nurse-patient relationship, patients appear to want to develop therapeutic nurse-patient relationships within the adult acute inpatient healthcare setting. Patients want to be 'known' as unique people in their own right, not solely as patients with diagnoses. However, the development of therapeutic relationships requires an investment of time, understanding, and skill on the part of nurses, in order to really get to know their patients. Expressed patient needs can be basic, and require nurses to treat them with respect and honesty, listening to them to work together towards meeting their needs.

### **Nurses' perspectives on the nurse-patient relationship**

The studies critically reviewed in the previous two sections revealed much about the realities of inpatient care and factors which impact on nursing practice and patient experience. Little can be drawn from this to help our understanding of the views and experiences of nurses regarding their experience of the nurse-patient relationship. This section explores this theme.

In a modified grounded theory study, Barker et al (1999) explored the role of psychiatric nurses within a multidisciplinary service across six sites in England, Eire and Northern Ireland. The theoretical sample included patients, carers, and health professionals (n=92) whose views were sought using focus groups. Findings included that the essential features of the role of psychiatric nurses included knowing the patient in three domains: 'Ordinary me' relied on ordinariness of nurse-patient interactions; 'Engineered me' represented nurses' more considered use of self and professional judgement; and 'Professional me' represented when nurses acted in ways considered 'best' for the patient. Nurses drew on these domains which they used at different times according to circumstances or context. This was a clearly structured, rigorous study.

In a grounded theory study conducted in Ireland by Scanlon (2006), psychiatric nurses' perceptions of the constituents of therapeutic relationships were explored. Six psychiatric nurses were selected using purposive sampling, and semi-structured interviews were undertaken with them. Among the findings, Scanlon found that the nurse-patient relationship was considered to be therapeutic, but that positive patient outcomes were difficult to measure. Nurses learned to develop therapeutic relationships through a combination of learned experience and the acquisition of new skills. Nurses also relied on having acquired sufficient life experience to intuitively appreciate therapeutic aspects of the nurse-patient relationship. Nursing was seen as a service in which nurses recognised their professional status and responsibilities, the need for individualised patient care, working as part of a team, and that the development of the nurse-patient relationship may be restricted or enhanced according to the nature of the patient's illness or disorder. Development of therapeutic relationships was also time limited owing to the diversity of the nursing role. Skills required to develop relationships included the building of trust, use of humour, providing information, and conscious decision-making. Respect for therapeutic boundaries, and adopting a non-judgemental attitude, were also important features of the nurse-patient relationship. Overall, this was a relatively rigorous study, though the sample size was relatively small, which may impact on the transferability of findings elsewhere. Only the nursing perspective is considered, and no account of patient perspectives is given. Data were only collected through interviews, so what nurses say they did and what they actually did may not be the same.

In an action research study conducted in Sweden, Sjöstedt et al (2000) used observation and questionnaires completed by 17 nurses and 16 patients in an acute psychiatric care ward to identify obstacles and possibilities for participants to learn from their first encounters with patients on psychiatric hospital admission. Nurses expressed basic values such as confirmation, safety, trust, sharing patients' suffering, and relieving patients' guilt. Half of all patients were satisfied with their first nurse encounter, whilst half were dissatisfied. Of those who were dissatisfied, this concerned their perception

that they were not given adequate opportunities to express their suffering, or even permission to do so. Although nurses had genuine intentions for the good of patients, and wished to work collaboratively with them, lack of time and too many competing demands were cited as reasons as to why they were not always able to meet patients' needs. This represents a recurrent theme present in a number of studies as described above. This was a rigorous study, with a relatively large sample size, which enhances the transferability of findings to similar contexts elsewhere.

In an Australian qualitative study by Cleary and Edwards (1999), a random sample of 10 nurses and a purposive sample of 10 patients was used to consider what factors influence nurse-patient interaction in an acute inpatient psychiatric facility. Using semi-structured interviews and thematic content analysis, Cleary and Edwards found getting to know the patient and being there for them to address their concerns, was a key focus of the nurse-patient relationship. A shared team philosophy and positive nurse qualities such as a positive, non-judgemental approach, were seen as helpful characteristics by patients. Nurses' role perceptions included promoting patient independence, advocating on their behalf, providing information, problem solving, answering patients' questions, promoting good communication and providing social interaction. Whilst nurses had good intentions to meet these aspects of their roles, this was commonly difficult to achieve in practice owing to time constraints and other more immediate risk assessment and management, and administrative demands placed on nurses' time. Again, here emerges an appropriate vision for the role of the nurse, but this is impeded by organisational and service constraints. A strength of this study is that both nurses' and patients' views were sought to explore factors which may influence nurse-patient interactions.

In an exploratory, descriptive study conducted in New Zealand, O'Brien (1999) used two small focus groups of inpatient nurses (n=4) and community nurses (n=5) to explore their views on what they considered to be expert mental health nursing practice. Following an inductive analysis of data, a central theme emerging about the nurse-patient relationship was a sense of

negotiating, maintaining, and renegotiating the relationship. Involvement with the patient over a period of time beyond the immediate focus of the present situation, and giving total commitment to the patient, was a central theme. Involvement with patients and their families was situational in individual episodes of care, as well as enduring over time over several patient admissions. Engagement with patients was regarded as meaningful in itself, rather than solely as a means to a therapeutic end. Experienced inpatient nurses saw 'bending the rules' to promote patient individualisation as a skill. This echoes the Goodwin et al (1999) study, finding the benefits of 'special' treatment where nurses display flexibility for patients.

Returning to O'Brien's study (1999), nurses also recognised and respected patient boundaries, minimising their visibility of involvement with patients at times when patients did not want involvement, as well as promoting an approach of 'being natural' with patients. Being human with patients, working together 'on the same level' was important, and minimising the clinical professional role was important as this was considered a barrier in getting to know patients. Here again, we can draw parallels with the work of nurse theorists which are revisited in the discussion chapter later. A limitation of this study is the relatively small sample size in each focus group, which may limit transferability of findings elsewhere.

This theme of relating to patients on a basic, more fundamental human level, is considered in a Norwegian qualitative study by Akerjordet and Severinsson (2004) which explored mental health nurses' experiences of the use of emotional intelligence in their nursing practice. Seven nurses, each with at least five years' experience of working in acute mental health care were interviewed, and a hermeneutic analysis of the data was conducted. Four main themes emerged: relationship with the patient; the substance of supervision; motivation; and responsibility. Nurse-patient relationships were characterised by genuine, authentic encounters with patients, and nurses handled their relationships in a purposeful way, being aware of their non-verbal and verbal communication styles with the patient. Mutual trust and confidence were regarded as the characteristics of high quality nursing.

Clinical supervision was regarded as an important process for reflection and coping with feelings, as nurse-patient relationships were both enjoyable but emotionally stressful on nurses themselves. Experienced nurses in this study were positively motivated to develop creative, new ways of thinking about the nurse-patient relationship, and accepted responsibility for their own learning and professional development. The finding in their study regarding nurses' awareness of the importance of their verbal and non-verbal communication can be related to nursing theory, as discussed earlier in the literature review. However, the sample size is small and may reduce the transferability of findings to similar contexts elsewhere.

In a North American exploratory, descriptive study, Heifner (1993) interviewed eight nurses working in acute psychiatric mental health settings to explore the concept of connectedness in the nurse-patient relationship. Participants in this study reported they were able to connect with patients when they were able to personally relate to the patient's situation. This was most easily achieved when nurses perceived the patient to be vulnerable, which facilitated their interactions with increased honesty and risk taking. A sense of connectedness emerged when both nurse and patient benefited from the relationship, enhancing the depth and pace of development of the nurse-patient relationship. A view could be taken here to consider the ethics of this nursing practice, since issues of transferences and lack of unconditional regard towards patients could be questioned. Limitations of this study include the small sample size which may limit transferability of the findings to similar contexts elsewhere.

In an ethnographic study conducted in England, Bray (1999) explored what is expected of psychiatric nurses, and actual observations of their practice. Participant observations and semi-structured interviews with 15 registered nurses working in one of three acute inpatient psychiatric units revealed three main themes: difficulty in working closely with mentally disturbed individuals; maintaining distance; and congruent care.

Difficulties of working closely with mentally disturbed individuals was characterised by nurses simultaneously feeling close to patients whilst

working with their challenging behaviours which sometimes pushed nurses away. This was emotionally draining for the nurse. Nurses sometimes felt a personal desire to keep in touch with some patients on their discharge to offer continued support, but recognised and respected professional boundaries that to do so would be inappropriate.

Maintaining distance arose whilst involved in the close observation of patients who presented risks of harm to themselves or to others. The practice of close observation of patients was perceived to be intrusive by nurses. Nurses engaged in close observation were also unavailable to other patients in their care. Maintaining distance in this sense could arise as planned activities with patients could be cancelled if more urgent nursing activities such as close observation arose. Distancing from patients was sometimes used by nurses as an emotional defence, for example, asking patients to wait for their primary nurse to come on duty to discuss issues rather than nurses available on duty at that time making time there and then to talk to the patient.

Congruent care was characterised by nurses wishing to be with patients to meet their needs, and to develop trust and therapeutic relationships with them. Nurses felt most connected to patients when involved in direct care with them, such as gardening groups, where there was a high level of nurse-patient interaction on a human level. Overall, this appears to be a rigorous study. The findings of this study present interesting tensions for nurses, with an apparent absence of practice being linked to underpinning theory, which could be helpful.

Hem and Heggen (2004) considered the role of rejection in the nurse-patient relationship. Their Norwegian ethnographic study drew upon observations and interviews with six nurses working on an acute ward of a psychiatric hospital, and focussed on their work with psychotic patients. They reported on the concept of rejection, focussing on one patient case of special interest to explore this phenomenon. They found that the vulnerable, dependent, trusting, psychotic patient constantly placed an ethical demand on the nurse to take care of him. This created a risk for the patient of being rejected by

the nurse. The nurse adopted impersonal professional routines in her approach to working with the patient, which were experienced by the patient as rejection. The researchers concluded that what at first sight seemed like friendly, professional encounters between nurse and patient, was experienced as rejection, as the patient's reality of psychosis was unacknowledged by the nurse. The researchers call for a common effort on the part of both nurses and patients to develop mutual understandings of patients' experiences. Nurses who inappropriately use professional distance with patients may fail to understand and meet patients' needs, instead reinforcing their institutional power over them. A strength of this study is that both interviews and observations were made, which strengthens the transferability of findings elsewhere.

In an earlier Norwegian ethnographic study, Hem and Heggen (2003) explored the contradictory demands of being human and being professional in nurses' work with patients. Their research was undertaken with six nurses working in an acute psychiatric hospital ward, and they published findings focussing on the case of one nurse. When the nurse used herself as a therapeutic agent, she was faced with the demands of being both human and professional. The nurse experienced empathy for the patient, but was simultaneously faced with personal attacks from the patient, which created tension for them. The nurse demonstrated empathy, loyalty, and goodwill towards the patient, whilst herself feeling frustrated, angry, and vulnerable at times. This contributed to the nurse feeling that she had not lived up to her professional ideals. Hem and Heggen argue that it is crucial that nurses recognise their own vulnerabilities in the nurse-patient relationship, and that appropriate support is offered for nurses to accept and acknowledge this feature of nurse-patient relationships with colleagues as part of their professional development. This example draws attention to the skills required for nurses to manage their own feelings in order to avoid possible incongruence of verbal and non-verbal behaviour. However, the sample size is small, reducing the transferability of findings to similar contexts elsewhere.



This challenge within nursing, to be human, has also been studied. In an Australian ethnographic study, Cleary (2003) observed nurses' practice, then interviewed 10 nurses about how they constructed their practice in an acute inpatient psychiatric unit. Nurses valued one-to-one time with patients, to develop trust and honesty in their approaches with them. 'Being there' and 'being human' were considered essential characteristics of the nurse-patient relationship. Challenges, of power and control of detained patients, arose when patients did not believe that they required hospitalisation. Nurses became a target for patients to express their anger and frustration, but nurses tended to persevere to show empathy and understanding with patients, even when patients were angry with them. Nurses commented on the rewards of their efforts, when they observed patients' acuity of illness reducing as they moved towards recovery. As with some other studies previously discussed, Cleary appears to find that nurses attending to the fundamental qualities of human relationships maintain more positive approaches in their nurse-patient relationships. The small sample size may also limit the transferability of findings to other similar contexts.

In contrast, in an English ethnographic study, Clarke and Flanagan (2003) used interviews and participant observation to explore patient interactions and nurse activities in acute inpatient psychiatric wards. Nurses' interactions with patients mainly occurred in crisis situations when reactive interventions were used to manage patient risk. Although nurses expressed a view that they would like to engage meaningfully with patients, they were disappointed with the realities of their role in acute inpatient settings. They perceived that it was futile to attempt to engage therapeutically with patients as all that mattered from an organisational perspective, was to 'put patients through the system' (Clarke and Flanagan, 2003: 134). Very little reference was made to the nurse-patient relationship itself, which is a major limitation of this study.

Higgins et al (1999b) were commissioned by the Department of Health in England to investigate the extent of change of acute inpatient populations in psychiatric settings; the grades, numbers and qualifications of nurses working there; the activities they performed; and patients' perceptions of their

nursing care. Among their findings, Higgins et al found that many patients experienced only passing relationships with nurses, who spent their time typically engaged in administrative duties at the cost of direct patient contact. This is mirrored in other studies discussed above. Higgins et al (1999b) found that nurses spent only 4% of their time in direct patient contact. It may seem remarkable to find such a low proportion of time could be sufficient to provide helpful nurse-patient relationships, but where these were possible, they depended on nurses' displaying empathy, being a good listener, being a good communicator, providing emotional support, being available for patients, and valuing patients as individuals. A major strength of this study was its large sample size, adding credibility to transferability of the findings to similar contexts elsewhere.

To summarise, nurses' perspectives of nurse-patient relationships in acute inpatient psychiatric hospital settings have been discussed. Essential role features of the nurse included prioritising risk assessment and management, maintaining safety, shift and care coordination, and administration. These competing, urgent demands placed on nurses tended to be prioritised over direct one-to-one contact with patients, generally constituting a small proportion of nurses' time. A shared team philosophy was preferred for best shared decision-making.

Therapeutic nurse-patient relationships were characterised by 'knowing the patient', preferably over an extended period of time beyond the present admission; establishing trust; connecting with the patient; positive non-judgemental attitudes; conscious decision-making using reflection and intuition; use of humour; providing information; listening to and addressing patient concerns and suffering; confident approach; persistent approach in the face of possible rejection by the patient; being natural and human with patients; involving family and carers as appropriate; and giving patients personal space. Trends and themes regarding being human again emerged as being valued and important.

Untherapeutic nurse-patient relationships were characterised by nurses maintaining a 'professional distance' from patients; use of impersonal

professional routines; reactive interventions to control and have power over patients when managing risk; poor and minimal time for one-to-one engagement; unwillingness to acknowledge and listen to patients' concerns and suffering; and disconnectedness with disliked patients.

Nurse skills included maintaining professional boundaries whilst acknowledging human connectedness with patients; active listening skills; self-awareness of verbal and non-verbal communication styles; and drawing upon personal life experience as appropriate. Attending to the nurse-patient relationship as well as other role demands was emotionally draining and stressful on nurses. The competing demands of the role could leave nurses feeling a sense of failure to live up to their professional ideals and expectations, and appropriate support through clinical supervision was required but the quality and frequency of this was variable and often inadequate.

A conceptual framework was developed from the preceding review of the empirical literature, and is presented overleaf in figure one.

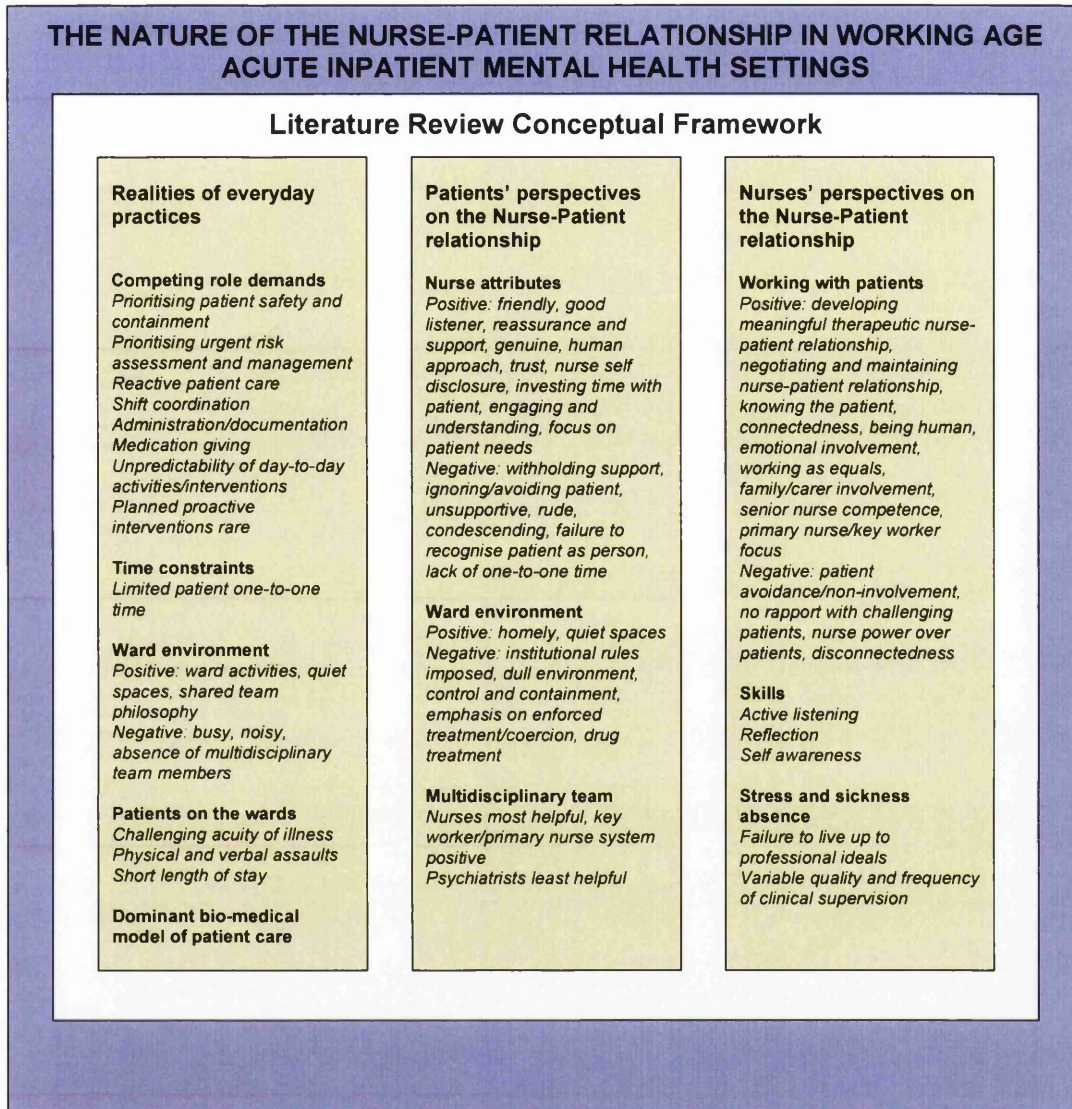
### **Empirical studies limitations summary**

Many empirical studies discussed in this literature review used qualitative methodologies to explore nurses' and patients' views of nurse-patient relationships, and wider roles and responsibilities of nurses working in acute inpatient psychiatric hospital settings. The small sample sizes used in these studies is a general limitation which is widely acknowledged within the qualitative research. Studies were commonly conducted in one setting, in different countries. These settings may present a variety of specific socio-cultural and organisational factors that may have a bearing on participants' views and behaviours there, thus impeding their transferability.

Data gathered through interviews alone provides information about what participants say they do in practice, but this may differ from their actual practice. Observation may present an apparent solution, but in studies where participant observation has been used, there is the possibility that

nurses' awareness of being observed may have influenced their behaviour, which may be different in the everyday context of care delivery.

Figure 1. Conceptual framework from literature review



However, in these studies, there was generally a close matching of what participants said they did in their nursing practice, and what was actually observed, so the impact of the researchers' presence was probably minimal. The range of views expressed in participants' narratives, including positive and negative aspects of their experiences, may also suggest that their accounts are honest and authentic. This is further supported as recurrent themes across the literature have become apparent.

Because of such limitations, qualitative findings cannot be generalised and are limited to the participants studied. However, a major strength of qualitative methodologies is that they can provide access into participants' lived world experiences. The value of the data lies in its richness and complexity, which may offer the reader new insights into the complexities of the phenomena under study, otherwise inaccessible and unknown.

Qualitative findings may be transferable to similar contexts elsewhere, but it is for each reader of each study to decide as to the significance of findings, in their own context. Collectively, qualitative research studies exploring similar phenomena may be used to begin to build a clearer understanding of the phenomenon itself, to yield fresh understandings and to identify areas for further development for practice, education and research.

## **2.5 CHAPTER SUMMARY**

This critical review of the literature continues to support the view that the nurse-patient relationship appears to be central within mental health nursing. Whilst we may assume that mental health nurses wish to develop therapeutic relationships with patients to meet their needs, this may not always be so. The realities of meeting this goal are complex, and are influenced by many factors including the organisational context, and the people with which such relationships develop, as well as by nurses' professional knowledge, attitudes and values.

Our understanding of the nature, extent and purpose of the development of nurse-patient relationships from nurses' and patients' perspectives, specifically in adult psychiatric acute inpatient settings, is limited. Further qualitative and quantitative research studies with nurses and patients is required to explore the concepts and processes involved in the development of nurse-patient relationships, and the impact that this may have on both nurses and patients.

Nurses' awareness of the extent to which they engage with patients to facilitate positive relationships should be addressed through continuing

education and clinical supervision, for them to understand the significance of their interactions from patient perspectives, to promote positive health outcomes. There may be a useful role for nursing theory within this process, and this is considered within the discussion chapter later.

Policy makers, commissioners, senior nurse managers and health care providers, need to consider the context of the inpatient environment, and its impact on the development of nurse-patient relationships. This includes provision of adequate staffing levels, skill mix, and an environment which affords nurses opportunities to develop positive therapeutic relationships with those in their care. The development of appropriate, realistic nursing interventions and outcomes within the context of the adult psychiatric acute inpatient environment should also be considered.

This study seeks to explore registered mental nurses' reported experiences about the nature of the nurse-patient relationship in working age acute inpatient mental health settings. The purpose of this phenomenological study is to explore with a sample of registered mental nurses their experiences about the nature of the nurse-patient relationship in one working age acute inpatient mental health hospital setting. It is hoped that this study will address the knowledge gap identified in the literature about nurses' perspectives about the nature of the nurse-patient relationship. This study's findings are intended to add to the evidence base reviewed, by identifying and articulating the complexities of the nature of the nurse-patient relationship in the adult acute psychiatric inpatient setting, as viewed by nurses themselves. This may lead to new possibilities for understanding what factors impact on interaction and care, to give direction to future opportunities for education, training and research.

## CHAPTER THREE: RESEARCH DESIGN

This chapter discusses the research design of the study. Its structure follows guidance by Bloomberg and Volpe (2008) and includes discussions around the following areas: rationale and overview for the research design; an overview of information needed; description of the research sample; data collection methods; data analysis and synthesis; ethical considerations; issues of rigour; and the limitations of the study. The chapter concludes with a brief summary.

The purpose of this research study was to explore with a sample of registered mental nurses, their experiences about the nature of the nurse-patient relationship in working age acute inpatient mental health settings. This focus has arisen from established theory and research summarised in the preceding literature review, and holds out the prospect of making an original, significant contribution to the academic literature and nursing practice. I believe that a better understanding of this phenomenon would allow practitioners, educators, researchers and patients to proceed from a more informed perspective in terms of promoting good nursing practice. I believe that the development of genuine nurse-patient relationships is fundamental to good nursing practice, and to nurses' and patients' wellbeing.

In seeking to understand this phenomenon, the principal research question asked 'What are registered mental nurses' reported experiences of the nature of the nurse-patient relationship in working age acute inpatient mental health care settings?' The study addressed six key objectives:

1. To review relevant literature relating to the nurse-patient relationship in acute inpatient care;
2. To explore nurse participants' reported lived experiences of the nurse-patient relationship;
3. To describe the essential components of nurse participants' experiences of the nurse-patient relationship emerging from these reports;

4. To interpret and understand the meanings of the relational themes and constitutive patterns of nurse participants' reported experiences of the nurse-patient relationship;
5. To provide a hermeneutical analysis of nurse participants' experiences of the nurse-patient relationship, as provided by them in the study; and
6. To generate new knowledge, making an original contribution to the field, with relevance for clinical practice, education and research.

### **3.1 RATIONALE AND OVERVIEW FOR RESEARCH DESIGN**

As the principal research question is concerned with exploring the reported lived experience of the participants under study, a phenomenological methodological approach was adopted. This approach is concerned with the ways in which individuals interpret their world, to discover their realities, to understand the meanings attached to their experiences, all from their own perspectives (Anderson, 1991). Phenomenology falls within the broader context of qualitative research, whose purpose is to produce work which says something of the meanings which people attach to their experiences (Williams, 1998).

Hermeneutic phenomenology has been used in recent times to interpret the world as though it were a text (Ehrich, 2003). Van Manen (1997) states that phenomenological text is descriptive in that it names something. Such description is said to have both an interpretive (hermeneutic) component as well a descriptive (phenomenological) element. Phenomenological descriptions aim to elucidate lived experience, but the meaning of lived experience is usually hidden. A good phenomenological description should resonate with our sense of lived life. Van Manen (1997: 27) states:

*" ... a good phenomenological description is collected by lived experience and recollects lived experience – is validated by lived experience and it validates lived experience."*



Heidegger and Gadamer were two eminent philosophers within the hermeneutic tradition (Ehrich, 2003). Heidegger's ideas were shaped by Husserl, another prominent philosopher, who believed that consciousness constituted the world. However, whilst Husserl argued that the essential attitude of the phenomenologist should be to bracket their 'natural attitude' to enable experience to be seen from a new, unconventional perspective, Heidegger disagreed with this notion. Heidegger argued that 'being' is present in all persons, which cannot be bracketed and set aside. Heidegger (1962) believed that people are experienced as being-in-the-world, and not set apart from it. Gadamer (2000), a student of Heidegger, developed ideas of a hermeneutic circle of comprehension, dialogue and a fusion of understandings. Within this interpretive circle, dialogue is viewed as dynamic, and during encounters between participants, change occurs in which new subjective realities form.

This research study is concerned with exploring the meaning behind registered mental nurses' reported experiences of the nature of the nurse-patient relationship within one working age acute inpatient mental health setting. It seems impossible to me to begin to attempt to bracket my own experiences of the nurse-patient relationship during the research process, as these draw upon my own personal values and beliefs shaped over the last 27 years of my professional practice. For this reason, I have rejected Husserl's philosophical approach in relation to this particular study.

Heidegger's notion of being-in-the-world reflects my own stance that my experience is potentially valuable in contributing to the research process. Gadamer's hermeneutic circle seems to be a helpful framework and was adopted within the research design, reflecting a hermeneutic, phenomenological philosophical approach within the research process.

Phenomenology seeks to reveal human perceptions and subjectivity in order to understand the experience of a phenomenon at first hand (van Manen, 1997). Practical acts of living are accessed through stories to reveal meanings (Crist and Tanner, 2003). The methodology increases sensitivity to understanding humans' ways of being-in-the-world, to provide new,

unexpected views of everyday phenomena which might otherwise be left uncovered.

As little is known about registered mental nurses' first hand experiences of *being* nurses experiencing the nurse-patient relationship, phenomenology has been used to reveal what it is like to *be* as a nurse from their own viewpoints, in other words, what it means for them. Coming to know what it means to be as a nurse in this context is best understood through exploration of their *lived experience* in their everyday world of nursing in these settings. Findings from this study may provide readers with further insights to enhance their understanding of what it is like to be as a nurse experiencing the nurse-patient relationship in the working age acute inpatient mental health setting.

The interpretive phenomenological approach to research is directed towards understanding ways of being human in specific contexts. Benner (1984; 1994) introduced this research approach to nursing and it is particularly suited to the exploration of the nurse-patient relationship in this study. This approach provides a means of interpretation of everyday experiences and practices to more fully understand their richness and complexity (Dieklemann and Ironside, 1998a).

The study was approved by a Local Research Ethics Committee and a Local NHS Research Consortium Research and Monitoring Committee (see section 3.6 for further details). The objectives of the study included to explore nurses' reported lived experiences of the nurse-patient relationship in working age acute inpatient mental health settings, informed through participants' stories on relevant aspects of practice chosen by them; to describe the essential components of those experiences; to interpret and understand the meanings of the relational themes and constitutive patterns of those experiences; and to provide a hermeneutic analysis of their experiences of the nurse-patient relationship, as provided by them in the study. This generated new knowledge which was compared and synthesised with the current literature, to make an original contribution to the field.

Participants were recruited from one working age adult acute inpatient mental health hospital setting. Fourteen individuals agreed to participate in the study. Demographic data collected evidenced a diverse mix of participants within the sample, which likely reflected that of the wider hospital registered mental nurse population.

Participants were asked in advance to choose some examples of their experiences from practice which they felt exemplified the nature of the nurse-patient relationship in these settings. Unstructured audio-recorded face-to-face individual interviews were conducted once with each participant. Field notes and a reflective journal were maintained throughout the research process. Each participant story was transcribed verbatim, with references to people and places being replaced with pseudonyms or removed.

Transcribed interview texts, field notes and entries in the reflective journal were considered as data for this study.

Transcripts were returned to participants for review for accuracy of content. The reviewed texts were analysed hermeneutically using Diekelmann and Allen's (1989) multiple stages of interpretation process. This approach to text analysis is a reflective, reflexive circular process which is complex and fluid in nature. Common experiences, practices and meanings were identified through the development of relational themes, defined as broad general descriptions of recurring experiences, which traversed texts. Interpretations were supported using excerpts from interview texts. Paradigm exemplars and constitutive patterns, the highest level of hermeneutic analysis, were sought to describe how themes meaningfully related to one another about registered mental nurses' reported experiences of the nature of the nurse-patient relationship in working age acute inpatient mental health settings.

Interpretations of early texts were considered in relation to interpretations from later texts to challenge and clarify the analysis to bring about new understandings. Findings were reviewed in relation to the relevant academic literature on the nurse-patient relationship to reach deeper levels of critique and understanding.

The written data analysis was reviewed by my research supervisor and an experienced senior registered mental nurse colleague as a means of reaching agreement of findings; and enhancing their contextuality, coherence and comprehensiveness (Plager, 1994). This process provided further opportunities to confirm, extend and challenge the analysis, and to identify unwarranted or implausible interpretations which were unsupported by the texts.

Ethical considerations using an 'ethics-as-process' approach were considered throughout the research process. The risks and wider ethical issues considered for participants and the researcher included physical health and safety; potential distress during face-to-face interviews; risk of the delusion of alliance when participants could inform more than they intended to; risk of pressure or coercion on participants to continue in the study; risk of the research becoming obtrusive; risk of misrepresentation of participants' views; handling of sensitive information; the safe acquisition, storage and transmission of data; and the risk of breach of confidentiality by disclosing the identification of participants to colleagues and in published papers, by themselves or others.

The trustworthiness of the study was provided through a detailed trail of the theoretical, philosophical and methodological decisions taken during the research process. The strategies I employed to enhance the trustworthiness of the research study are discussed.

Finally, limitations of the study, including the small sample size drawn from registered mental nurses working in one working age acute mental health setting in England, are discussed.

### **3.2 OVERVIEW OF INFORMATION NEEDED**

This interpretive phenomenological study focussed on 14 registered mental nurses within one hospital setting. In seeking to interpret nurses' reported experiences of the nature of the nurse-patient relationship in working age acute inpatient mental health care settings, the six key objectives discussed

above were explored. Bloomberg and Volpe (2008) suggest that four general areas of information are needed to address these: contextual; perceptual; demographic; and theoretical. Each is discussed below.

### **Contextual information**

Morse (2008) asserts that the description of context can be as important as the description of the participants in qualitative inquiry. For this reason, the research site and setting have been described to enhance the credibility and the possibility of transferability of the study's findings to similar contexts elsewhere. This information was collected from discussion with the hospital clinical nurse manager, the NHS Trust website and through one-to-one interviews with participants.

### **Demographic information**

The characteristics of participants were described including their present post, professional qualifications, post-registration experience, age, higher education qualifications, gender identity and ethnicity. These were aggregated to respect and protect participants' anonymity. Their inclusion is required to enhance the credibility of the study, and to assist readers in considering the transferability of findings to similar contexts elsewhere. This information was gathered through one-to-one interviews with participants.

### **Perceptual information**

Participants' perceptions of their experiences of the nurse-patient relationship from their lived world viewpoints were collected through one-to-one interviews. Their stories informed the study and the development of key relational themes and constitutive patterns which described what nurses believed to be true about the nature of the nurse-patient relationship within one working age acute inpatient mental health care hospital setting. Interview data were triangulated with supplementary data recorded in the form of field notes before and after each interview, to capture my own immediate interpretive thoughts of the content and context of each. A reflective journal was maintained throughout the implementation of the study to later assist in the write up process.

## **Theoretical information**

Theoretical information was searched and collected from different literature sources prior to beginning the study, to assess what was already known about the nature of the nurse-patient relationship in working age acute mental health care settings, and to justify the research purpose. This information was regularly reviewed and updated throughout the research study to inform the development of the literature review and its conceptual framework. An account of the literature search process used to inform the literature review is included within that chapter. A further literature search was conducted following the identification of key findings. This information also provided support for the interpretation, analysis and synthesis of the data collected, leading to my findings, final conclusions and recommendations. Critique of these theoretical sources also led to the development and ongoing refinement of my research findings' conceptual framework.

Further theoretical information was searched and collected to inform my methodology and research design as related to the research purpose. The following databases were selected owing to their broad coverage of health and social sciences research methodologies and methods literature: Allied and Complementary Medicine (AMED); British Nursing Index (BNI); Cumulative Index to Nursing and Allied Health Literature (CINAHL); and PsycINFO. Keywords used to undertake an initial extensive search across these databases from 1990 to current date included 'method\*', 'research design', 'Gadamer', 'Heidegger', 'van Manen', 'hermeneutic', 'phenomenology', 'anonymity', 'consent', 'ethic\*', 'sampl\*', 'demographic', 'data collection', 'interview', 'observation', 'transcription', 'data analysis', 'computer', 'rigor', 'rigour', 'audit trail', 'trustworthiness', 'fit\*', 'credibility', 'triangulation', 'validity', 'reliability', 'reflexiv\*', 'power relations', 'research-researched', 'supervision' and 'limitations'. These keywords produced numerous hits, including many duplicate sources which were sifted by title and/or abstract in order to exclude irrelevant material. Electronic records of the retrieved references were stored in Endnote, a bibliographic database

(Adept Scientific, 2010), to build a reference library and later facilitate the production of a reference list using its 'cite as you write' facility.

The selected literature was sorted thematically in order to facilitate its critical appraisal. Searches were updated every six months to identify newly published appropriate sources, until the final drafting of the thesis was completed. Relevant books were identified by searching the online library catalogues of Swansea University and the University of Brighton, as well as the British Library (<http://www.bl.uk/>).

My early understanding, interpretation and application of the underpinning methodology presented considerable challenges, so expert guidance and peer support were sought through attendance at two international training events: the 2006 Institute for Heideggerian Hermeneutical Methodologies and the 2007 Institute for Interpretive Phenomenology, both hosted by George Mason University, Virginia. These events were invaluable in illuminating my understanding of the philosophical underpinnings of my research study, and provided discussion, presentation, and networking opportunities with like-minded researchers.

### **3.3 RESEARCH SAMPLE**

#### **Research site and setting**

One English health and social care hospital setting, serving a local community, was selected to identify potential participants for the study. The hospital provided acute mental health inpatient services to adults aged between 16 and 65 years, in mixed gender accommodation.

The hospital served a diverse demographic, including approximately 300,000 residents living in a small city, nearby towns and rural communities. Data drawn from the 2001 Census (Office for National Statistics, 2003) showed that the locality served by the hospital included a high proportion of working age adults, of which 49% were male and 51% were female, reflecting national trends. The mean age of the population was 39 years, with a relatively high proportion of young working age residents. The locality had a

high proportion of white residents and a relatively low proportion of non-white residents (4%) compared to England and Wales (9%). There was a high proportion of single adults (43%) compared to England and Wales (30%). Population growth has been seen mainly among working age people, particularly 30-39 year olds. There was a high proportion of people living alone (39%) compared to England and Wales (30%). A small number of local government wards within the locality were shown to be among those with the highest levels of unemployment and deprivation in England (Social Disadvantage Research Centre, 2007). This is relevant to the research study as psychiatric disorders, suicide attempts, social isolation and poorer health outcomes are more likely to occur in people facing socio-economic disadvantage (Singleton and Lewis, 2003). This includes factors such as people with unskilled occupations; who are unemployed; who lack formal qualifications; who are renting accommodation from a local authority or housing association; and who are living alone, are separated or divorced.

The range of services provided by the hospital included Acute Inpatient Care, Acute Home Treatment, Day Hospital Services, and Outpatient Psychiatric Clinics. The hospital was purpose built in the mid-1990s, and provided a relatively modern mental health care experience for its patients. The service functioned in a way broadly in keeping with current policies, thinking and contemporary service models.

Within the hospital, 72 acute inpatient beds were provided across four mixed gender open (unlocked) acute admission wards, each accepting referrals from different geographical localities, and one mixed gender 10 bedded locked Psychiatric Intensive Care Unit (PICU). Single bedroom accommodation with wash hand basin facilities was provided, together with communal bathroom, lounge, and dining room facilities in each ward. The study required access to registered mental nurses with experience of the nurse-patient relationship in working age acute inpatient mental health care settings in order to address the research objectives. Given the relatively modern facilities and contemporary service model for care delivery, the



hospital presented an appropriate setting from which to take forward my study.

The principal research question asked 'What are registered mental nurses' reported experiences of the nature of the nurse-patient relationship in working age acute inpatient mental health care settings?' As the study required access to participants with common, in-depth experiences, careful consideration was given as to whether to include nurses working in the PICU as well as the open acute admission wards. It was important to include potential information-rich participants with the objective of yielding in-depth common insights and understandings of the phenomenon under investigation.

The role and function of the PICU adhered closely to the national minimum standards policy implementation guide for PICUs and low secure environments (Department of Health, 2002b). In contrast to the open acute admission wards, patients within PICU settings commonly demonstrate higher levels of risk to self and others, including challenging behaviours (Turner, 2008). Whilst both acute care wards and PICUs provide similar services, each has a particular focus on the needs of patients during different stages of their journeys through illness and recovery. The PICU environment is generally a busy place, with behaviourally challenging patients. Interventions commonly focus on reduction of aggression and violence, making use of containment, de-escalation, restraint and high dose medications and rapid tranquilisation as the mainstays of treatment. In contrast, interventions in the open acute admission wards generally focus on a broader range of needs, where attention is also given to active support regarding social needs including accommodation in preparation for discharge. PICUs may also be different in that they are often treated as 'secure units' by the courts and forensic services, so admissions may include patients presenting higher risks including those transferred from prisons and others who may arguably require or be transferred to medium secure provision.

Following a discussion with the hospital clinical nurse manager, it became clear that the local PICU included the latter client groups. The locked PICU had 10 beds and a higher staff-patient ratio (one staff member to two patients) to meet the complex needs of patients there. Staffing levels included five nursing staff on early and late shifts (two registered mental nurses and three unqualified) and four nursing staff on night shifts (two registered mental nurses and two unqualified). All patients in the PICU were detained under the Mental Health Act 1983, amended 2007 (Department of Health, 2007a), and commonly presented risks of absconding, violence towards self or others, challenging behaviours, and refusal of medications. The PICU accepted court referrals and prison transfers of low to medium level mentally disordered offenders. Nursing interventions focussed on medication concordance and risk management, typically managing interactions between patients to avoid escalation of conflict to violence.

In contrast, the open (unlocked) acute admission wards had 20 beds and a significantly lower staff-patient ratio (one staff member to five patients). Staffing levels were lower in comparison to the PICU, and included four nursing staff on early and late shifts (two registered mental nurses and two unqualified) and three nursing staff on night shifts (two registered mental nurses and one unqualified). Whilst some patients on the open wards were detained under the Mental Health Act 1983, amended 2007 (Department of Health, 2007a), many patients were admitted to hospital on an informal or voluntary basis. According to the hospital clinical nurse manager, patients in the open wards presented with a more diverse range of needs and the focus of nursing interventions was broader than on PICU. Alongside less intensive medication concordance and risk management, interventions included social challenges such as addressing employment and housing needs, state benefits claims, and negotiating leave, as patients prepared for discharge from hospital. The views of the hospital clinical nurse manager about differences between PICU and open acute admission wards also mirrored my own views, drawing upon the literature and on my experiences of working in similar clinical areas in my own professional practice as a registered mental nurse.

Given these significant differences between the PICU and the open acute admission wards, and how these influence the roles of nurses, and drawing upon factors which impact on the nurse-patient relationship discussed in the literature review in the previous chapter, it was apparent that nurses' experiences of nurse-patient relationships in the PICU were likely to be different to those on the open acute admission wards. It was important to include participants with common insights and understandings of the phenomenon under investigation. I therefore decided to exclude nurses working in the PICU from participating in the present study. Whilst it would be interesting to explore nurses' experiences of the nurse-patient relationship in the PICU setting, this would necessarily form part of a different research study.

## **Research participants**

### *Identification of potential participants*

Participants were not approached until a favourable ethical opinion was confirmed in writing by the Local Research Ethics Committee (appendix A) and permission to commence the study was granted via research governance approval from the local NHS Trust Research Consortium where the study took place (appendix B). Ethical issues pertaining to the study are discussed later.

Registered mental nurses working in one of the four open acute admission wards in the hospital setting, and who met the specific inclusion criteria (discussed later), were invited to volunteer to participate in the study. All registered mental nurses working in these wards were regarded as potential participants. As I could not establish which nurses met the inclusion criteria until they volunteered to participate, permission to approach all nursing staff was initially sought through the hospital clinical nurse manager. The manager identified that the pool of potential participants was 52 staff nurses, eight charge nurses and four ward managers. A condition of approval of this study by the local NHS Research Consortium Research and Monitoring Committee was that an initial letter of approach to staff about this study should come from their service manager. This is presented in appendix C.

### *Approaching potential participants*

All potential participants received an information pack sent to their workplace address, which included a personal letter of invitation and reply slip to participate in the study (appendix D); a participant information sheet outlining the proposed study (appendix E); and a participant consent form (appendix F). These included an explanation of the purpose of the study, why participants were being asked to take part, that they were free to decide whether or not to take part, that their participation was voluntary, the nature of interventions required for their participation, the possible risks and benefits of taking part, to whom complaints should be made should things go wrong, the confidential nature of the study, the proposed dissemination of anonymised findings from the study, the data security measures in place, informed consent, and their right to withdraw from the study at any time without affecting their employment or legal rights. Details of an independent contact person for general information and advice about the rights of research participants were provided. The inclusion criteria for participation in the study were clearly identified to enable nurses to decide if they were likely to be suitable to volunteer to participate in the study.

In addition, I arranged to attend a ward manager's meeting, and shift handover meetings in each ward, to verbally explain the purpose of the study to available qualified nursing staff. Care was taken to avoid exerting any undue influence on participants to take part in the study, and staff were informed that participation in the study was entirely voluntary, and that participants could withdraw at any time without affecting their employment or legal rights.

As Bryman (2004) highlights, gaining access to an organisation does not mean it will be an easy task to access people themselves who may be suspicious about the true motives of the researcher. Participants may be concerned that their comments may get back to their managers or colleagues, and may even sabotage the study by providing misinformation. These informal meetings gave me opportunities to engage staff interest and to allay any concerns with a view to their possible participation in the study.

Potential participants were invited to contact myself directly as the researcher for further details. They were asked to return a reply slip to me with their confidential contact details, should they wish to participate in the study. This ensured that those willing to participate in the study could do so in confidence. Those who returned reply slips were contacted by telephone to discuss the study, and to ensure that they met the study inclusion criteria. A convenient time and venue for interview was offered from a range of pre-booked sessions, at least one week ahead, to allow participants a 'cooling off' period in which they could withdraw from the process. A confirmation letter stating the agreed venue, date, and time for interview was sent to participants in advance of the interview. Participants were asked to think about one or two examples of nurse-patient relationships from their experience in acute inpatient care, which stood out for them for some reason. Participants' examples were used as a starting point to explore their views about the nature of nurse-patient relationships in acute inpatient care.

#### *Recruiting potential participants*

In seeking to explore the meaning of nurses' accounts of their experiences of the nurse-patient relationship, the question arose as to how to select from populations, and employ sampling strategies that would enable statements about meaning to be made with some authority. In considering this issue, Williams (1998) suggests that the researcher should consider which people are most able to assist them with an exploration of the research question. Popay et al (1998) state that in qualitative work, relevance of the sample population is of most concern to the researcher, rather than issues of randomness and representativeness.

A purposive, criterion based sampling procedure was used to select the study's sample. Purposive sampling involves the selection of individuals based on their first hand experience of the phenomenon of interest (Speziale, 2007). Participants are selected for the purpose of describing an experience in which they have participated, to provide greater understanding of the phenomena. In this study, participants were selected in the sense that

only those who met the specific inclusion criteria outlined below were eligible to volunteer to participate in the study.

Purposive sampling used in this study is different from theoretical sampling which is used primarily in grounded theory. Whilst these are similar, theoretical sampling is a more complex form of sampling based on concepts with proven theoretical relevance to the evolving theory (Coyne, 1997).

Theoretical sampling involves a process of the collection, coding and analysis of data to generate theory, the researcher deciding what data to collect next and where to find this from specific participants, in order to develop the emerging theory (Glaser, 1978). Theoretical sampling therefore proceeds on the basis of emerging, relevant concepts, and is guided by developing theory. In my research study, participants were included solely on the basis that they met the inclusion criteria following a purposive sampling strategy designed to ensure participants would be the most able to assist with the research question.

Inclusion criteria to obtain participants with common experiences relevant to the research question were established, in order to reveal the meanings of RMNs' particular experiences of nurse-patient relationships in the working age adult acute inpatient care setting (Patton, 2002). Of those who expressed an interest to participate using the reply slip, the following principal inclusion criteria for the selection of participants were applied:

1. All participants held a 'Registered Nurse – Mental Health' recordable professional qualification, and were registered with the United Kingdom Nursing and Midwifery Council;
2. All participants were employed on a full-time basis within one NHS Trust, and worked in one of four open acute admission wards in the hospital setting selected for the study;
3. All participants were employed either as staff nurses (Grade 'D'); senior staff nurses (Grade 'E'); charge nurses (Grade 'F') or ward managers (Grade 'G');

4. All participants had at least six month's nursing experience in acute mental health inpatient services to adults aged between 16 and 65 years, within their current clinical grade; and
5. A maximum number of 15 participants would be included for pragmatic reasons, given the relatively short two-year timescale to complete the study within the Doctorate in Nursing Science programme.

Mental health professionals other than those holding a 'Registered Nurse – Mental Health' qualification, and unqualified staff working at the hospital were specifically excluded from the study as their experiences of staff-patient relationships were likely to be different to RMNs, owing to their differing roles, responsibilities, and working patterns. Part-time RMNs were excluded from the study on the basis that they may not have adequate experience of nurse-patient relationships across the full 24 hour shift rotation pattern worked by full-time nursing staff. They may also have different experiences such as not undertaking primary nursing roles with patients.

A delimiting timeframe of six months' nursing experience was decided to ensure participants' adequate experience of nurse-patient relationships, to promote meaningful exploration of the research objectives. In a qualitative research study, Miller and Blackman (2005) explored nurses' learning during their first three years of post registration employment. Their findings revealed that newly qualified nurses typically viewed the transition from student to staff nurse as being 'massive'. Novices felt responsible for the total care of the patient which seemed a daunting task, and they experienced a crisis in their confidence between four and six months in post. With appropriate induction, monitoring and support, nurses developed their competence and confidence within 12 months in post.

Discussion with the hospital clinical nurse manager confirmed my beliefs from my own professional experience that most newly qualified mental health nurses applying for jobs in this particular NHS Trust were offered their first posts in working age acute inpatient mental health settings. Many left post within their first year of employment there. I therefore decided that a

delimiting timeframe of six months' experience in working age acute inpatient mental health settings was required to capture newly qualified nurses' reported experiences of nurse-patient relationships, as they formed a significant part of the workforce.

Initially, eleven staff who met the inclusion criteria volunteered to participate in the study in Spring/Summer 2006. The sample size could not therefore be determined at the beginning of the study. The sample size in qualitative research is likely to be small, but this cannot be theoretically pre-determined. It should be such that it permits deep analysis of rich data that leads to new and rich understandings of the phenomena under study (Sandelowski, 1995).

Bénner (1994) explains that the sample size in interpretive phenomenological studies may only be considered adequate as the study progresses, when interpretations become visible and clear, and that no new findings from all previous stories are revealed from new participants.

Following the preliminary data collection and data analysis of eleven stories in Spring/Summer 2006, interpretations and meanings were not completely clear. More potential participants were therefore sought in Autumn 2006 through further informal visits to staff in each ward during ward handover meetings. From this, three more staff volunteered to participate in the study and all met the inclusion criteria. Following further interview data collection and analysis of their stories in Winter 2006/Spring 2007, interpretations were considered to be visible and clear, with no new findings being revealed, so further interviews became unnecessary.

### *Research sample*

Participants were selected using purposive, criterion-based sampling methods (Coyne, 1997) and 14 RMNs in total volunteered to participate in the study, and all met the inclusion criteria. This sampling strategy was selected to provide 'information rich' participants with shared experience of the phenomenon under investigation, with the purpose of yielding detailed insights and understandings about the nature of the nurse-patient relationship in the working age acute inpatient mental health setting. These staff grades were selected because they comprise qualified nursing staff who



carry responsibility for the day-to-day nursing care in their ward areas (Higgins et al., 1999b).

All 14 participants attended for interview. Of these, three to four staff happened to be drawn from across each of the four wards. All participants worked on a full-time basis, 37.5 hours each week, in one of four acute admission wards in the hospital setting described previously. All staff nurses (Grade 'D'), senior staff nurses (Grade 'E') and charge nurses (Grade 'F') worked on a 24 hour shift rotation, generally working three weeks of day shifts and one week of night shifts. Day shifts were worked as a mix of early shifts from 07:30 to 15:00 hrs, and late shifts from 13:30 to 21:30 hrs. Night shifts were worked from 21:00 to 07:45 hrs. Staff numbers on each shift were generally scheduled as follows: four on early shift (two qualified, two unqualified); four on late shift (two qualified, two unqualified); and three on night shift (one qualified, two unqualified). Ward managers (Grade 'G') were scheduled to work Monday to Friday from 09:00 to 17:00 hrs, and were not included in the staff shift numbers.

Participants' demographic descriptors were aggregated to protect their anonymity and are presented in tables one to seven below. Morse (2008) advocates against the use of a participant demographics matrix, listing participants' demographic characteristics one-by-one, as pseudonyms can aid in the identification of participants and threaten anonymity. Later, confidentiality may be threatened when pseudonyms are linked to quotations. The differences among participants' demographics included the following parameters: present post, professional qualifications, number of years' post-registration mental health experience, age, higher education qualifications, gender identity, and ethnicity.

Of the 14 individuals, four were employed as grade 'D' staff nurses, five as grade 'E' senior staff nurses, and five as grade 'F' or 'G' senior nurses. Senior nurses included staff employed either as grade 'F' charge nurses or grade 'G' ward managers. It was agreed with charge nurses and ward managers that they would be identified only as 'senior nurses' in any written publication from the study in order to safeguard their anonymity. All 14

participants were recorded as 'Registered Nurse – Mental Health' on the United Kingdom Nursing and Midwifery Council Register. Of these, three nurses held a second registration: two as 'Registered Nurse – Adult' and one as 'Registered Nurse – Learning Disabilities'.

Participants' post-registration experience in mental health care ranged from 10 months to over 21 years. This was skewed towards the lower years range, with a median value of four years, nine months. Participants' age ranged from 26 years to 61 years. This parameter was relatively normally distributed with a mean value of 40 years, six months.

Nine participants gained their nursing registration as part of a Diploma in Nursing programme of study and one through a Bachelor of Nursing with Honours Degree. One participant held a Master's Degree in Mental Health Nursing, having qualified with a Bachelor of Nursing Degree previously. Three participants gained their nursing registration prior to the introduction of Diploma in Nursing programmes of study in the early 1990s, and had no formal higher education qualifications.

Ten participants identified their gender as female of which one was transgender. This participant asked for their transgender status to be made explicit in the study, as this aspect of self was integral to their story of their experiences of the nurse-patient relationship. Four participants identified their gender as male.

Finally, 12 participants were White British, one Black British, and one White (Other).

**Table 1 Present post**

Attribute value	Total cases
Staff Nurse (Grade 'D')	4
Senior Staff Nurse (Grade 'E')	5
Senior Nurse (Grade 'F' or 'G')	5
<b>Total</b>	<b>14</b>

**Table 2 Professional qualification(s)**

Attribute value	Total cases
RN – MH	11
RN - MH and Adult	2
RN - MH and LD	1
<b>Total</b>	<b>14</b>

**Table 3 Post-registration experience**

Attribute value	Total cases
0.5 to < 1 year	3
1 to < 2 years	1
2 to < 3 years	1
3 to < 4 years	1
4 to < 5 years	2
5 to < 6 years	2
6 to < 7 years	1
7 to < 8 years	1
14 to <15 years	1
21 to < 22 years	1
<b>Total</b>	<b>14</b>

**Table 4 Age**

Attribute value	Total cases
25-29 years	3
30-34 years	1
35-39 years	3
40-44 years	3
45-49 years	1
50-54 years	1
55-59 years	1
60-64 years	1
<b>Total</b>	<b>14</b>

**Table 5 Higher education qualification**

Attribute value	Total cases
None	3
Diploma in Nursing	9
Honours Degree in Nursing	1
Masters Degree in Nursing	1
<b>Total</b>	<b>14</b>

**Table 6 Gender identity**

Attribute value	Total cases
Female	10
Male	4
<b>Total</b>	<b>14</b>

**Table 7 Ethnicity**

Attribute value	Total cases
White - British	12
White - Other	1
Black - British	1
<b>Total</b>	<b>14</b>

### **3.4 DATA COLLECTION METHODS**

The primary source of knowledge in hermeneutics is everyday practical activity (Leonard, 1994). The text becomes an analogue of human behaviour which may be interpreted to disclose hidden meanings which are normally unnoticed and taken for granted. Transcripts of individual interviews with participants are therefore an analogue for their experiences of human behaviour in the context of the nurse-patient relationship. Whilst this everyday world cannot ever be made fully explicit, hermeneutics affords the researcher opportunities to achieve new insights into this everyday lived experience.

Use of a range of data collection methods enhances the credibility of empirical research (Guba and Lincoln, 1989). Data in this study were collected via audio-recorded, unstructured, face-to-face, individual interviews conducted by myself as researcher; via field notes and a reflective journal.

#### **Interview venues**

Easton et al (2000) suggest that researchers should select interview venues away from the main flow of activity to avoid common environmental noises. Prior to interview, suitable quiet environments, free from distractions, were negotiated with the NHS Trust. Participants were offered a choice of convenient venues where interviews would take place. These included booked consulting rooms either in the hospital outpatient department or in an NHS Trust polyclinic building nearby the main hospital building where privacy was assured. Both venues afforded participants' anonymity as they were used for a variety of purposes. The purpose of the room booking on specific days for participant interviews was known only to me and the participant. Venues were generally relatively quiet spaces with few staff around.

Photographs of each consulting room were taken to document the environmental context of the interviews. The consulting rooms provided relatively spacious, comfortable accommodation with good natural light. Soft furnishings included low level easy chairs which were positioned to facilitate good interpersonal communication, informal interaction, and rapport. A small digital audio-recorder and unobtrusive clock were placed on a small coffee

table beside the chairs, together with copies of participant information sheets and participant consent forms. A desk was available in each room which facilitated the recording of field notes prior to and following each interview.

To help dispel any perceived power imbalance in the researcher-researched relationship, and to create a welcoming environment, a selection of teas, coffees and chilled water were offered to each participant on their arrival. I chose to attend wearing smart-casual dress. These factors helped to establish a friendly, relaxed atmosphere in which participants were able to speak freely about their experiences.

### **One-to-one in-depth interviews**

Data were collected using individual in-depth interviews to explore, illuminate and gently probe participants' descriptions of the phenomena under study (Kvale, 1996). This approach is grounded in the tradition of phenomenology where interview data is a major source of information. The interview process affords great flexibility for the interviewer to phrase questions in ways that elicit the meaning of participants' experiences, to collect thick descriptions of that experience, and to facilitate its later interpretation, leading to greater understanding of the phenomenon.

Prior to any intervention, participants were reminded that their participation in the study was entirely voluntary. Each was asked to read the participant information sheet, and read and sign a fresh consent form prior to any intervention, including face-to-face interviews and the reading of transcripts to check their content and accuracy.

Throughout each interview, I was mindful of the risk of possible intrusion and distress to participants, who had been informed at the beginning of their interview of their right to stop the interview at any time. It was explained that the content of the interview would be transcribed, and that direct quotations from their transcript may be used in anonymised form in any publication from the study. It was explained that participants' names and personal details would not be disclosed. An exception to this would be disclosures which raised professional dilemmas. Confidentiality may be broken in the interests

and safety of patients, as I am a registered nurse bound by the then Nursing and Midwifery Council Code of Professional Conduct (Nursing and Midwifery Council, 2004).

Sorrell and Redmond (1995) suggest that a separate guide sheet, addressed directly to each participant prior to interview, may be helpful in establishing the specific focus of the interview and in facilitating rapport. This will likely assist participants to come prepared with meaningful narratives that can be explored during the interview. Participants were therefore asked to consider in advance one or two memorable examples of nurse-patient relationships which they would like to share as a starting point in the interview.

Price (2002) suggests that open interviews with the minimum of steering often result in relatively superficial accounts. However, emphasis in interpretive phenomenology should be placed on obtaining rich, freely given data, rather than attempting to elicit data directed along pre-determined channels (Holloway and Fulbrook, 2001). A dilemma arose in that the development of some interview questions was made a requirement for formal ethical approval of the study by the Local Research Ethics Committee. Some broad, open-ended questions were therefore developed to meet this requirement, and were available to me to use where relevant as a possible device to probe in interviews, which may have lead to richer data collection.

The open structure of the interview was explained. Kvale (1996) offers helpful guidance regarding types of qualitative research interview questions, which were adopted in the study. I began by asking participants for straightforward factual demographic information, which helped to set the tone of the dialogue, put them, at ease and establish rapport. Following the collection of participants' demographic data, I began with open-ended introducing questions, such as 'Can you tell me about an experience of a nurse-patient relationship that stands out for you?' Follow-up questions to extend participants' answers included 'What was that experience like for you?' When further probing or clarification was needed for me to understand the specific situation being shared, I used prompts such as 'Can you tell me more about that'; 'What did that mean for you?'; and 'How did that feel ...

what was that like for you?' Direct questions later in the interview focussed on specific issues raised by participants. Further questioning techniques included use of structuring questions such as 'Let's move on to ...' to focus on relevant information; use of silence, allowing pauses for reflection and association; and use of interpreting/paraphrasing/clarifying questions such as 'So you mean that ...'. These questions helped to ensure that data were closely tied to the primary research question, whilst allowing participants' freedom of expression to explore issues of relevance to them (Holloway and Fulbrook, 2001). Questions were intended to maintain participants' engagement in their stories without directing them to particular issues or events (Benner et al., 1996). No other prepared questions were asked by the interviewer. Interviews provided opportunities to talk about issues and feelings otherwise unheard within participants' everyday working practices.

Any ambiguities arising were addressed during the interview, or at the end. Participants were asked towards the end of the interview if they had any further issues to add, to offer them a final opportunity for comments.

Interviews were audio-recorded and transcribed verbatim for later analysis and coding by me. May (1998) highlights the need to ensure that recordings are of high quality for later transcription. For this reason, I used a digital audio-recorder which clearly recorded even softly spoken speech, and had the advantage of allowing interviews to be securely stored electronically as computer files, which were password-protected to assure confidentiality. The digital audio-recorder was unobtrusive and enabled continuous recording without interruption for the duration of each interview. This enabled me to focus on participants' stories using active listening, paying due regard to paralinguistic features of the voice and non-verbal communication.

### **Participant debriefing**

On completion of their interviews, participants were informally debriefed as to their thoughts and feelings as to what had been discussed. I re-established informed consent with some participants who had made particularly sensitive personal disclosures, to ensure that they were fully aware that their

transcribed data may be used in anonymised, published form. Participants were reminded that they would receive their transcript to check for accuracy and integrity, and that this would afford them a further opportunity to remove specific comments should they choose to do so. An 'Arrangements for Participant Support' information sheet was offered (appendix G), but this was declined by all participants as no-one had experienced undue distress. Most participants commented as to how helpful and interesting the interview process had been, and that this had afforded them opportunities to talk about their experiences. In some instances, this had been quite cathartic, participants having gained a richer understanding of their lived experience. The mean interview duration was one hour, 17 minutes (range 49 minutes to one hour, 43 minutes; see appendix H).

### **Reflective journal and field notes**

It is acknowledged that neutrality and detachment in data collection, data analysis and interpretive processes are impossible (Mason, 2002). My prior background, knowledge and preconceptions of the nurse-patient relationship were therefore interconnected with the research and the data generated (Rogers and Cowles, 1993). It was therefore important to pay special attention to my own self-awareness as part of the research process, to have a positive impact on the credibility of the reported findings. My preconceptions and their possible effects were documented using a reflective journal. This also served to note the methodological decisions made throughout the study. This was important as the study design was in part emergent, which is typical in qualitative research (Lincoln and Guba, 1985). Attention was paid to recording my rationale for all methodological decisions throughout the investigation, as part of an audit trail to add to the rigour of the study. This included maintaining consistent notes during the interpretive phase of the study. Rogers and Cowles (1993) suggest this includes all analytic or theoretical insights, and speculations, to demonstrate that reasonable analytic procedures and lines of enquiry were followed.

Lowes and Prowse (2001) recommend that researchers should record their thoughts about interview questions and subsequent responses, before and



after each interview, using field notes. Further notes were made to describe non-verbal behaviours and gestures of the participant, distractions or other interruptions or other occurrences. My own thoughts, feelings, and verbal and non-verbal communications were recorded in this way. These served as contextual field notes to be later incorporated into the interpretation of transcribed texts. This, together with listening to audio-recordings and reading transcripts, helped me to recall significant issues arising during each interview. This was a means to add to the thick description which is required in the reporting of qualitative research (Rogers and Cowles, 1993).

My preconceptions were continually reflected upon during the data collection, data analysis and interpretative processes. Use of these different methods of data collection may be helpful in enhancing the transparency and validity of findings using triangulation (Redfern, 1995).

### **Transcription process**

Audio recordings were downloaded from the recorder to my computer and saved as anonymised files using NVivo 8 (QSR International, 2010), a computer-assisted qualitative data analysis software package (CAQDAS).

The transcribing conventions suggested by Silverman (2001) were adopted during the transcription process (appendix I). Specific attention was paid to transcribing participants' vocal intonations and pauses, to enhance the rigour of later analysis. Transcripts were continuously checked for accuracy by reading/re-reading them through, whilst simultaneously listening to audio-recordings using electronic voice editor software. This assisted in navigating within each recording to find specific speech content, and to add specific timed pauses and emphasis during the transcription process. Segments of each recording could be slowed and repeated on a loop to ease transcription. All names and references to specific people and places were anonymised. The mean length of transcripts was 37 pages, each taking approximately 12 hours to transcribe (see appendix H). The 14 participant interviews generated 519 pages of transcripts for later analysis.

## **Member checks**

Transcripts were returned to participants to verify their accuracy and integrity, which added to the credibility of the research. This process afforded participants the right to check how they were represented in their transcripts, and allowed any errors to be identified and rectified. Easton et al (2000) highlight that such errors can be simple punctuation errors, or more seriously, mistyped words which may change the entire meaning of the sentence. Participants were reminded that they may add or remove comments as they wished. They were asked to return amended transcripts within three weeks, and that should I not hear from them, I would assume that they were happy with their content and accuracy, and that they did not wish to make any changes. Nine of the 14 participants returned transcripts. Of these, seven had minor corrections/clarifications and two had no changes (see appendix H).

## **3.5 DATA ANALYSIS AND SYNTHESIS**

Transcribed interview texts, informal observations recorded as field notes, and reflective journal contents, were considered as the data for this study during the interpretive analysis process. The process of conducting interviews, the interpretive process, and ongoing participant recruitment proceeded simultaneously until no new common relational themes arose.

### **Philosophical background**

The underpinning methodology for this study is grounded in the hermeneutic phenomenology of Heidegger (1962). Whilst Heidegger does not discuss a method as such, I drew upon central notions of Heidegger's and Gadamer's philosophy of hermeneutic phenomenology to guide the procedural steps of the study. In considering data interpretation, May (1998) reminds us that underpinning theory forms the lens through which data should be interpreted, and conclusions drawn. In this regard, I was guided by the philosophical perspectives of Heidegger (1962) and Gadamer (2000) when analysing data.

Hermeneutic phenomenology considers the '... practice of interpretation of understanding of human concerns and practices' (Benner et al., 1996: 351). The primary knowledge source for the study was the everyday practice experiences of registered mental nurses employed in working age acute inpatient mental health settings. Accounts of these experiences were collected via in-depth individual interviews. Interpretation of transcribed interview data, and reflective journal and field notes informed the study findings to reveal the common experiences and shared meanings of the nurse-patient relationship. The purpose of the data analysis process was to facilitate understanding of the meaning of the phenomenon itself, whilst preserving the uniqueness of each participant's lived experience (Cohen et al., 2000).

Two key methodological assumptions are relevant to the analysis of the data. First, there is no privileged foundational view of the world which is atemporal and ahistorical (Leonard, 1989). According to Heidegger (1962), humans operate contextually within a set of historical and temporal relationships. These are expressed by interpretation through language. The personal meaning of each individual's experience is embedded within their lived life, and may be illuminated through a hermeneutical process of systematic interpretation. Hermeneutic phenomenology is concerned with understanding the individual as situated in the world, which is defined as meaningful sets of relationships, practices, and language one has by virtue of being born into a particular culture. Within a phenomenological, hermeneutic research context, both the researcher and the researched bring with them their lived world experiences situated in historical time. This approach acknowledges that people are inextricably situated in their own worlds, which informs the interpretation of their stories. Data collected by the researcher is fused with their own experience (Koch, 1996). The interpreted text is therefore a result of the inter-subjective, contextual situation. Objective, valid interpretations free from contextual and historical factors are therefore impossible to attain. In contrast to Husserl's phenomenological methodology, hermeneutic interpretive phenomenology does not therefore require the researcher to bracket their own preconceptions and theories

during the research process (Lowes and Prowse, 2001). Second, given common background meanings through culture and language, as researcher, I brought my own preliminary understandings of the phenomena under study. This background understanding rendered the process of bracketing both unrealistic and undesirable.

In contrast with structured, linear quantitative scientific methods, hermeneutic scholarship is characterised by a fluid, seamless, iterative method of inquiry involving reflective, reflexive thought processes, characterised by their circular nature. Whilst there is a danger in describing hermeneutical scholarship as a method in a traditional sense, failure to describe the processes undertaken in detail may imply a lack of rigour. I have therefore described these in a sequential manner, which is intended to evidence the depth and detail of the scholarly processes undertaken.

Data were analysed according to the seven stage hermeneutical method described by Diekmann and Allen (1989), using Heideggerian phenomenology as the philosophical background. This approach was used to identify the categories, relational themes and constitutive patterns of 14 texts. In brief, the analysis explored passages for meanings arising either implicitly or explicitly within these texts. Meanings were compared and contrasted to identify any conflicts and contradictions, and constitutive patterns were developed to describe relationships between the categories and relational themes.

Diekmann and Allen (1989) advocate a team approach to data analysis. This presented a conflict in that the research study was undertaken for submission as a thesis for examination for a doctoral award. This required the thesis to be the result of my own investigations, except where otherwise stated (Swansea University, 2011). Texts were therefore analysed solely by me as researcher. Crist and Tanner (2003) argue that whilst team involvement may add depth and insights to interpretations, this approach is not a requirement for analysis in interpretive phenomenology. My own individual interpretative approach was therefore justified.

## Data analysis procedural stages

Data analysis proceeded in seven stages, simultaneously with data collection, involving continual movement between the parts of the text, to the whole, across texts, then back to the parts, as follows:

1. Beginning with early stories, each of the 14 texts was considered as a whole. Each transcript was read to gain an overall understanding of each participant's story, and to begin to identify common relational themes embedded within them. Any assumptions which might influence my conduct of interviews, observations, and interpretations, were acknowledged when possible, using field notes and a reflective journal. Attention was paid to the critical evaluation of my early interview and observation techniques, to further develop and focus these skills in subsequent interviews. New lines of inquiry resulting from early, tentative interpretations guided subsequent interviews and future sampling, to facilitate deeper, richer understandings (Crist and Tanner, 2003). Early understandings occurred when particularly dynamic examples of practice stood out from others when encountered. Benner (1994) suggests that part of the work of interpretation is to ask why such instances appear to stand apart and catch the reader's attention. Such examples may later become paradigm cases, or strong instances of patterns of concerns, of ways of being-in-the-world. Through writing and re-writing, each was summarised in its entirety as a three-to-five page summary of central concerns. Crist and Tanner (2003) argue that these summaries provide a vehicle for discussion as team, interpretations begin to be formed. In my study, these summaries served as a vehicle for reflection as my analysis progressed.

Sections within each text were summarised and categories of participants' experiences identified. An interpretive plan was constructed to note the raw categories emerging (appendix J). Written interpretations of the categories were produced, each

supported with direct quotations from the texts. These were the lowest units of analysis. In order to enhance the rigour of the study, I shared my interpretations with my research supervisor, to clarify the analyses and supportive evidence provided by the text. Preliminary interpretations and a critique of the methods adopted were also presented to experienced researcher attendees at the 2006 Institute for Heideggerian Hermeneutical Methodologies and the 2007 Institute for Interpretive Phenomenology, both hosted by George Mason University, Fairfax, Virginia. My reflection on feedback received enhanced my insights and critical appraisal of my interview techniques and initial interpretations, through which I progressed to a deeper understanding of the methodology.

These processes were helpful in identifying whether similar or contradictory themes had emerged from my interpretations. This led to the extension, enhancement and rejection of emerging themes, with any ambiguities or discrepancies being clarified through referral back to participants' original stories. In this way, my interpretations proceeded '...in cycles of understanding, interpretation and critique' (Benner, 1994: 116), acknowledging the underlying assumption of hermeneutical analysis that no one single 'correct' interpretation exists, and that each interpretation is complete but never ending (Diekmann and Ironside, 1998b).

2. Summaries of central concerns reflecting the shared experiences and practices of nurse-patient relationships continued to be reviewed, with reference to transcripts when clarification of emerging interpretations was required.
3. Diekmann and Allen recommend further independent analysis of each document at this stage, where team members' interpretations of categories may be compared for similarities and differences. This stage was not followed, nor was it an absolute requirement, for the reasons discussed above.

4. Relational themes, defined as ones that cut across all texts, were next identified and documented, linking categories together to convey unified meanings. Crist and Tanner (2003) refer to these as exemplars. Texts and summaries of central concerns analysed in the early stages were re-read and compared with later texts to identify any similar or contradictory meanings. Conflicts arising among the various meanings within the texts were resolved using evidence from the texts to support the choice of relational themes, and through discussion with my supervisor.
5. In this stage of the interpretation, constitutive patterns were sought. Considered the highest level of hermeneutic analysis, these patterns are shared meanings, present across all texts, and expressed the relationships among the relational themes. Interpretive summaries guided further lines of inquiry during subsequent interviews and later sampling until no new interpretations emerged. This process occurred simultaneously with the final three interviews conducted in Winter 2006/Spring 2007.
6. Diekleman and Allen recommend that the analysis be validated by persons outside the 'research team', but who are familiar with both the content and the research method. To this end, the detailed analysis was shared with my research supervisor.
7. The last stage involved preparation of a final report incorporating sufficient direct quotations from 519 pages of interview transcripts, to support my written interpretations of identified relational themes, and to allow for readers to validate my final interpretations. This took the form of the final thesis. The relational themes and constitutive patterns were considered in relation to a wide range of literature related to the nurse-patient relationship, further challenging and extending my interpretive thinking. This exploration sought to augment and further illuminate the richness and complexity of registered mental nurses' lived experiences of the nurse-patient relationship in working age acute inpatient

mental health settings. These texts also helped me to maintain a focus on the common experiences of the registered mental nurse participants by grounding me in considering their human way of being. The nature of Heideggerian hermeneutical phenomenology is that it is reflective, reflexive, and circular, with interpretations continually held open and problematic by reading widely in the research literature. This process brought a variety of perspectives to bear on my interpretive thinking which Diekmann and Ironside (1998a) advocate as a means to extend, support, challenge or reject emerging themes.

Van Manen argues that theme analysis is often oversimplified, and is understood as an unambiguous, fairly mechanical process of coding of selected terms in transcripts, for which he states computer programmes claim to do the theme analysis for the researcher. As human science research is concerned with meaning, phenomenological themes should be understood as structures of experience. Van Manen (1997: 79) states:

*“Ultimately, the concept of theme is rather irrelevant and may be considered as a means to get at the notion we are addressing. ... After all, it is lived experience we are attempting to describe, and lived experience cannot be captured in conceptual abstractions.”*

The development of themes to describe aspects of the structure of participants' lived experiences are at best a simplification that falls short, and may provide an inadequate summary of the notion. None-the-less, themes present a means to get at the notion, expressing the essence of the notion, but are always a reduction of the notion:

Whilst van Manen highlights the potential limitations of computer assisted qualitative data analysis software (CAQDAS), Bazeley and Richards (2000) argue that the NVivo computer programme offers a flexible, dynamic approach to support the researcher to analyse data, taking account of the emergent nature of qualitative research themes. May (1998) comments that such software packages are valuable as a means of manipulating



transcribed material, but cannot analyse the data in a way that some statistical packages do. Bryman (2004) argues that, whilst CAQDAS has its critics, NVivo software warrants serious consideration because of its power and flexibility. I therefore chose to use CAQDAS to assist in the data analysis process without compromising the nature of the meaning of emergent themes within a human science context.

### **Data handling and management**

Data handling and management were assisted through use of CAQDAS NVivo 8 software package (QSR International, 2010). It is important to note that NVivo 8 package does not undertake the analysis for the researcher. The heart of the analysis still requires thoughtful interpretation of the text as explained above. However, NVivo 8 can facilitate good record keeping of hunches, ideas, searches and analyses within the research project. This can make the analysis of the data more accurate, reliable and transparent (Gibbs, 2002). The software provides a vehicle for the skilful handling of qualitative data, enabling the building of a live, changing body of information, from which new meanings can be created (Richards, 2005).

Following attendance at an NVivo workshop, it took some time to become familiar and comfortable with the software package, but this was later recouped through time savings in the management and handling of the data during the interpretive process. Basit (2003) argues that CAQDAS software is particularly useful for the proficient handling of large amounts of interview data. I found this to be the case, having 519 pages of text to consider. Initial audio files, word processed transcripts, and demographic information, were imported and stored within an 'NVivo project'. Summaries of central concerns, categories of participants' experiences, relational themes and constitutive patterns, were initially identified using hard copy of transcripts. These were later electronically recorded in the 'NVivo project' to assist in the management and retrieval of data. Possible connections among categories, relational themes, and constitutive patterns were visually represented using NVivo 8 to help make sense of the data.

Figure 2. Diagrammatic summary of the interpretive process

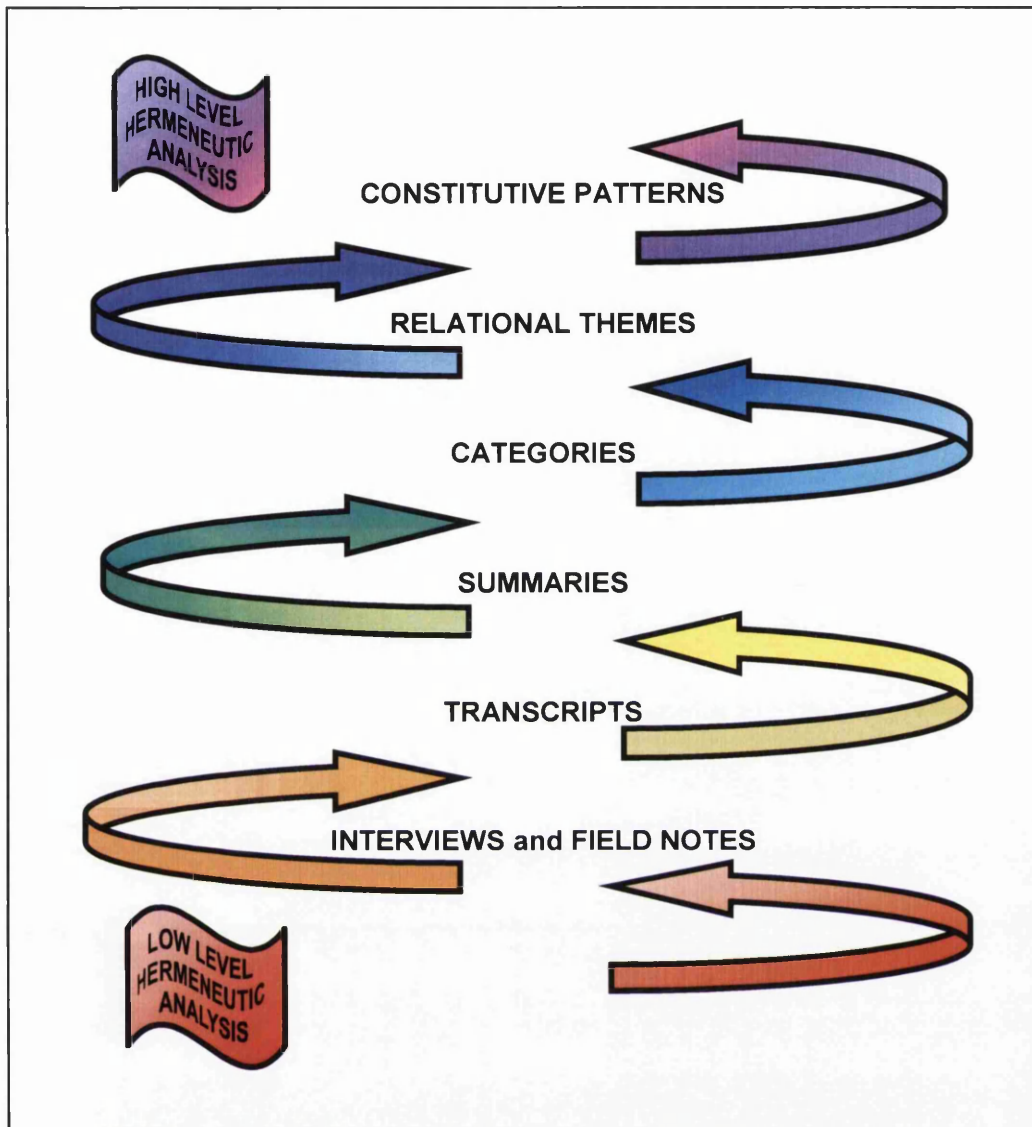


Figure two provides a diagrammatic summary of the interpretive process. Diekmann and Allen (1989) claim that these multiple stages of interpretation provide a bias control, exposing any conflicts and inconsistencies arising through reappraisal and comparison. In this way, unsubstantiated meanings and inaccurate interpretations were challenged and resolved through further reinterpretation and discussion with my supervisor. This process ensured that interpretations were focussed and grounded through constant reference to the text, whilst acknowledging that there can be no single 'correct' interpretation.

Through the cyclical process of interpretation, more sophisticated understandings of the texts may evolve over time, even years later, the researcher questioning their original thinking and questioning in a continuous but never identical pathway of thinking. Sloan refers to this as three different 'moments' in the analytic process: 'In the moment' interpretations which occur as the original story is gathered; moving to 'individual interpretation of each story in its entirety'; then to 'interpretations of collections of stories' which are '... collected across a life's work (to date) of inquiry' (Sloan, 2002: 129). Ultimately, it is the readers of the final report who make the final interpretation (Dieklemann and Ironside, 1998a).

### **3.6 ETHICAL CONSIDERATIONS**

In the United Kingdom, ethical review of research using human participants and NHS premises and facilities is the responsibility of Local Research Ethics Committees (LREC) (Tod, 2002). Under the Research Governance Framework for Health and Social Care (Department of Health, 2005), it is a statutory requirement that any research project taking place in an NHS organisation receives formal approval from the Local NHS Research Consortium Research and Monitoring Committee before the project commences. These committees aim to protect research subjects and patients, and to facilitate research that may lead to improved treatment and health care delivery. Key ethical concerns for this qualitative research study were the possible impact of the methods utilised in the research study upon the participants, and the suitability and rigour of the research study itself. Issues of rigour are discussed separately in the next section.

The key ethics focus in all phases of the research study was to establish and maintain safeguards to protect the rights of participants, paying specific attention to informed consent, minimising potential risks, protecting them from harm, and ensuring their confidentiality. Richards and Schwartz (2002) identify four potential risks to research participants: anxiety and distress; exploitation; misrepresentation; and identification of participants in published papers, by themselves or others. Their recommended strategies for

reducing the risk of harm to participants were followed, including ensuring the scientific soundness of the study; considering obtained consent as a process; organising support where appropriate; and taking a reflexive stance towards analysis. Cutcliffe and Ramcharan (2002) also provide a helpful summary of ethical issues using an 'ethics-as-process' approach which was adopted in the study.

Participants were made fully aware of the potential risks involved through voluntarily choosing to participate in the research study. These potential risks were anticipated to be minimal, and in reality, they were countered by the actual benefits of participating in the study. These are discussed later.

The potential risks were outlined in the participant information sheet (appendix E) which were discussed with them at the recruitment stage and immediately prior to interview. Participants signed a participant consent form (appendix F) prior to interview and member checks being undertaken, indicating that they had read the participant information sheet, and that they understood the information that it contained. This ensured that the establishment of consent was ongoing throughout the research study. It was made explicit to participants throughout the research process that they had the right to withdraw from the study at any time.

The risks and wider ethical issues considered for participants and the researcher included physical health and safety; potential distress during face-to-face interviews; risk of the delusion of alliance when participants could inform more than they intended to; risk of pressure or coercion on participants to continue in the study; risk of the research becoming obtrusive; risk of misrepresentation of participants' views; handling of sensitive information; the safe acquisition, storage and transmission of data; and the risk of breach of confidentiality by disclosing the identification of participants to colleagues and in published papers, by themselves or others. These issues are discussed below.

### **Risk of physical health and safety**

Interviews were conducted during office hours at NHS premises which met statutory health and safety requirements, being subject to organisational risk assessment. I ensured that my whereabouts were known by NHS reception staff, but the purpose of my meetings and the personal details of each participant were not disclosed to them.

### **Risk of distress for participants and the researcher**

During the course of data collection using face-to-face interviews, it was possible that participants may have become distressed. Continuation with an interview in such circumstances may in turn cause distress to the researcher. The likelihood of participants becoming distressed in this study was low, as they were not being selected from vulnerable groups. I planned that if distress occurred, then participants would be asked whether they would like to continue with the interview, or whether they would like the interview to be stopped. If participants decided to continue with the interview, I planned to use my professional judgement to decide whether or not to do so. As an experienced mental health lecturer and mental health nurse, I brought to the research study competence in managing such distress. Throughout the research study, I ensured the sensitive and considered handling of relationships with all participants, being mindful of loneliness and vulnerability.

At the end of each interview, participants were debriefed and given opportunities to ask questions. They were reminded of their right to air complaints and the process for doing so, outlined in the participant information sheet.

In the event, no evidence of distress or harm arose for participants. However, all participants were offered an 'Arrangements for participant support' sheet to keep (appendix G), outlining appropriate confidential support networks available to them. This included contact details of their workplace NHS Trust Occupational Health department, clinical supervision arrangements, the Nursing and Midwifery Council (NMC), the Royal College of Nursing (RCN), Unison and the Samaritans.

I anticipated that the potential adverse risks for me as researcher would be minimal. During the course of conducting interviews, data transcription and analysis phases, I adopted a reflexive approach, reflecting on participants' stories via their transcripts, the research literature reviewed, and my own professional practice. I was mindful that reflecting on the issues raised during interviews had potential to lead to possible researcher distress whilst reflecting on my own professional practice. This did not occur, but appropriate support networks were in place, including access to my research supervisor, and professional bodies such as the Nursing and Midwifery Council.

### **Risk of the delusion of alliance, and pressure or coercion to continue in the study**

In mental health care, the term 'delusion' is often used to describe psychiatric abnormality (Brennan, 2007). Within the context of this research study however, regard was given to a research phenomenon known as the 'delusion of alliance' which may form between researcher and participant. Care was taken to avoid the risk of the 'delusion of alliance' which occurs when participants discuss more than they intended to (Stacey, 1988). The term 'delusion' is used here in a broad sense. For clarity, an authoritative definition is provided as 'The action of befooling with false impressions or beliefs; the fact or condition of being cheated and led to believe what is false' (Oxford English Dictionary, 2011: entry 49546). In terms of this research study, it is about the risk of development of a false sense of alliance between researcher and participant.

Whilst Stacey (1988) discusses the risk of the 'delusion of alliance' by the researcher unintentionally conveying false impressions to participants within the context of ethnographic research, the points made are also relevant to interpretive phenomenology, in the context of the research process and the research product.

The research process involves a human relationship, an 'alliance' between the researcher who engages with the participant. This could place the participant at risk of potential manipulation by the researcher, leading to the

participant possibly discussing more than they had intended to. In the context of my study, participants could have revealed sensitive information, for example, an incident of alleged patient harm, which would be in breach of their professional code of conduct (Nursing and Midwifery Council, 2008). In such circumstances, as a registered nurse myself, I too would be bound by the same professional code, and would be obliged to take appropriate action to report the allegations, to safeguard patients' best interests. This could be viewed as an act of betrayal by the participant, placing me in a position of inauthenticity with the participant, leading to separation rather than alliance between the researcher and the researched. This risk is inherent in fieldwork research conducted by nurse researchers bound by their professional code of conduct.

Stacey (1988) reminds us that no matter how welcome the researcher's presence may appear to participants, fieldwork represents an intrusion and intervention into participants' lives, where the researcher is far freer to leave than the participants. The greater the apparent mutuality of the researcher/researched relationship, the greater the danger faced by participants of possible exploitation, manipulation, and feelings of betrayal. For the researcher, participants' stories are ultimately data, and these may challenge the researcher with confusing ethical dilemmas.

Mindful of these challenges, I maintained honesty and openness with participants throughout the research process. Participants were informed that if disclosures were made which raised professional dilemmas, then confidentiality may be broken in the interests and safety of patients. Participants were made aware of this in writing in the Participant Information Sheet (appendix E) prior to their decision to participate in the study, and this was discussed immediately prior to interview. The possible risks and benefits of their participation in the study including possible intrusion, were explained. I conducted each interview with sensitivity, with due care and attention for participants to avoid the possible risk of the 'delusion of alliance' with them.

Stacey (1988) highlights a further ethical quandary, the risk of desertion by the researcher, for some participants who may find emotional support in the researcher/researched relationship, particularly during the interview process. Participant feedback was therefore sought immediately following each interview. This indicated that the researcher/researched relationship and the interview process itself had been constructive and was appreciated. At the end of the interview process, desertion had not been raised as a concern. All participants were offered a participant support sheet (appendix G) following each interview, as I was mindful that some participants may have required further support later as a result of their participation in the study. Throughout the research process, I maintained self-awareness of the ethical risks and potential dangers to which participants may be exposed.

A further dilemma arising is that whilst the research process places the researcher/researched in a collaborative, reciprocal exploration for understanding, the research product is ultimately that of the researcher (Stacey, 1988). In this study, my thesis has been authored by me, primarily for my own purposes, offering my interpretations of participants' lived experiences, illuminated in my own voice. Stacey argues that this too may represent elements of inequality, exploitation, and/or betrayal, on the part of the researcher. To address these issues, participants' voices and perspectives were extensively represented through use of anonymised in-depth direct quotations from their transcribed interviews. In this way, whilst acknowledging that this thesis offers my own interpretation and account of their experiences, I endeavoured to maintain authenticity throughout the interpretive process, by maintaining closeness to the data representing participants' voices.

I also took care to avoid exerting pressure on or coercing participants throughout the study. The ongoing nature of written informed consent was re-established prior to any intervention. It was made explicit to participants throughout the research process that they had the right to withdraw from the study at any time. The establishment of trust between participants and me was paramount when using face-to-face interviews for data collection. Using



a process of reflection and research supervision, and drawing upon my own self-awareness, I monitored the research process to ensure that it was being sustained with good intention.

#### **Risk of the research becoming obtrusive**

I used my professional judgement to recognise when the research could become obtrusive. Should this have occurred, participants were to be reminded of their right to withdraw from the study at any time, without giving any reason, and without affecting their employment or legal rights.

#### **Risk of misrepresentation of participants' views**

Participants were sent a copy of their interview transcripts to check for accuracy and integrity. This process afforded them the right to check how they were represented, as well as allowing any transcription errors to be identified and rectified. Participants were reminded that they could delete content from their transcripts.

#### **Handling of sensitive information**

As a registered nurse, I was bound by the then Nursing and Midwifery Council Code of Professional Conduct (Nursing and Midwifery Council, 2004) during the recruitment and data collection phases of the research study. This has since been superseded by updated guidance entitled 'The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives' (Nursing and Midwifery Council, 2008). Participants were informed that, in the unlikely event of them disclosing any information which raised a professional dilemma, then my first consideration would be the interests and safety of patients and clients, and that I would act to identify and minimise the risks to them. This would mean that confidentiality would be breached. In such a case, confidential support from the research supervisor and from a professional advisor at the Nursing and Midwifery Council would be sought to decide what appropriate action(s) should be taken. These circumstances were outlined in the participant information sheet, and in the event, no such sensitive disclosures were made.

### **Safe acquisition, storage and transmission of data**

The safe acquisition, storage and transmission of data is acknowledged as a major ethical consideration. Personal details of participants were known only to me as the chief investigator, in order to maintain confidentiality. Personal data held as hard paper copy included participants' signed reply slips, personal contact details and signed consent forms. These were securely stored in a locked cabinet to which only I had access. A unique reference number and pseudonym were allocated to each participant to allow anonymised cross-referencing, for example to interview arrangements and to transcripts, the details of which were known only to me.

Electronic interview transcripts in anonymised form were stored on my home personal computer, which was password protected, the details of which were known only to me. Electronic back up files were named and stored in anonymised form on an external hard drive which was stored securely in a locked cabinet to which only I had access.

### **Risk of breach of confidentiality by disclosing the identification of participants to colleagues and in published papers, by themselves or others**

The selection of participants involved interaction with a range of health care professionals within the NHS Trust, but care was taken to ensure participant confidentiality during this process. Content within written publications respected anonymity, care being taken to protect the identities of individuals and organisations, for example when direct quotations from participants' transcripts were used. Pseudonyms were used within transcribed data and any reference to places and people within the text were anonymised or removed. Participants were asked to carefully consider whether they chose to disclose to colleagues and others that they have participated in the study.

Whilst these potential risks are acknowledged, they are balanced by the benefits to participants in having been involved in this research study. The reality was that in-depth interviews afforded them opportunities to 'tell their own stories'. Most viewed the experience as a positive, therapeutic, beneficent act, offering them time for self-reflection to make sense of their

experiences. Further benefits are likely to be for the wider population through the dissemination of findings in refereed journals and elsewhere, to develop deeper, more comprehensive understandings of the nurse-patient relationship and its impact on the quality of patient care. Participants may further benefit from sight of these publications as they gain a sense of being listened to, whilst others may benefit from reading their experiences.

### **Study approval, ongoing monitoring and progression**

The Local Research Ethics Committee and Local NHS Research Consortium Research and Monitoring Committee formally approved the study in December 2005 (see appendices A and B). The data collection phase formally began on 6 March 2006 and ended on 31 May 2007. Annual progress reports were sent to these organisations in January 2007. Finally, a 'Declaration of End of Study' form was completed and sent to each organisation in August 2007. A 'Summary of Final Report on Research' was sent to each organisation in September 2010.

As sponsor, Swansea University had overall responsibility for monitoring and auditing the conduct of the research. This was undertaken by a Faculty Board and a Faculty Progression (Examination) Board on an annual basis. In addition, the College of Human and Health Sciences, Swansea University monitored progression every six months. A robust system of formal reporting to these boards by my research supervisor was in place, informed through regular face-to-face meetings and email communications with me.

### **3.7 ISSUES OF RIGOUR**

Issues of rigour in qualitative research remain controversial despite much discussion in the literature (Lincoln and Guba, 1985; Rolfe, 2006; Sandelowski, 1986; Sandelowski, 1993). Whilst there is lack of consensus, the legitimacy of knowledge claims in qualitative research are dependent on how believable and trustworthy the research study is (Koch, 1996). Rolfe (2006) argues that there can be no universal criteria for judging qualitative research, as the reality is that no such unified qualitative paradigm exists.

The philosophical position underpinning each research study should inform the research process (Cutcliffe and McKenna, 1999; Koch, 1996). The research paradigm's ontology and epistemology inform the interpretive framework, and ties with the rigour and legitimacy of the study to answer the research question.

Rolfe (2006) argues that the quality of a research study must be judged on its own merits, and is revealed in the write up of the study. Its quality is judged by the reader who requires some practical expertise in the research process in order to make a reasoned appraisal. In effect, the quality of a research study resides in the research report itself, and is revealed through a detailed decision trail providing a rationale for decisions made during the actual course of the study. This view is supported by Johnson et al (2001) who conclude through their analysis of different examples of qualitative research that the methods used are often more varied than is often admitted. They argue for 'British Pluralism' in qualitative research, to accept this reality that there is no 'pure' method, and advocate that the rigour of one's own work and others' should be maintained through integrity, clear accounts, reflexivity, and constructive critique.

In implementing this hermeneutic inquiry, I have given an account of the philosophical position which informs the research process. The trustworthiness of the study may be established if the reader can audit the events, influences and actions of the researcher, provided through a detailed trail of the theoretical, philosophical and methodological decisions taken (Koch, 1996). It is concerned with whether the findings are true and applicable to the participants and their context.

### **Trustworthiness criteria**

Lincoln and Guba (1985) defined the concept of trustworthiness using four criteria: credibility; transferability; dependability; and confirmability. The strategies I employed to enhance the trustworthiness of my research study are discussed next in relation to each.

### *Credibility*

Credibility is concerned with the issue of 'fit' between participants' views and the researcher's representation of them. Lincoln (1995) suggests that this may be demonstrated by using strategies including audit trails, prolonged engagement, peer debriefing, and member checks.

A detailed audit trail was maintained throughout the study which Sandelowski (1993) suggests as a strategy to ensure the trustworthiness of qualitative research. Data were collected in this study through an academically supervised process using individual interviews, field notes and a reflective journal. This supports my contention that the data obtained is trustworthy and original. I established closeness to the data itself through conducting interviews and transcribing them myself; by reading and re-reading transcripts; and by listening to audio-recordings several times during the interpretive process. The research process itself as a practice was continually reviewed over a prolonged period, as I gained further knowledge and insights into the methodology and methods utilised through reading and discussions with my research supervisor, expert colleagues, and peers. I have written the thesis to reflect the reflexive stance I have taken throughout the research process, acknowledging that interpretation of the data in interpretive phenomenology values both participants' and the researcher's experiences, including them both in the final interpretation.

Hermeneutic phenomenology recognises the influence of the researcher on the conduct and reporting of a study (Guba and Lincoln, 1989). The researcher's ability to describe and interpret their experience is integral to the research process. It was therefore important to record my own influences upon the study. Relevant academic, professional and personal background information was discussed in the introduction chapter to this study.

Throughout the study, I maintained field notes and a reflective journal to record the content and process of interactions, including my reactions to various events. Koch (1994) recommends this as a means of raising the researcher's self-awareness, to clarify up front the bias that the researcher brings to the study. For example, during the interview process, I was aware

of my duty of confidentiality and support towards participants, particularly when sensitive disclosures were made. Reciprocity in the researcher-researched relationship was acknowledged in my dialogue with participants, where it was sometimes relevant to briefly share my own experiences with them. Such situations, and my later reflections, were briefly recorded as field notes following the interview. Reflections from field notes and my reflective journal are incorporated into the research findings to lend further credibility to the research.

Throughout the study, I engaged in repeated and substantial involvement in the data collection, data analysis and write-up phases of the study. This prolonged involvement facilitated a more in-depth understanding of the phenomenon under study, and is evidenced through a detailed account of the methods used, and reported findings in the thesis. Peer debriefing was undertaken through exploration of my interpretations and conclusions with my research supervisor on a continuous basis as the study progressed and was written up. This helped me to further examine my preconceptions and consider alternative ways of interpreting the data to enhance the accuracy of my account. These strategies further enhanced the credibility of the study.

Member checking to determine the accuracy of findings involved sending interview transcripts to participants to check them for content and accuracy. Member checking as a means of influencing how participants' perspectives could be portrayed in my interpretation was not undertaken in the present study, as its philosophical underpinnings acknowledge the multiple realities of interpretation of the findings, that no single 'correct' or 'guaranteed' interpretation can exist. Rather, it is the plausibility of the study that should be the central concern. This negates the use of member checking for this purpose, as it presents a philosophical contradiction. Silverman (2010) states that this is an inconsistency of Lincoln and Guba's criteria.

Finally, triangulation using multiple data sources including individual interviews, field notes, and a reflective journal were used. Questions from individual interviews promoted discussion of each participant's experience, and discrepant as well as common findings were reported. This provided

different perspectives on the phenomena under investigation, and challenged my own expectations of emergent findings. This helped me to decide which inferences from those data were valid to corroborate my conclusions.

### *Transferability*

Transferability, or fittingness, is concerned with the 'generalisability' of the findings of the study. Findings are not expected to be generalisable, but it is likely that the lessons learned in one setting might be useful to others in similar contexts elsewhere. Guba and Lincoln (1989) suggest that this depends upon the degree of similarity between two contexts. Readers may judge whether the study findings are meaningful and may be transferable to their context, only if the original study context is adequately described. The context of this study and thick descriptions of participants' experiences have been described in detail earlier in the thesis to this end.

### *Dependability*

Dependability is concerned with ensuring that the study is logical and clearly documented, and that the processes undertaken can be audited (Koch, 1994). This may be judged by others through reading a detailed audit trail of the steps taken and decisions made throughout the research process. Data were also available for review by my research supervisor.

Tobin and Begley (2004) state that reflexivity is central to this audit trail, the researcher offering a self-critical account of the research process. A reflective journal was maintained for continuous self-evaluation, including consideration of the theoretical, methodological and ethical issues emergent in the research process.

### *Confirmability*

Confirmability is concerned with establishing that data and interpretations of findings are true to the data, and have not been 'made up' by the researcher. Confirmability is established when credibility, transferability and dependability are achieved (Guba and Lincoln, 1989).

My research supervisor read the thesis in its entirety for plausibility, thoroughness, comprehensiveness and coherence, as a means of enhancing the rigour of my interpretations (Plager, 1994; Madison, 1990).

A presentation of findings to academic and clinical NHS Trust colleagues unfamiliar with the research method, but likely readers of the study, further enhanced the rigour of the study by exposing any unwarranted, inaccurate interpretations unsupported by the data.

### **3.3 LIMITATIONS OF THE STUDY**

The limitations of this study include that data were collected from mental health nurses from one working age acute inpatient mental health setting in one NHS Trust in England. The small sample size was determined by the chosen methodology. These factors may limit the transferability of findings elsewhere.

The registered mental nurses interviewed volunteered to participate in the study, and may include those with a special interest in the phenomenon under investigation. Their experiences are not intended to be representative of all registered mental nurses in the research setting, or in the wider population elsewhere. Findings cannot be generalised to the wider population.

Whilst Silverman (1998) suggests that focussing on participants' perceptions using interviews can be balanced by a focus on their actions and behaviours using observation, this approach was not selected for this study. Silverman proposes that such approaches could potentially enhance rigour using data triangulation. I considered participant observation as a possible additional means of data collection, but concluded this did not sit well within the context of this hermeneutic phenomenological study. This important decision is discussed further below.

The purpose of this research study was to explore with a sample of registered mental nurses, their reported experiences about the nature of the nurse-patient relationship in working age acute inpatient mental health



settings. The aim of this study is not to find whether or not registered mental nurses actually give holistic care and engage in therapeutic relationships, but rather, it is to find what nurses report of their relationships with patients. As such, observation could result in further distracting dimensions detracting from the chosen focus on nurses' self-report in interviews, to provide accounts of their experiences of nurse-patient relationships. It is not the purpose of this study to determine if these self-reports do actually reflect their practices. This study seeks to understand how participants experience and describe these relationships, not the outcomes of their interactions as perceived by others, or the specific skills they do or do not use in practice. This may be viewed as a limitation of this study, however, from a hermeneutic perspective, participants' understanding always comes first. A hermeneutic phenomenological approach was adopted as a way to explicate that understanding, to give my interpretation of participants' own accounts of their own experiences of nurse-patient relationships. My interpretation of these multiple accounts provides insights into the nature of the relationships nurses experience with patients in the context of their work in the acute mental health inpatient setting.

The usefulness of a hermeneutical, phenomenological approach has been demonstrated by others. Benner (1984) used such an approach to explore the tacit practices of nursing to explicate the ways in which nurses understood the situations they encountered. She did not set out to evaluate the actual care delivered. For example, when the expert neonate nurse says 'this kid looks funny', they do not mean that the child is ugly, rather, that something is amiss, even before there are clinical signs of this. In this way, Benner identified that this kind of sense, intuition or understanding is only possible because of a deep background understanding of neonatal nursing, and having seen many previous patients in similar circumstances. This level of understanding is often developed before the nurse's ability to articulate it. This parallels what I am investigating in this study, in that I provide an interpretation of nurses' accounts of how they come to understand the nature of the relationships they develop with patients in the acute inpatient mental health setting.

It could be argued that the use of observation of actual nurse-patient relationships in action could have added value in pointing to possible inconsistencies between what nurses say they do and what they actually do. For example, participants may articulate that they are open and flexible, whereas the researcher/observer may perceive the opposite. The limitation of observation for this study would be that in such circumstances, what I might observe and perceive about nurses' interactions with patients does not reveal how participants themselves understand their nurse-patient encounters. The only way to access this personal experience of nurses is to have participants themselves tell us about it – what was going through their mind at the time, what they were noticing, and what those things meant to them. To use Heidegger's (1962) example, we can observe a person hammering, but that does not tell us how they come to understand the height to swing the hammer, how to hold it, how to select the right size of hammer for the job. All we see is someone hammering, in essence, stripping it of the world that gives it meaning in the first place. To conclude, observation would indeed provide another data set of impressions about what is observed – but just that – the outside view of what is happening. For this reason, the use of observation in this study was rejected.

Whilst this is a major strength of the study, paradoxically, it may be viewed as a limitation in that accounts of patient experiences were not sought. The study solely focused on exploration of the nurse-patient relationship from the perspectives of nurses. This was designed as the principal research question asked: 'What are registered mental nurses' reported experiences of the nature of the nurse-patient relationship in working age acute inpatient mental health care settings?'

In any interpretive study, there are always more perspectives to the experience under investigation than can be accounted for in any single interpretation. Whilst I understand and acknowledge these different perspectives, my sense as a beginning researcher was to move forward carefully in the knowledge that I would like to focus further on this phenomenon in my future research career. As a logical next step, I would

like to explore the possibility of interviewing dyads, so that nurse and patient participants could talk together about their shared experiences of the nurse-patient relationship. There is already a precedent in the literature for this approach. Ironside (1999a; 1999b; 2005) used interpretive phenomenological approaches to explore with just teachers, just students, and then some together, their stories of their experiences of nurse education. It would be interesting to use a similar approach to seek nurses' and patients' stories of their shared experiences of the nurse-patient relationship using dyads. Such an approach would add further value to our understanding of nurse-patient relationships by fostering participation, cooperation, and co-learning between patients, nurses and the researcher, and are promoted as good practice by Minkler and Wallerstein (2003). Nolan et al (2007) suggest that cooperation between mental health service users, health staff and researchers within the research process, may also contribute to creating an environment where all participants may experience a common sense of purpose and belonging. Service user involvement is often welcomed by service users themselves, who may wish to put something back into the healthcare system that has benefited them, motivated by a desire to improve services (Faulkner, 2009). Involvement in research may in some small way also serve as a useful introduction for service users to think about their own future.

Even taking such an approach using dyads, I would argue that in any interpretive study, the notion of getting a 'complete picture' of participants' accounts of their experiences of the nurse-patient relationship is contrary to the philosophical underpinnings, and is impossible to obtain. In any study, decisions have to be made about how to get started. In the present study, as a beginning researcher, I took the decision to interview nurses alone, to proceed carefully at this early stage in my research career. Patients' perspectives of the nurse-patient relationship in working age acute inpatient mental health settings have been reported widely in the literature, and these were discussed in chapter two, which helps to contextualise the findings in this study.

The findings are context bound, and are my own interpretation of the experiences of mental health nurses' nurse-patient relationships in one working age acute inpatient mental health setting in England. The process of interpretation in hermeneutic, phenomenological research is never absolute, but is always open, leading to possibilities for further complimentary, richer, deeper descriptions (van Manen, 1997). My own experiences and perspectives about the nature of the nurse-patient relationship have necessarily influenced my interpretation of participants' experiences. Whilst it would have been desirable, it was not possible to involve participants directly to co-create as well as to confirm, extend or challenge identified themes during the interpretive analysis process. This aspect of participant involvement was not possible for two reasons. First, the research was undertaken and written up as a thesis, as part of the requirements for a doctoral award. This required the research and submitted thesis to be the result of my own investigations. Second, time limitations for direct interventions such as face-to-face contact with participants were agreed with NHS Trust hospital clinical nurse manager, and were agreed in advance as part of the conditions of approval of the study by the Local Research Ethics Committee.

Participants were selected using purposive sampling, for their ability to provide information about nurse-patient relationships within a specific working age acute inpatient mental health setting context. In qualitative research, it is situational, rather than demographic representativeness, which is sought (Horsburgh, 2003). In this context, it is intended that findings and their interpretations from this study will have relevance in relation to nurses working in similar clinical contexts elsewhere. Morse (1999) states that qualitative research findings are transferable in this way, and should be considered useful, powerful and significant.

Findings from this hermeneutic, phenomenological research study do not claim to represent the universal lived experiences of all mental health nurses' nurse-patient relationships in all working age acute inpatient mental health settings. The findings may not be typical of registered mental nurses'

reported experiences of the nurse-patient relationship elsewhere, and should be interpreted cautiously. Qualitative data in general will have limited transferability to similar contexts. Findings from this study are therefore limited to the nurses studied, but may be transferable to contribute to the ongoing development and understanding of the nature of the nurse-patient relationship in similar contexts elsewhere. Whilst findings cannot be generalised to the wider population, they may compliment and add fresh insights to the existing body of knowledge and future research in this field.

### **3.9 SUMMARY**

This chapter has discussed the research design developed and implemented in this study, reflecting its philosophical underpinnings in the tradition of hermeneutic phenomenology.

The purpose of this research study was to explore with a sample of registered mental nurses, their experiences about the nature of the nurse-patient relationship in working age acute inpatient mental health settings. In seeking to understand this phenomenon, the principal research question asked 'What are registered mental nurses' reported experiences of the nature of the nurse-patient relationship in working age acute inpatient mental health care settings?' The study addressed six key objectives:

1. To review relevant literature relating to the nurse-patient relationship in acute inpatient care;
2. To explore nurse participants' reported lived experiences of the nurse-patient relationship;
3. To describe the essential components of nurse participants' experiences of the nurse-patient relationship emerging from these reports;
4. To interpret and understand the meanings of the relational themes and constitutive patterns of nurse participants' reported experiences of the nurse-patient relationship;

5. To provide a hermeneutical analysis of nurse participants' experiences of the nurse-patient relationship, as provided by them in the study; and
6. To generate new knowledge, making an original contribution to the field, with relevance for clinical practice, education and research.

These key objectives were explored using contextual, perceptual, demographic, and theoretical information.

A phenomenological, hermeneutic study was conducted to understand the meaning of the nature of the nurse-patient relationship in one working age acute inpatient mental health setting.

The research sample was drawn from one English health and social care hospital setting providing acute mental health inpatient services to adults aged between 16 and 65 years in mixed gender accommodation. The hospital served a diverse demographic of residents living in a small city, nearby towns and rural communities. This site was selected as the service was broadly in keeping with contemporary service models of the day. Participants were informally approached on site with their manager's approval, and information packs outlining the nature of the study were distributed. A purposive sampling strategy using principle inclusion criteria was applied to nurses who volunteered to participate in the study. Fourteen nurses were selected to take part, and all attended for interview. Their demographic descriptors demonstrated broad diversity in the sample.

Primary data were collected through face-to-face individual interviews, to access and describe the everyday practical activities of registered mental nurses about their experiences of the nurse-patient relationship. Their stories were transcribed to become a text analogue for later interpretation, to disclose hidden meanings which are normally unnoticed and taken for granted. Further data were collected using field notes and a reflective journal to supplement interview data.

Data analysis proceeded in seven stages, simultaneously with data collection, involving continual movement between the parts of the text, to the

whole, across texts, then back to the parts. This approach was used to identify the categories, relational themes and constitutive patterns emerging from the 14 texts. Data handling and management were assisted using NVivo 8, a computer-assisted qualitative data analysis package.

The ethical concerns of the study were considered on an ongoing basis throughout the study using an 'ethics-as-process' approach. Key ethical concerns included the possible impact of the methods utilised upon the participants, and the suitability and rigour of the study itself. Participants were contacted once the Local Research Ethics Committee and Local NHS Research Consortium Research and Monitoring Committee formally approved the study in December 2005. Participants were made fully aware of the potential risks and benefits of participation in the study outlined in a participant information sheet, and their written informed consent was obtained prior to any intervention with them.

The risks and wider ethical issues considered for participants and the researcher included physical health and safety; potential distress during face-to-face interviews; risk of the delusion of alliance when participants could inform more than they intended to; risk of pressure or coercion on participants to continue in the study; risk of the research becoming obtrusive; risk of misrepresentation of participants' views; handling of sensitive information; the safe acquisition, storage and transmission of data; and the risk of breach of confidentiality by disclosing the identification of participants to colleagues and in published papers, by themselves or others.

Arrangements for overall responsibility for monitoring and auditing the conduct of the research were discussed.

Issues of rigour in relation to this study were discussed. It was acknowledged that there are no universal criteria for judging the quality of qualitative research. The strategies I employed to enhance the quality of this interpretive research study were discussed, based on Lincoln and Guba's (1985) concept of trustworthiness.

Limitations of the study included the small sample size drawn from mental health nurses working in one working age acute mental health setting in England. The sample was self-selected and may have included participants with a special interest in the phenomenon under investigation. The study focussed solely on nurses' perceptions of the nurse-patient relationship, and did not explore patients' perceptions. Whilst the data collection methods used yielded rich data, other data sources such as observation were not used owing to time constraints imposed within the original two year timescale for completion of the study. Findings are my own interpretation of the experiences of mental health nurses' nurse-patient relationships in one setting, and they are reported on the basis that these can never be absolute, but are always open to further richer, deeper interpretations in the future.

These factors may limit the transferability of findings to similar contexts elsewhere, but they may contribute and extend the existing body of knowledge and future research in this field.

Findings emerging from participants' stories of their experiences about the nature of the nurse-patient relationship in one working age acute inpatient mental health setting took the form of relational themes and constitutive patterns. These are discussed next in the chapters which follow.



## **CHAPTER FOUR: THE CONTEXT OF THE NURSE-PATIENT RELATIONSHIP**

The purpose of this research study was to explore with a sample of registered mental nurses, their reported experiences about the nature of the nurse-patient relationship in working age acute inpatient mental health settings. I believe that a better understanding of this phenomenon would allow policy makers, commissioners, practitioners, educators, researchers and patients to proceed from a more informed perspective in terms of promoting good nursing practice.

The lived world of nurses' reported experiences of the nurse-patient relationship was explored using data obtained from in-depth face-to-face individual interviews with participants, and data drawn from my reflective journal and field notes. The data collection and analysis processes followed in the study have been discussed in the preceding research design chapter. An interpretive plan was constructed to note the raw categories emerging (appendix J) which led to the development of findings.

Key findings are presented and discussed under the following emerging themes, in this and the following two chapters:

1. The context of the nurse-patient relationship;
2. Characteristics of the nurse-patient relationship and nurses' skills and qualities brought to the nurse-patient relationship; and
3. The impact of the nurse-patient relationship on nurses.

This first chapter presents the emerging themes obtained concerning the essential components of nurses' reported experiences about the context of the nurse-patient relationship. This context is described as it impacts in different ways on nurses' reported experiences of nurse-patient relationships.

Three major themes emerged from participants' accounts:

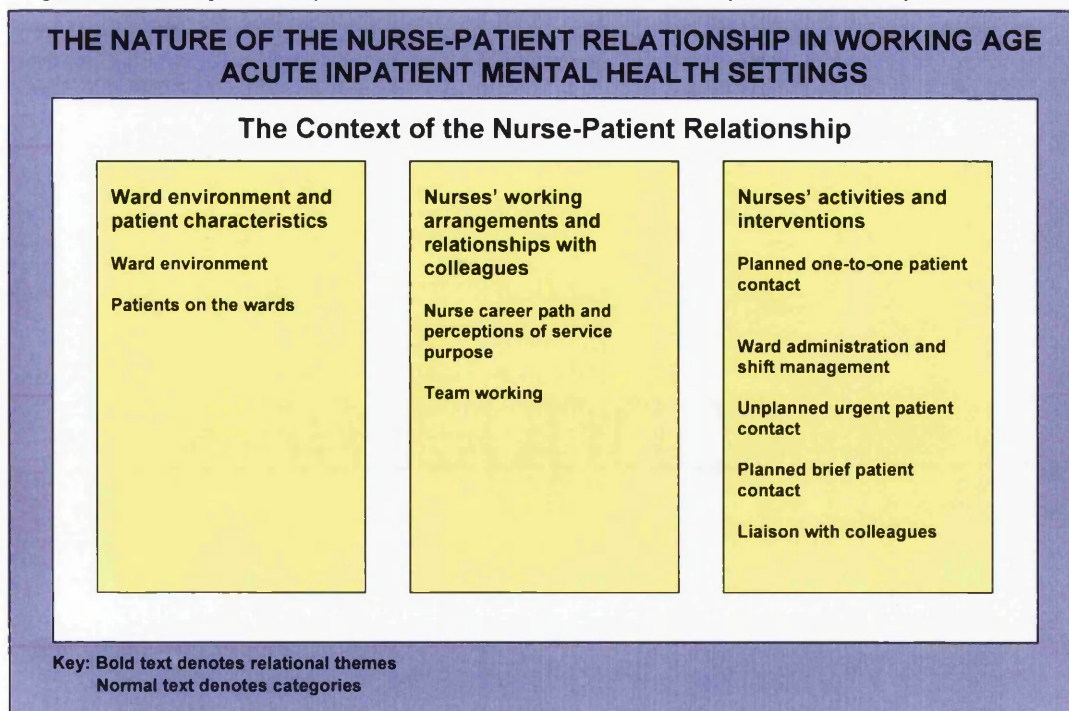
1. Ward environment and patient characteristics;
2. Nurses' working arrangements and relationships with colleagues; and
3. Nurses' activities and interventions.

Each theme is discussed according to their prominence across and within participants' transcripts, moving from most to least prominent issues. The discussion is supported by use of a broad range of direct quotations taken from participants' transcripts to illustrate each finding, and these are related to the literature.

Transcribing conventions suggested by Silverman (2001) were adopted during the transcription process and these are presented for information in appendix I. Sources of participants' quotations are indicated by citing participants' pseudonyms and paragraph number(s) within their transcripts. Direct quotations provide the reader with opportunities to enter into this study and better understand participants' accounts of their lived world experiences. In this way, use of multiple participant perspectives conveys the richness and complexities of their experiences about the nature of the nurse-patient relationship, in one working age acute inpatient mental health hospital setting.

A conceptual framework of the context of the nurse-patient relationship is provided below to illustrate the linkages between each relational theme and its subthemes. The chapter concludes with a brief summary.

Figure 3. Data analysis conceptual framework: The context of the nurse-patient relationship



## 4.1 WARD ENVIRONMENT AND PATIENT CHARACTERISTICS

### Ward environment

#### *Patient diversity*

Almost all participants reported their ward environments were unsettling and not always conducive to the development of therapeutic nurse-patient relationships. This was explained in part by the diversity of patients' problems, needs and behaviours, and communal living arrangements. One nurse, Zoe, spoke of the varied factors affecting the ward environment:

*Zoe 102:*

*There's a whole, a whole range. It's for people from 16 to 65 years old, em, with a whole range of mental health problems, em, including paranoid schizophrenia, em, persistent delusional disorders, acute psychotic episodes, drug induced psychosis (1.0), em, people with alcohol problems, depression, em (1.5) self-harm, borderline personality disorder, other personality disorders, bi-polar affective disorder (1.0). A whole range.*

Rachel talked about the challenge of being with patients living in close proximity:

*Rachel 307:*

*... Living with 18 people is not normal ((laughs)). And I couldn't do it. I couldn't live with 18 patients, and you know, and for them to have outrageous behaviours. Fire alarms going off at three o'clock in the morning. CandR ((control and restraint)) happening in the corridors. People being incontinent. People smoking drugs on the ward. I mean, they're all extremes but they happen.*

#### *Ward busyness*

Ward environments were perceived as busy, stressful places for patients and nurses, owing to the acute nature of patients' problems and behaviours. Most nurses perceived there was a lack of time to deliver comprehensive packages of care for individual patients:

*Jackie 201:*

*...the environment itself is quite stressful, for anyone, em, because of the sort of mixture and the acute nature of peoples' illnesses. Very frightening. And people will isolate themselves. And shy away. Em (1.0) I hate this ward office. It's awful! It's like a goldfish bowl. And it's (1.0), it's having the staff enclosed in this goldfish bowl, and the patients outside it. And (1.0) it's, that I think, is really difficult. Especially if somebody is fearful in any way. You know, we're not always particularly (1.0) approachable. We all look very busy!*

Some nurses felt overwhelmed by the busyness and demands placed upon them, but managed to maintain a resolve to do the best they could:

*Colin 578:*

*... we all really wanna care. We all really wanna do this and that for the patient. There's not the time. The ward's too busy. Eh, we can't physically. It, it's, it's untenable, not possible to provide the (1.0), the complete adequate eh holistic care package for this individual because you've got 20 – 19 others to make sure that they don't commit suicide or run off the ward. It's just not do-able. We all realise that, but we want to do the best that we can, and make do under the circumstances.*

These findings are supported by some negative experiences reported in patient feedback that the inpatient ward environment can be unhelpfully institutionalised (Goodwin et al., 1999). Nursing staff experiences elsewhere report an unsatisfactory work environment, and organisational hindrance (Berg and Hallberg, 2000), which adversely affect the development of therapeutic nurse-patient relationships. Patient acuity of illness, multiple and competing demands on nurses, lack of time, and the unpredictable nature of working in acute inpatient care were reported by Cleary (2003); Cleary and Edwards (1999), and Higgins et al (1999b), as contributing to a negative, institutionalised ward environment. Adams and Bond (2003) reported that inadequate numbers of nursing staff contributed to hierarchical attitudes to care provision and lower standards of nursing practice, adversely impacting on the quality of nurse-patient relationships. Shattell et al (2008) found that nurses reported lack of time, pressure, and chaos in the inpatient environment, as a source of stress, and patients reported that lack of time and boredom in turn caused them stress. In a recent national NHS staff survey 2009 (Care Quality Commission, 2010), 63% of staff said that, in an average week, they worked longer than their contracted hours, and experienced moderate work pressures.

#### *Acuity of illness*

The very acute nature of patient illness was seen as a factor adding to 'busyness'. A few participants perceived over time that patients' acuity of illness on admission was increasing, with more florid symptoms. This adversely impacted on the potential for the development of therapeutic

nurse-patient relationships and contributed to the stressful ward environment. Staff perceived an increase in numbers of patients being admitted against their will to hospital under a section of the Mental Health Act 1983, amended 2007 (Department of Health, 2007a). This too adversely impacted on the nurse-patient relationship and on less prominent patients on the wards.

*Steph 293:*

*... People are coming in much more acutely ill (1.5). ...They've broken down (1.0), and that happens when they're floridly psychotic. ...To try and build a relationship's really difficult. They don't want to be there. We're getting more and more people under section, which we never used to get. So that makes a difference. Whereas before, they were coming in (1.0) just as they started to break down. It was easier to build relationships.*

Paula described the impact of these challenges on the ward as a whole:

*Paula 860:*

*... If you've got some people who are acutely unwell, are very disruptive, and eh, throwing things about, shouting or yelling, then it's not gonna (1.0) work wonders for other people who aren't like that. Who are depressed. And it's a scary environment (1.0). Yeah. People coming in to an acute ward, and they're depressed. And there's people wandering round, throwing food about, or, yelling and screaming and shouting at staff. That's not good. It's scary for people. You know. And making people feel safe in that environment can be very difficult sometimes (3.0).*

Further factors which may influence participants' views that the ward environment was unsettling and not always conducive to the development of therapeutic nurse-patient relationships, include the overall reduction of inpatient beds. Over the last 10 years, there has been a 24% reduction in short stay acute admission mental health beds in England (Department of Health, 2010). The World Health Organisation (2010) cites the availability of mental health inpatient beds in the United Kingdom to be 23 per 100,000 population, second lowest only to Italy in the European Union. This is explained in part by the move to care in the community, where increased emphasis has been placed on the development of community crisis resolution and home treatment teams to address mental health service users' needs without admission to costly hospital care.

Participant impressions about the changing profile of their ward patient populations are supported by the evidence. In the same 10 year period, there has been a 25% reduction in patient admissions to acute inpatient admission units in England. However, there has been an increased trend for formal patient admissions under the Mental Health Act 1983, amended 2007 (Department of Health, 2007a) during the same period, from 26,700 formal admissions in 1999-2000 rising to 28,673 formal admissions in 2008-09, a 7.4% increase. Of these admissions in the last 10 years, the number of patients with a diagnosis of schizophrenia, schizotypal and delusional disorders fell by 2%, to 33% of all patient admissions; patients with a diagnosis of mood disorders fell by 2%, to 41% of all patient admissions; and patients with a diagnosis of neurotic, behavioural and personality disorders increased by 4%, to 26% of all patient admissions. These statistics suggest that it is likely that patients' acuity of symptoms and complex needs would have increased, further supporting participants' views in the present study.

At the same time, some studies discuss nurses' aspirations to provide a 'healing' environment in acute inpatient care to promote positive nurse-patient relationships, although factors such as lack of time and too many changes presented challenges to meeting this goal (Sjöstedt et al., 2001). The inpatient ward environment was seen positively in terms of providing a safe, structured, supportive environment for assessment and stabilisation of patients' serious mental illnesses. Sun et al (2006) discussed how the psychiatric ward environment can be protective in reducing patients' self-destructive behaviours by providing a closed, calm environment, and by removing dangerous objects from harm's way. However, noise and deprivation of liberty impeded patients' autonomy, and led to lack of sleep.

Patients also report that the design of the physical ward environment can have a significant positive impact on their health and recovery (Douglas and Douglas, 2005). These were characterised by homely environments that supported normal lifestyle and family functioning, and offered easy access and movement through transitional spaces. Such positive environments can have a positive impact on patient behaviour (Tyson et al., 2002).

### *Locked door*

Some nurses perceived the care provided on their wards as very custodial at times, when patient access to and from the ward was restricted by locked doors. This was sometimes put in place to prevent some patients absconding from the ward, but this could adversely affect nurse-patient relationships., as discussed by Hannah and Rachel:

*Hannah 608:*

*... I think a really big, big challenge is keeping the ward open. ...and that affects your relationship... Just actually, trying to manage the fact that there are informal patients and there are formal patients. And the formal patients – sometimes they have restricted access... We're getting a lot of problems at the moment with the police. Because we keep calling them because there's people missing. And (1.0) they now feel that we should take more of the responsibility for the missing people. Well obviously, we should. So what's happened then is we have to lock the door.*

*Rachel 142:*

*... The ward at the moment is on five staff and we've been periodically locked on and off for the last (1.0) two weeks to prevent em, a particular young man from absconding. So, the nursing care can sometimes appear very custodial, em (1.0), and, we're dealing with, we're dealing with emergencies. We're dealing with crises. Em, and I don't think (1.0), I don't think we can (1.0) realistically get involved in, and we shouldn't be getting involved in long term work.*

The often busy ward environment was such that nurses sometimes locked the ward to manage patients' risk of absconding. At other times, the ward door was open to patients leaving the ward, which some nurses believed promoted a more therapeutic environment. Some patients had access to outside garden space with low level fencing. There were times when patients absconded from the wards, either via the open ward door or over the garden fence, who were a cause for concern to nursing staff.

Police were sometimes called to intervene to return patients to hospital, impacting negatively on nurse-patient relationships, and relations between the police and the hospital, when several patients had absconded in the same week.

*Jackie 249:*

*Em, there's a, a young woman, who's on a section three ((Mental Health Act 1983, amended 2007)). ...who'd gone AWOL the night before... And (1.0),*

*I'd actually been there when she was brought back by the police. And I've got a reasonably good rapport with her, ...she was pretty distraught.*

Absconding from acute admission wards is a significant clinical problem which can result in harm to patients and others (Bowers et al., 2003). The risk of absconding repeatedly is more likely in young adult males than females, and once a patient has absconded, the likelihood of future absconding is increased (Dickens and Campbell, 2001; Muir-Cochrane and Mosel, 2009). Absconding behaviour is linked to other forms of non-compliant patient behaviour, including refusal of medication and violence towards others (Bowers et al., 2000). Whilst use of locked doors may be justified to protect patients and others, participant views that this was unhelpful to nurse-patient relationships could be challenged. Locked doors may not always adversely impact on the nurse-patient relationship. Johansson et al (2007) found that if space is offered for nurse-patient one-to-one meetings and social events, then a locked ward environment can provide opportunities for positive relationships, friendship and unintentional insights into patients' suffering. In a stepped before-and-after trial, Bowers et al (2003) found that use of interventions other than a locked door can reduce absconding behaviour. These included use of a signing in and out book for patients, careful and supportive breaking of bad news to patients, targeted nursing one-to-one time and facilitated social contact with patients, and post-ward incident debriefing with patients.

### **Patients on the wards**

Many nurses referred to 'unpopular patients' on the wards. Patients could be labelled as unpopular owing to aggressive and/or violent behaviour towards themselves or others, or by virtue of their medical diagnosis.

### *Patient aggression and violence*

An overwhelming majority of participants had experienced aggression and violence from patients. Staff sometimes felt intimidated by these patient behaviours, particularly if inexperienced.



Jackie 170:

...The young man with paranoid schizophrenia. Eh, that's been in and out of hospital, I think >since about the age of 18<. He's only 22 now. ...he's a big chap. ... physically, he looks intimidating. He is very verbally abusive at times. His language skills, and his communications skills, are not good. Em, and it's almost as if he's like an adolescent in a full adult-sized body. And, he, he can appear incredibly intimidating. And yet, as far as I'm aware, there hasn't been an incident where he's actually struck a member of staff. It's, it's verbal abuse. Em (1.0), and yeah. There was an incident where I was, I'd been in the clinic room or something. And I'd come out into the ward. And, all staff were in the ward office. And this chap's like a raging bull on the ward. His chest is puffed up. Red in the face. He was banging doors. He was banging on the staff office window. He was shouting and swearing. This happened on a fairly frequent basis.

It should not be surprising that nurses are fearful of assault. Nurses are more than four times more likely to be assaulted than all other healthcare staff (Economic and Social Data Service, 2010). In its national NHS staff survey 2009 update, the Care Quality Commission (2010) found that 18% of staff in mental health/learning disabilities NHS Trusts had experienced physical violence from patients or their relatives in the last 12 months. Twenty-five percent of staff reported experiencing harassment, bullying or abuse from patients or their relatives in the same period. The incidence of physical assaults on front-line nurses working in acute inpatient mental health units was 46%, and there was an upward trend of increased severity of assaults, sometimes involving weapons (National Patient Safety Agency, 2006).

### Unpopular patient diagnoses

Unpopular patients, by virtue of their medical diagnosis, included 'personality disorder'; 'substance misuse'; and 'psychosis'. It has been discussed that admissions of those with diagnoses of personality disorders have increased 4% in 10 years. Sophie remarked on some of the impact of this:

Sophie 771:

I think it makes you too hard. I think, you don't have enough time to em (1.0), to allow yourself to be compassionate, and caring towards people. That you end up being very judgemental about people. You only have to listen to a handover on an acute inpatient ward. And everyone's labelled as a PD. Em, with no kind of real (1.0) consideration about what that means. Or how we as nurses can approach that.

Paula spoke about the challenges presented by working with patients with drug and alcohol problems:

*Paula 171:*

*Em (3.0). Most eh, the alcoholics that we've had on the ward, or the people with drug problems em (1.0); some of them have been quite violent. ...They come in because they wanted drugs. And they knew they'd get drugs ...they obviously come in informally, so we can't detain them. So they'll go off the ward and get their drugs, or go off the ward and get drunk. And come back on the ward, which causes problems. It puts other clients at risk and puts staff at risk as well. Like, obviously, we don't have any control over that whatsoever.*

Steph talked about the challenge of trying to build relationships with psychotic patients:

*Steph 397:*

*... Psychosis. I think that's the hardest one, to build a relationship with. Especially, we get a lot of young first presentation males (1.5). And so at first presentation, they're scared. They don't know what's happening. You know, you try and reassure them. At the same time (1.0), you can't really say to them 'You're unwell' because they just won't take it on board. They just get frustrated and just (2.0). Because you're trying to keep the amount of violence down as well (1.0). It's something you - I find, I'm treading water all the time (1.5). [Trying to keep them calm, keep the ward calm, and (1.0) cos you've got people that are ready to go, and sometimes, if things get out of hand, and that starts affecting them as well (1.0). So it's, IT'S HARD! ((laughs!))].*

Where diagnostic problems overlapped, further challenges could become apparent:

*Susie 189:*

*... I do have difficulty with a particular group of persons, which is young, drug-induced co, co-psychotic. They tend to be young men in particular (1.0)... People are constantly being injured by them... I suppose, part of me thinks that >they shouldn't be in a place like this really<. There should be special places for them, because they're kind of using up the beds of well, what is very frequently said, more kind of 'real' psychiatric cases. The 'real' mental health problems.*

Graham went further in articulating his approach to working with unpopular patients:

*Graham 427:*

*I think there's an element of commitment to the types of people you're working with (1.0). Em (1.5), and by no means is it every patient. We don't like every patient. Nobody can. Some people are really horrible ((laughs))! They just are! You just have to contain that, and scream in the back office (1.0).*

Coid et al (2006) reported a primary association of physical assault with people with hazardous alcohol consumption (over half of reported incidents), and antisocial personality disorder (24% of incidents). In contrast, people with psychosis accounted for only 1.2% of violent incidents. The increased incidence of violence and aggression from patients with substance misuse and antisocial personality disorders may explain in part why such patients are regarded as unpopular by a majority of participants in this study.

Stockwell (1984) explored the concept of the 'unpopular patient' in a study of interpersonal relationships in general wards. Methods included rating and ranking techniques for identifying popular and unpopular patients. She found that patient personality factors, long length of stay, and physical impairments, all contributed to nurses regarding such patients as significantly more unpopular than others. Interestingly, there were unexpected observable differences in the ways nurses interacted with patients, least attention being paid to those mid-group patients who were neither particularly popular nor unpopular with nursing staff. It may be that whilst some patients are labelled as unpopular, this may not affect the care received by patients from nurses in the present study.

To summarise, an overwhelming majority of participants indicated that the ward environment was unsettling and not always conducive to the development of therapeutic nurse-patient relationships. This was explained in part by the diversity of patients' problems, needs and behaviours. Evidence from the literature supporting participants' views include increased patients' acuity of illness, with an increased number of patients formally admitted under the Mental Health Act 1983, amended 2007 (Department of Health, 2007a); increased work demands placed on nurses to work additional hours; lack of time for direct patient contact; and increased risk of violence, aggression and harassment from patients. The increased presence of 'unpopular' patients on the wards, by virtue of their violent and aggressive behaviours and complex needs, further challenged the development of therapeutic relationships with them. Despite these adverse factors, some literature indicated that the ward environment provided a safe,

structured, supportive environment for the assessment and stabilisation of patients' serious mental illnesses. Good design of the physical ward environment, and creating more one-to-one time with patients could also have a significant positive impact on mental health recovery.

## 4.2 NURSES' WORKING ARRANGEMENTS AND RELATIONSHIPS WITH COLLEAGUES

### Nurse career path and perceptions of service purpose

#### *Career path*

A majority of participants discussed their career path and aspirations working in working age acute inpatient mental health care. Nurses' career choices and expectations were varied. Many nurses began their careers there as newly qualified, inexperienced nurses, sometimes not through choice but through lack of other alternative employment. Nurses were expected to consolidate their training within months, usually in response to rapid nursing staff turnover, to assume full responsibilities of taking charge of the ward.

Participants had mixed views about their experiences:

#### *Sophie 763:*

*As a newly qualified nurse, you have to work in (1.0) inpatient care. [Generally speaking, it's not something I enjoyed. It's not something I would want to do again (1.0). I think that em, that there are some good things about it. Provides you with a wealth of experience. [You encounter a wide variety of patients and situations. Em (1.0), but I don't think it necessarily makes you a very good nurse. Mm (2.0).*

#### *Steph 889:*

*It is really quick... I went from 'D' to 'E' ((former nurse clinical grading bands)) within six months (1.0). I just think there's such a high turnover of staff (2.0), that when I went from 'D' to 'E', I think the 'E's left. Cos people were just leaving us. They'd gotta have it that the 'D's had to start moving up. Quite rightly, cos it is a (1.0) massive turnover of staff.*

Some nurses found their experiences of practice fell short of expectations, and sought to leave the service within a year or two. Some inexperienced nurses had anticipated more opportunities for counselling with patients to

address their long term problems which had contributed to their acute hospital admission, but this had not materialised.

*Colin 608:*

*...I wanna move into CBT. Because I found when I did work in a day hospital on em, on one or two of my placements. And that's real working. That's when you're really working on people's problems.*

Whilst Colin placed greater value on more structured psychotherapeutic interventions difficult to apply in the acute inpatient setting, others thrived on the challenging, unpredictable nature of working in acute inpatient mental health care, and had made positive career choices to remain there.

*Zoe 347:*

*... You know, newly qualified nurses work on the ward. Couple of years (1.0), you know, just to consolidate their training on the ward. And then they progress into the community. And I think that's wrong! Em, I think that, by doing that, we have the most unwell people being looked after by the (1.0), the least experienced nurses. ...I think that we need to kind of redress the balance. And (1.0), that we need more experienced nursing staff on the wards to look after people who are acutely unwell. Em (1.0), and that's why I've just (1.0) made the conscious decision to stay in acute nursing. Because I think that the way that it is at the moment, that balance is wrong. Em, I did enjoy my time in the community. I enjoy working in acute settings. ...I get a buzz from the chaotic, unpredictable environment ((laughs))!*

*Janet 378:*

*...I just enjoy it! ((laughs)). Em (1.0), yeah, I think (1.5), I enjoy the work. ...because it's challenging. There's always something different going on. Em, you're always talking to different people. You never know what you're going to walk into. You can be away from work for two or three days and (1.0), the place is totally different. Most of the people may be the same, but (1.0), because of their mental state, or because of new patients coming in, the whole dynamics of the ward have totally changed. Em, so (1.0), it is an ongoing challenge. Em, you never get bored.*

In contrast, one experienced nurse had become cynical about working in acute inpatient care, and had decided to resign. Whilst she had enjoyed her time on the wards, she now felt dissatisfied, as patients were quickly discharged before they were 'at their best'.

*Steph 756:*

*...Well, up until now yeah ((referring to enjoying nurse role)), cos I'm leaving! ((laughs)). I did, two years ago, I was gonna, I was gonna go to the community teams when they first started up. And then, I was just like, I really like acute. I like team work (1.5). And I like the team dynamics on the*

ward (1.5). And just I like the variety of people you get in. But it's now (1.0) I've got cynical that it's too quick. Rapid turnover. There's not really a lot of satisfaction doing it, because you never see anyone improve. You see them improve, but you don't see them at their best or at their wellst.

### *Perceptions of service purpose*

Like Steph above, just under half of participants were dissatisfied with their perceptions of service purpose – to manage and contain patient risk behaviours. These nurses felt a need to engage in more meaningful interventions and activities to meet patients' immediate and sometimes long term needs, but opportunities to do so were not available owing to a perceived lack of time, shorter admissions, and inadequate staffing. Colin typifies a confused perspective on the purpose and value of inpatient care:

*Colin 489:*

*I mean, it's great the training we get and that, but. It'll be, you know, we're part of a sort of small cog in a big wheel, aren't we. It would be nice to do proper interventions for long term resolution of issues. But we just don't have the time cos we don't have the staff cos there isn't the money (1.0) to provide the staff. And our job, really, is mainly risk management. Stopping people from committing suicide. Stopping people from hurting other people.*

*Natasha 218:*

*... You know, staff need to be engaged in a meaningful activity. And if all they're doing is (1.0) containing problems, and readmitting their old clients, they will feel this way. They will feel disempowered. They won't feel able to make (1.0) any kind of connection, or see any kind of em (1.5) value or importance to their work. And I think, you know, we talk a lot of the time about meaningful occupation for clients. You know, so why are we making nurses occupation 37½ hours a week meaningless? Why are we allowing it to be a job which is not more fulfilling. A job which is not em (2.0), based in a sense of positivity? (1.0). You know, and benefit for people.*

Understanding sources of employee satisfaction and dissatisfaction may be of interest to senior nurse leaders in their organisations (Murrells et al., 2009). Job satisfaction is an important indicator of nurses' contributions to the overall quality of patient care, but the measurement and understanding of the concept is underdeveloped. High levels of job dissatisfaction contributes to nurses' intentions to leave the profession (Aiken et al., 2001). Increased attrition may contribute to a potential worsening of nurse-patient ratios and subsequently adversely impact on nurse-patient relationships. Self-nurturance, life satisfaction and career satisfaction in nurses are cited by

Nemcek (2007) as important interlinked factors which can be used to enhance staff retention. According to the national staff NHS survey 2009 (Care Quality Commission, 2010), 28% of staff working in mental health/learning disabilities settings said they often felt like leaving their Trust, with 20% reporting that they would probably look for another job in the next year. There was a strong downward trend in the number of staff intending to leave their current jobs. This may be explained in the context of the recent dip in the UK economy in general. Given the paucity of research regarding job satisfaction and dissatisfaction among nurses in general, and registered mental nurses working in acute hospital inpatient mental health services in particular, it is unclear as to why some nurses' career choices are varied. Nurses' dissatisfaction with their perceptions of service purpose is discussed further later.

## **Team working**

### *Nursing team*

Almost all participants indicated generally positive experiences within their nursing teams, where trust and close working relationships developed:

*Nick 651:*

*Well, the immediate team is, it's the nursing team. So that's your immediate colleagues, and that's the people who you work with, most closely and most often.*

*Sophie 627:*

*...By the team, I would mean the nursing staff. Em (1.0), mainly the other staff nurses. Em, also including the nursing assistants. But really, particularly kind of discussing someone's care would be particularly the other staff nurses. Em (1.0), and I think I, I would, that's what I would mean by the team.*

*Janet 382:*

*... I had to learn to trust my colleagues to pick up from where I left off... You know, you have to be able to trust your colleagues, to continue on. And, if things don't get done, ok, you can pick them up again tomorrow. But em, you know you've handed over the most crucial things.*

Just under half of participants discussed negative experiences within the nursing team. For example, established team dynamics could be challenging for newly qualified staff. Two nurses were critical of nursing staff

inaction to meet patient needs at times, and lack of leadership and expertise from charge nurses.

*Jackie 408:*

*...And it's, yeah, it's tough. Especially on a particular team, if they're well established, and, you know, their places are quite firmly fixed within that team. And you are new. It's quite difficult finding where you fit. And looking at the dynamics that are going on. It's a tough, a tough place to be.*

*Hannah 403:*

*I've always got ideas and stuff. And nobody really quite takes (1.0), takes on board anything you've got to suggest. But when you're the senior nurse, and you're really telling someone about something, they have to respond. And they have to do something about it.*

*Sophie 651:*

*Oh, well, I mean, they ((the charge nurses)) were completely part of the team, because they worked shifts. They're there. But, I, I always felt that they didn't really provide (1.0) anything particularly special. I felt that, perhaps as charge nurses, they should of been providing more. More leadership, more kind of, em, more of the expert nurse role, which, to be honest, I (1.0) I never really felt they provided. But they were completely part of the team.*

### *Multidisciplinary team*

A majority of nurses expressed negative views of the multidisciplinary team, particularly in relation to medical colleagues. They cited a dominant medical model approach to patient care, imposed on nursing staff. Nurses claimed that an holistic approach to patient care and management would be preferable. Nursing staff sometimes agreed strategies together, to put their views across to doctors.

*Sophie 627:*

*... I'm aware that there's also the ward doctors, and the consultant. Um, and (1.0), on the periphery, community staff. But, I wouldn't include those I think, mentally in the team, because, em, I think, often what happens is, you discuss things with your fellow staff nurses. And you agree on a strategy. And then you present that to either ward doctors or the consultants. And there isn't such a feeling of team work. Often, there's a feeling of having to put your point across, or em, defend your position or that sort of thing. So, for me, the team is very much about staff nurses.*

*Graham 339:*

*((On the prevalent medical model)) Medication. WE do the relationship. We do it. The doctors try on ward round. Have a little joke. But, you know, they only see them once a week. We see them up, down, sideways and, back to front.*



Nurses saw themselves and their nurse colleagues as a team, and found the lack of a day-to-day presence of many doctors on the wards unhelpful. Difficulties in contacting them when off the wards also contributed to a sense that they were generally not part of the ward team.

*Sophie 635:*

*There's just been so many times when it's been impossible to get hold of the ward doctors to do ward jobs. And that's, that's a big frustration when working on the wards.*

A few nurses adversely commented about their role in orientating and training inexperienced medical staff on the wards, which was seen as time consuming in their busy working lives.

*Hannah 570:*

*... That consultant always has GP trainees. So they start off from zero. It can be a bit (1.0) 'This is what a drug chart looks like! This is psychiatric medication!' They know stuff! Obviously, they have to know, but (1.0), starting all over again. It's not like an SHO who's rotated across the wards and knows all the, everything, apart from just the drugs. This is someone who's pretty much starting from scratch for work experience.*

Interestingly, half the participants expressed positive views of specific medical colleagues in relation to their high day-to-day presence on the wards. This also applied to other allied health care professionals with a regular presence on the wards, including art and occupational therapists, and the pharmacist. The contributions of these colleagues in addressing nursing staff concerns and directly meeting patients' needs was welcomed by nursing staff who mentally included such colleagues as useful members of the team.

*Hannah 562:*

*The doctor from my team, particularly, is quite good. Because he has to be there, because there's 15 inpatients ((under that specific doctor's care)). And that's just on our ward. Obviously, he's got a lot of people to pay attention to. He is very good. He'd be there every day he's supposed to be there. Which is about three days of the week. Maybe two-and-a-half days. And he'll stay 'till quite late, until after five o'clock as well. So he's (1.0) quite solid. Quite reliable. But, he's only here for six months. But, I would see him as ...quite an important part of the team.*

*Hannah 531:*

*The OT's brilliant. She's a high presence. I consider her part of the team. And em, quite an important part of the team (1.0). Obviously, the pharmacist is quite important (1.0). Because she comes to the ward round weekly. And we can talk about various issues. And, she'll see the patients outside that. ...and the art therapist as well is also around a couple of days a week. And she's quite important... So, yeah, there are other people in the team... And that's brilliant.*

In respect of the nurse team, just under half of participants discussed some negative experiences including challenging team dynamics. A majority of participants expressed negative views of the multidisciplinary team, particularly in relation to medical colleagues. It was perceived that a dominant medical model approach was imposed on nurses, who preferred a broader holistic approach to patient care. Participants felt that many medical colleagues lacked a day-to-day presence on the wards, so were not considered to be part of the team.

The historical relationship between mental health nursing and psychiatry was discussed by Brimblecombe (2005). Psychiatry established itself as a profession at the end of the 18<sup>th</sup> century, and its power base in the county asylums by the mid-19<sup>th</sup> century. In contrast, the mental health nursing profession developed later, initially from training for asylum attendants, instigated by psychiatrists. More recently, changes in the relationship between psychiatrists and mental health nurses began to take place with the weakening of psychiatrists' management roles and strengthening of nurses' professional status through changes in nurse education. Psychiatrists continue to maintain their power base, as nurses pursue their agenda of professionalisation.

Barker and Walker (2000) highlight that psychiatrists continue to hold power over key decision-making over the admission and management of patients' treatment. Ward based nurses on the other hand are powerless in this regard, and have no authority to influence patient admissions. This power imbalance is evident in multidisciplinary team ward rounds, which are seen as largely undemocratic, with psychiatrists making key patient treatment decisions with little collaboration with others. Vuokila-Oikonen et al (2004)

suggest that cooperation among teams and patients in team meetings is an important intervention in mental health care. In many instances, staff-patient interactions, controlled and defined by health care professionals, were of a detrimental quality to the development of effective staff-patient relationships. Interactions between psychiatrists and others including staff and patients were characterised by poor eye contact, medical staff holding fixed opinions, and interrupting other multidisciplinary team speakers whilst other health care professionals remained passive.

Some research studies (Barker et al., 1999; Hinojosa et al., 2001; Latvala et al., 2000) indicate that psychiatrist-patient interactions are medically-oriented, with medical staff deciding the structure and focus of discussion. When such discussions occurred within multidisciplinary team meetings, nurses often remained outsiders with their medical colleagues, as their professional views were not explicitly sought. This poor communication may be particularly problematic in situations where nurses experience unresolved moral conflicts, which are not always acknowledged by the multidisciplinary team, and may lead to nurses experiencing moral distress (Deady and McCarthy, 2010). Moral distress arises when nurses are unable to act according to their professional values and duty of care, owing to internal and external constraints (Ulrich et al., 2010).

Stark et al (2002) found that effective multidisciplinary team working can be a scarce reality, particularly when health professionals are working with increased workloads and tight financial constraints. They conclude that multidisciplinary team working may appear to be a sound concept, but in reality, this may be a utopian vision. This is further supported in the national NHS staff survey 2009 (Care Quality Commission, 2010) where just 41% of staff in mental health/learning disability Trusts stated that they worked in a well structured team environment. There is little research evidence as to the effects of multidisciplinary team working on patient outcomes.

Participants in this study appeared dissatisfied with the medical model perceived to be imposed on them by their medical colleagues.

Multidisciplinary team meetings were perceived to be dominated by medical

colleagues. In contrast, nurse participants held power and responsibility for the day-to-day care of patients, largely in the absence of other health care professionals.

### *Primary and associate nursing*

Nearly all participants discussed the implementation of primary and associate nursing as an effective strategy to focus nurses' attention on meeting with their named patients to address their specific needs. Zoe and Hannah provided examples of this:

*Zoe 165:*

*Well (1.0), as soon as possible, em, after admission, the patient would be allocated a primary nurse. And that would be a registered mental health nurse, and they'd also have at least one associate nurse. That might be a qualified nurse; it might be a nursing assistant. .Hhhh, em, and (1.0) so they, they know who, who their main nurses are. And when those nurses are on duty, em, they, they would be their allocated nurse for the shift.*

*Hannah 226:*

*... So, for a shift, ...your primary patients are the ones that you're focussed on. Because, you know, you're keeping up-to-date with their mental state. And, whether it's improved. And whether we can try leave. And if we try leave, how often? And when that leave works out, shall we have some more leave? Just to sort of keep the pace up.*

This may be explained because nurses are relatively autonomous to make decisions in their primary nursing roles, largely in the absence of other multidisciplinary colleagues. The primary nurse or 'keyworker' model of patient care delivery is well established within nursing teams in acute psychiatric settings, and provides an effective model of care (Barker and Walker, 2000).

However, participants explained that this approach sometimes fell short of meeting patient needs when urgent unplanned activities and interventions arose on the ward, or when patients themselves chose not to engage in the process.

*Sophie 491:*

*... My contact with somebody who's my primary patient, I'd be kind of doing a longer term thing. So, if I didn't have contact with them this shift, I would be planning to have contact with them tomorrow. [Em, or, you know, if I hadn't spoken to them for a couple of days, I would be aware I would be*

wanting to sit down with them the next day. But it very much depends on the patient themselves, and I suppose on the relationship that you have with them. Because I've primary nursed people who, em, weren't interested in talking to nurses, didn't want to have any contact with you. Em, were fed up, em, being in hospital, and didn't really feel it was in any way beneficial to be talking about their problems for an hour.

Patients allocated for a shift were seen less often than primary patients, unless they had pressing needs.

*Sophie 483:*

*... I'd have to be completely honest ((laughs softly)) and say that when you're somebody's allocated nurse, em, ideally you see them during the shift ((laughs softly)). But you don't necessarily, depending on how busy you are. Em, depending on what they're doing. Em (1.0), basically, yeah, depending on how busy you are. Because I've had shifts where I haven't seen any of my allocated patients. And em, you know, that's not the majority of shifts. But they're not unusual either.*

To summarise, nurse participants in this study appeared to identify more readily with their nurse peers as part of a team, as they shared responsibility for the day-to-day management of patient care delivery. The absence of other members of the multidisciplinary team on a regular basis, with the exception of ward rounds, may support nurses' perception of a lack of recognition as a core part of a functioning multidisciplinary team. In many cases, psychiatrists' power to make patient treatment decisions largely without collaboration with others further strengthens nurses' poor views of the multidisciplinary team, and medical colleagues in particular.

This related to the dominant medical model approach to care, as well as a general lack of a regular presence of medical colleagues on the wards, except for scheduled weekly ward rounds. This was seen to hinder patient inclusion in decision-making about their care.

## 4.3 NURSES' ACTIVITIES AND INTERVENTIONS

### Planned one-to-one patient contact

#### *Managing one-to-one time*

All participants indicated that they valued one-to-one patient contact, and planned this into their shift activities on a regular basis. This activity was seen as essential for establishing and developing therapeutic nurse-patient relationships. The amount of time made available was negotiated in collaboration with their primary patients. The length of time allocated varied according to patient needs and engagement with nursing staff, and ranged between as little as five or 10 minutes, up to an hour or two at a time. Nurses generally negotiated planned one-to-one time with their primary patients at the beginning of each shift, on the understanding that this could be postponed or cancelled if more pressing urgent care issues arose with more prominent patients on the ward. Pressing administrative tasks and documentation of care sometimes also took precedence over planned one-to-one care. Nick and Steph described flexible approaches to this:

*Nick 307:*

*... I try to make at least half an hour available, so the person knows that they've got that time. They don't always choose to, to use it. ...it's not something you can adhere to rigidly. There might be days when you can sit for a couple of hours with someone or, ...other days which tend to be ...more the norm really. Where you just haven't got the time, because you're completely tied up with administration and bureaucratic tasks.*

*Steph 571:*

*[With some of them, it would have to be, ... only be five or 10 minutes, because they couldn't cope with any more. With other people, you could be an hour (1.0). And there'd be (1.0) probably two days in the week when they'd get nothing, just because of other things going on, or the busyness.*

#### *Care planning with patients*

Just over half of participants discussed the focus of one-to-one time with their primary patients. For newly admitted patients, time was generally used in developing and documenting a plan of care in collaboration with patients. This was seen as a good basis for the early development of meaningful relationships, taking cognisance of patients' views and immediate and ongoing needs. One-to-one time also helped nurses take a more holistic

view of their patients' needs, to advocate for them with colleagues and relevant others.

*Adam 291:*

*If it's the first time ((meeting the patient for one-to-one planned time)), it's usually starting with a care plan. I'll tell them what the care plan is. Or if it's not my care plan, I ask them if they know what their care plan is. Em, so talk through that. So that's a good starting point. Em, at the end of it, we've usually got a few little items that need to be carried over. So the next time I meet them, it's usually starting off with those items that we'd said we'd come back to. So, 'Did we get that sorted? Did you get that sorted? Here's what I found out for you.' All those kind of things. And that usually leads onto the next things. And of course, they've always got the (1.0) opportunity cos, if they've got something on their mind, they'll tell me. Or if I think they've got something on their mind, I'll (1.0) prompt them to tell me. Or, if we've got to the end of it, and I think, 'Have they been asked? I'll talk to them again.'*

*Hannah 380:*

*I'd do basic stuff, like doing the care plans together. Talking about where we wanna go this week. What you want, what we want to do. What groups do we think are a good idea. What groups do they think are a good idea. Not being prescriptive with the care. Em (1.0), and, it depends on the patient. But just making plans. Weekly plans. Em, how much medication do they want to be on? What drugs do they prefer? What medications have they been on before? What would they like to do post discharge? What needs do they have that they feel aren't being met? What can we do about those? Em, talking to the care coordinators then, to say 'Well, blah, blah thinks that you didn't see her often enough so, can that now be changed?' Or, 'She feels bored at home. Can we do something about that.' It's just talking about what they feel they can get out of the service (1.0).*

### *Monitoring of medication therapeutic and side-effects*

A few participants discussed the use of one-to-one time as a means to assess patients for therapeutic and side-effects of prescribed medication, for feeding back to medical colleagues in ward round later.

*Zoe 203:*

*... nine times out of ten, em, people have prescribed medication. So we need to ensure that they're receiving that, that it's the right medication for them. So we will monitor for effects and side-effects of the medication. Em (1.5), we'll also be, ...spending... therapeutic time with that individual as well, and getting them to kind of talk through the issues that have led to their admission. Em, it might be that they've become non-compliant with medication, so it's about trying to get them to identify themselves that that's been the trigger factor.*

## *Social engagement*

Only a few participants discussed the benefits of social engagement with patients, either on or off the ward. This provided opportunities to assess patients' ability to function in an ordinary, everyday context, as a means to review their treatment and progression. Nurses also acknowledged that patients could become frustrated when the focus of discussion was constantly about their mental health problems. This approach was particularly helpful in ongoing nurse-patient relationships, where both parties had an understanding of one another, and how the relationship best worked.

*Steph 613/621:*

*Yeah. Sometimes I won't talk anything about mental health at all. Sometimes, I'll say, 'Do you want to go for a walk?' Just to get out and get fresh air. Or just to (1.0), just to have a normal conversation. Just to see how they react to normality and normal conversation. So it just, it depends on the patient. A lot of the patients know what they want. After a while, they're used to the way you work. They kind of know what they want and they know that during that time (1.0), like one of them will say 'Can I just go out in the grounds?' ... So you'll, if I've got the time, I'll put that time aside for them, I'll take them out. And then others will come up with a great big list of things that they want resolved, or need, or they need help to sort it out. Cos benefits and things always take time and forms and (1.5), and referrals.*

## **Ward administration and shift management**

### *Shift coordination*

Most participants discussed their concerns over the amount of time they spent on shift coordination at the expense of direct patient care. This involved allocating patients to staff for the shift, taking account of the immediate needs of prominent patients on the ward matched to the most experienced staff, as well as trying to respect allocating patients to their primary nurses and task allocation. Prominent, challenging patients' needs would generally take precedence over named primary nurse-patient relationships when patients were allocated to nurses for each shift. The shift coordinator also checked that shifts in the near future were adequately resourced with staff, and addressed any staffing shortfalls using agency and nurse bank staff. Enquiries from other healthcare colleagues and patients' relatives or carers were generally directed to the shift coordinator, taking up



more of their time during each shift. Adam provided an illuminating account of this challenging role:

*Adam 323:*

*If you're coordinating, starting at the beginning of the shift, you're eh (1.0) first thing you do after taking handover from the previous shift, is allocate patients to nurses. So spend some time, picking out the balance of that, who's needing your attention, getting the right patients with staff. Then making sure that the shifts are covered for the following shifts. And then maybe they're not. So you're spending quite a lot of time on the phone, trying to get staff cover. So you're dealing with the agencies. Eh, answering the phones a lot of the time. People will not speak to anybody but the nurse-in-charge. So the bed manager won't speak to anyone but the nurse-in-charge, for all good reasons. The mental health act administrator won't speak to anyone but the nurse-in-charge. Consultants will generally only want to speak to the nurse-in-charge, if it's about something important. Em, patients' relatives complaining will obviously want to speak to the nurse-in-charge. Em, senior managers will come down, and they'll want to know what's going on in the ward, spend a lot of time with you standing in front of the white board explaining what each patients' problems are, because they'll be going on about ['Does a patient really need to be here?' Eh, 'They should be moving towards discharge'. Or 'Can you make a bed available? Are you sure that person needs to come back from leave, because, if they don't, then we've got a bed available.' So bed management is a lot of it...*

### *Documentation*

A majority of participants indicated that much of their time was taken up in the day-to-day documentation and administration of patient care. Whilst staff acknowledged the importance of accurate record keeping and documentation of care, not least for legal reasons, there was a feeling that too much time was required to complete NHS Trust documentation as a requirement of senior hospital managers, at the expense of spending time with patients.

*Adam 316:*

*As you imagine .hhhhhh, staff nurses spend a lot of time in the office, shuffling bits of paper around, and (1.0) sitting in front of the computer. I wish we didn't have to, but we have to. Because we're told we have to do certain things, otherwise we're negligent. So we have to take cognisance and we have to do it. Because it's em, the latest directive. You know, you've got to em, fill out a checklist of how many people had their section rights read to them that week. Em, yes, there is reasons why it should be done. Eh, but, because there's a form there, and you've got to fill it in, and it's got to be in that week, you have, you know. Today, I'd just like to be able to say, you know, 'It's not life and death. I could just do without doing that today. I'll just go and talk to a patient.'*

*Nick 307:*

*... There might be days when you can sit a couple of hours with someone or, you know, might be other days which tend to be more (1.0), more the norm really. Where you just haven't got the time because you're completely tied up with administration and bureaucratic tasks.*

The volume of documentation presented staff with challenges in managing their time between administrative duties and working directly with patients. This was particularly so for inexperienced staff who sometimes struggled in prioritising administrative tasks and direct patient care during their shift. Jackie illustrated this commonly felt nursing dilemma:

*Jackie 265:*

*... I know that, the further I go on, the more proficient I'll become. The quicker I'll become, I hope, at dealing with some of the paperwork. And, and being able. It is, it's one of the most difficult things I've had to do, is the prioritising. You know, the paperwork. The paperwork or the patient?*

To summarise, all 14 participants valued one-to-one patient contact, and planned this into their shift activities on a regular basis. This is identified as a constitutive pattern running across all participants' stories. However, planned one-to-one patient contact was often postponed owing to other demands. An overwhelming majority of participants expressed concerns over the amount of time spent on shift coordination at the expense of direct patient care. A majority of participants indicated that much of their time was taken up in the day-to-day documentation and administration of patient care.

In the national NHS staff survey 2009 (Care Quality Commission, 2010), whilst 76% of staff felt satisfied with the quality of work and patient care they delivered, a large minority of staff (46%) said that they didn't have sufficient staff or enough time themselves to do their jobs properly. Jones (2010) explored the concept of nursing time. Among his conclusions, physical nursing time measured in hours was found not to reflect or take account of nurses' reported experiences of psychological or sociological nursing time, and both held little meaning in isolation. Jones advocates that the perceptions of patients and nurses of the value of psychological nursing time should be taken into account, as well as physical nursing time, when determining hospital staffing and resource requirements. Delayed and

hurried responses to requests from patients may be perceived by patients as a general lack of concern for their well-being. Jones concludes that further research is required to explore how nurses prioritise overlapping time demands, taking account of how these influence patient outcomes.

### **Unplanned urgent patient contact**

#### *Risk assessment on admission*

A key priority cited by a majority of participants was patient risk assessment. This was often on an unplanned basis when staff accepted newly admitted patients, as well as planned on an ongoing basis with patients with known risks on the wards. Addressing immediate risks through patient assessment and management required immediate attention, and took precedence over all other ongoing activities and interventions. Risks included those of harm to self or others, and could be potentially life-threatening, such as active suicidal intent. Many nurses viewed risk assessment and management as the main purpose of the service, and the main focus of inpatient assessment. Part of risk management involved deciding on an appropriate level of observation to protect the patient from potential harm, as Sophie described:

*Sophie 379:*

*...risk of self-harm, ... suicide, ... absconding, ...violence, to other people, ...they might be vulnerable ...from others. Also, immediate needs. Like, any kind of immediate treatments, nursing observation levels, things like that.*

*Nick 227:*

*I suppose uppermost, you're trying to determine the level of risk someone's presenting. ...essentially, ... the service we provide, is keeping people safe.*

Nurses sometimes used collateral information from colleagues and/or patient hospital electronic records summarising patients' current risks, and risk history, in their risk assessments, but as Steph reported, these were not always available:

*Steph 485/493/509/517:*

*[I'll get the information page on the admission,.. So I get the risk (1.0), why they're coming in... And ... it'll just be broken down by diagnosis, and if there's any major risks or concerns from previous admissions, and possibly a risk linked to that admission. It would always be flagged up when someone's admitted, if they've got a past history of assault, or violence on*

*staff... So you get the basic information, and basic risks, but you don't know how many admissions they've had, or where they've been treated, or what they were treated with.*

Nurses used their professional judgement and intuition to assess patient risk, taking account of current presentation and previous history. Assessments also took account of subjective information from patients:

*Nick 235:*

*There are formal tools, available, but I don't really tend to find them very useful. I think it's just down to (1.5) experience, it's (0.5) intuition, and (1.0) how the person's presenting (1.0) when they're admitted. Have they, are they being admitted because they've made an attempt on their lives? Eh, have they done it before? If so, has it been (1.0) significant? I mean, a serious attempt, or does it tend to be (2.5) some sort of em (1.0), coping mechanism that the person's evolved? ...I mean, history plays a large part in their immediate presentation. Em, if they're willing to (1.0) tell you honestly how they're feeling. You know, are they, do they intend on making another attempt on their lives or (1.0), are they happy to be in hospital, or are they gonna attempt to leave etc. All those factors.*

#### *Patient observation levels*

Three observation levels were used in the hospital: level three as normal observation, to check all patients' whereabouts on an hourly basis; level two's, checking patients' whereabouts and behaviour every five (2 05) or fifteen (2 15) minutes; and level one constant observation, for patients with imminent risk of harm to self or others.

*Adam 193/199*

*Eh, there's three, the third being normal observation, and we have a fire check board. So, at least once an hour, you should know if the person's there, asleep or out. So we make a note on them. Eh... On the fire board, you've got everyone's name. [So you walk around with the board. You tick people off, and make a note saying they were asleep, or you make a note saying they were out on leave. And then, if there was a fire, you can take that board out [and you could say that, this person wasn't here an hour ago. So, you presume they're not in the building. And then there's the level two's, which break down into various minutes of degree. A level 2 05 would be every five minutes. And a level 2 15 would be every 15 minutes. There used to be 30, but that, that seemed a waste of time really (1.0). ...[If it's more serious than that, and you think they could kill themselves in five minutes, then they're on a level one which is constant. And the rule is, you've got to have eye contact ((within sight of)).*

Staff relied on discussions with colleagues, when available, to assess ongoing risk to inform future management decisions, and to decide patient

observation levels which were an immediate nursing priority. Discussions often involved a doctor when patients were newly admitted, but were sometimes made quickly with little objective information to hand.

*Adam 148:*

*... So, observation levels (1.0). You have to decide that straight away. ...Usually, we have a doctor there very quickly. Especially, if it's a difficult admission (1.0). Eh, so it, the observation level is usually decided with the doctor. We've usually got a good idea what we're going to do anyway (3.5). [Hopefully, have a few notes to refer to. ...That's not always the case. ...The door can ring. And someone's there. 'You expecting an admission?' 'No, we weren't.' 'Somebody's forgot to tell you.' This happens on weekends and nights sometimes. So then, you're really blind. You've got to make (1.0) decisions on, on gut feelings... is this person is a risk to others, themselves?'*

In reaching decisions about observation levels, nursing staff were cognisant of staff resourcing implications and imposing patient intrusions and restrictions, particularly for level one constant observation which required a staff member to be present with the patient at all times. This could mean that additional staff resources were required, or that planned duties would have to be amended.

*Adam 231:*

*People on a level one. That involves extra staff. So we're usually careful about that. Because, if you put someone on a level one, you have to reorganise ...to fit round that one-to-one.*

A few participants described how nurses sometimes decided to implement an 'unofficial' temporary observation level when concerned about an individual patient's increased risk. This was not documented. Whilst nurses had formal authority to increase patient observation levels, the NHS Trust observation policy stated that they were not permitted to decrease observation levels without a doctor's consent. Adopting an increased 'unofficial' observation level was a strategy used in order to avoid placing restrictions on the patient for an unnecessarily long period of time, for example, over a weekend, when the permanent medical team were unavailable and junior medical staff may be unwilling to agree to a change in observation level.

Sophie 403:

*On a weekend, I would feel rather reluctant to put somebody on a very restrictive level, because it would remain for the rest of the weekend... As a team, we would do things like have an unofficial level, which wouldn't be documented, but we would be checking somebody. ...so at the end of that three hours, we'd then be able to be more flexible and let them go out into the garden.*

### Control and restraint

A majority of participants raised control and restraint (C&R) as an issue which impacted on the nurse-patient relationship. Nurses held mixed views as to whether this intervention could adversely or positively affect the nurse-patient relationship. Control and restraint often involved forcible administration of medication by intramuscular injection, and sometimes disagreement among nurses as to whether this was always appropriate. Some nurses viewed control and restraint as a therapeutic act, whilst others expressed concerns about the perceived 'heavy handed' nature of the intervention, which sometimes had negative consequences on the nurse-patient relationship.

Susie 445:

*... Because of the attitude towards C&R (1.0), em, there does tend to be a nasty taste in your mouth if you do it. ... there's a lot of disapproval about C&R where ...most people think it shouldn't have been done. And that relates also to something that impacts on the nurse, on the therapeutic relationship, which is, is the therapeutic relationship out of the window when you C&R somebody? I don't feel that personally... I have no problem generally with the therapeutic nature of C&R. And I think that if you're gonna work out your therapeutic relationship, it's no good thinking that the minute you C&R them, ...all the therapeutic relationship's out the window.*

Hannah 358:

*I will try not to be involved in the heavy handed stuff with patients of mine. I'd try and get other people. So, I wouldn't be the one ...Cos that would ruin our relationship, whatever relationship we did have. But anyway, that's not always possible really. Cos otherwise, it looks like you're passing the buck really. What could happen then I suppose is that they ((the patient)) don't really want you as their primary nurse any more. And, you have to accept that that's fair enough.*

Some nurses appropriately suggested that other interventions should be considered first such as 'taking time out' to de-escalate the situation with the

patient, and that control and restraint should be used as a last resort. This required skill and expertise on the part of the nurse involved.

*Steph 795:*

*I think medication has its place but, I do think em, people medicate too quickly. I think when someone's shouting and bawling, and if you just give them time to talk rather than saying 'Stop shouting and bawling. Please take some meds.' And they don't take it. Quite often, they end up in a restraint. I just think we should say 'Take time out.' And just sit with them. You don't have to speak to them really, but you can just sit with them down in a quiet room. To me, someone's shouting and bawling for a reason (2.0)... It is really loud. It is really aggressive, and it does sound very aggressive. It can be quite daunting, but I've always found that (1.0), even if someone's aggressive. If you just say to them 'Ok, I'll come down the end and talk to you.' Nine times out of 10, all they just want to do is just say something. They just can't get the words out. Or they've just got themselves in too much of a pickle (1.0). All the voices or something's happening that they just can't (1.0). And even if you just sit in silence, I just think they appreciate it.*

Clear communication, honesty and boundary setting were seen as the key to the best possible outcomes for patients when control and restraint was being considered. Patient involvement and choice in decision-making to exercise control over their behaviour in the situation was promoted. In this way, nurses could balance their responsibilities to protect the patient and others from harm whilst seeking to maintain a therapeutic, meaningful relationship with them. Natasha spoke of the value of this whilst recognising the limitations presented in practice:

*Natasha 545:*

*... I have been working for years doing this, and no-one has ever said to me 'You were out of order when you C&R'd me.' Or 'You hurt me' or anything like that. Because of the emphasis that's put on risk assessment at the start. Clear communication, honesty, boundary setting. You know, 'If you do this, we are gonna have to do this. And we will do it. And I need, I need you to know that before you make that decision.' (1.0) You know, we're very clear all the time, and em, people ask 'how do you square or cover your practice with these terrible ideas of laying hands on people?' I mean, nobody in their right mind would want to grapple with anybody else. You know, it's so (1.0) pointless. It's damaging to both parties. You know, it's, it's not something that you would want. On the other hand, if someone's really manic, and they're running around and they can't stop themselves, you're an idiot if you don't intervene. You can't not intervene.*

### *Police interventions*

Half of participants discussed police involvement with patients on the wards. Nurses perceived that the threshold of patients' acuity of symptoms to warrant a hospital admission had increased. There is evidence for this as discussed earlier. Some nurses perceived that a lack of adequate community mental health support had contributed to patients' acuity of symptoms increasing immediately prior to admission. Nurses believed more patients were now being admitted against their will under sections of the Mental Health Act 1983, amended 2007 (Department of Health, 2007a), and were therefore often accompanied by the police. This often adversely impacted on establishing positive nurse-patient relationships with patients in these circumstances.

#### *Steph 301:*

*I've just bumped into them ((a former patient known to the nurse)) ...who's just come onto the ward who I admitted (1.0) five years ago. One of my very first admissions, she had come in, nipped in the bud, just before she broke down. But she's now just been brought onto the ward. ... She's been in four or five times since. She was absolutely floridly psychotic. She doesn't recognise me, and doesn't (1.0) acknowledge me. But before that ever happened, ...they were just easier to engage because they were there, they were informal, they were realising they were breaking down. I think, cos sometimes, the community's failing, they're coming in. They haven't got insight. They don't want to be there. They're brought in by the police. And then everything's just removed from them. And then that just, straight away, causes antagonism within the relationship (1.5).*

Participants talked of rare occasions when patients' unpredictable, violent behaviour became unmanageable, and police were called to remove them from the ward. This generally occurred when staff had exhausted all other avenues to transfer patients to more appropriate, secure mental health services such as psychiatric intensive care or low secure units, to meet their immediate risk needs. Colin provided a graphic account of a highly challenging situation where ultimately the police were involved:

#### *Colin 189:*

*... Well, she ((the patient)) was, she was really chaotic. Unable to manage her personal boundaries. ...Extremely high, believing that she was a goddess. And ... very sexually disinhibited, ...quite labile, a history of violence in the past as well. ..A huge risk to herself and others. Completely unpredictable. So we had to contain her. ... It put a lot of pressure on all the*



*staff as well as, as well as me, and wearing a lot of us down. .Hhhhhh, so in the end, I tried to get this woman transferred to em, the em, intensive care unit, and they wouldn't accept her. So then I had to write off to the consultant, who said 'I agree it was a bad situation.' And he says, 'You know, until a real catastrophe happens, maybe people won't listen.' Three or four days later, she ended up using quite a heavy chair to completely smash up her room. Quite a dangerous incident occurred, and the police had to be called, and she was then taken away.*

In summary, most participants cited risk assessment and management as a key priority. They raised control and restraint as an issue which impacted strongly, adversely or positively, on the nurse-patient relationship. During team discussions about specific patient incidents, nurses held mixed views about the appropriateness of the use of control and restraint. The term 'control and restraint' itself is contentious, reflecting an attribution of the primary source of violence to be 'within' the patient (Paterson, 2009) rather than being 'co-created' by the patient and others, including the nursing team. Decisions by nurses to use control and restraint as an intervention to manage patients' aggression and violence are complex and multifaceted (Lindsey, 2009). Nurses' differing judgements as to how best to manage the same patient's behaviours leads to a variation in choice of interventions. This may involve the use of control and restraint as well as common use of 'as required' medications to reduce patient agitation and aggression. In a systematic review of the literature, Nelstrop et al (2006) explored the use of control and restraint interventions in adult psychiatric inpatient settings, and concluded that there was insufficient evidence to determine if such interventions were safe or effective in managing patients' disturbed/violent behaviours. They recommended that alternative calming de-escalation interventions should be used as a first line intervention.

### **Planned brief patient contact**

#### *Medication giving*

A majority of participants discussed medication giving as the primary intervention in managing patients' symptoms and behaviours. Whilst it was acknowledged that medication prescribing was necessary and generally effective, nurses expressed concern that the dominant medical model

approach to patient care was imposed upon them by doctors and senior hospital managers at the expense of adopting a broader, more holistic approach to patient care. It was felt that medication addressed immediate patient needs on the ward, and led to shorter length of hospital stay, but that patients' underlying longer term issues were left unaddressed. This left some nurses like Colin concerned about unresolved patient problems:

*Colin 117:*

*The long term resolution of patients' problems. I don't think that really gets addressed as well as it needs to be... most people are stabilised with medication ... effective in stabilising people who are very distressed (1.0), or depressed, or if their mood is up or down. Medication is very good for that. But long term resolution is what I would like to see more of.*

Steph spoke of medication as a device to facilitate discharge:

*Steph 772/788:*

*And they ((patients)) challenge ((staff)) and start getting aggressive... And it's just waiting for them to settle. ...If there's a risk of assault or something. But once that risk's gone, then they'll be back out in the community... It's medical, very, very medical model orientated at the moment. Because that's how quickly they come in and out. I think it's, they whack them full of meds!*

Medication giving by nurses was a daily occurrence on the wards, and participants reported that the administration of medicines provided them with opportunities for brief one-to-one interactions with patients. This was viewed as a helpful intervention in that it afforded staff regular opportunities for direct, if brief, contact with patients. This helped to foster the development of meaningful relationships with them. This view is supported by the literature. Such interactions are believed to be valued by patients, and provide opportunities for nurses to maintain control over patients' total care (Duxbury et al., 2009; Haglund et al., 2004).

*Graham 323:*

*... When you do the tablets, it's a good time to chat, actually. You've got time. That's when things do come out (1.5). Especially morning meds. Cos most people are on meds in the morning (1.0) or on the evening meds (1.0). Or when somebody's anxious. You say 'Well, let's see if there's something we can give you for that' (1.0) if nothing else works.*

Patients themselves were often grateful to leave control over medication administration to nurses. An exception to this was when patients were coerced into taking medication in response to nurses' perceived threats of assault by them (Jarrett et al., 2008).

Kemppainen et al (2003) found that mental health nurses used a range of medication adherence interventions with patients, including providing medication education, monitoring medication adherence, and assessing the effectiveness of prescribed medications. In order to fulfil this role effectively, nurses require extensive knowledge of medications. Happell et al (2002) cite a lack of formal in-service education in this regard, leaving nurses themselves to keep up-to-date, using resources including pharmaceutical representatives and the ward pharmacist.

### **Liaison with colleagues**

#### *Advocating for patients*

Half of participants discussed advocating for patients as a key nursing role. This reflected their professional philosophy of care towards a more holistic view of the patient and their needs. As primary nurses, they adopted a sense of ownership of their named patients' needs. Like Hannah, nurses felt a sense of responsibility and accountability for ensuring that their named patients' holistic needs were being addressed with colleagues, working with the patient towards discharge:

*Hannah 226:*

*... When you've got problem patients, they're your patients. So, you've got kind of ownership in a way, that you sort of. These are my people. I need to pay attention to these guys, I need to make sure that their needs are pushed forward. I need to make sure they don't just flap about the ward and their needs just get ignored for a couple of weeks or. I need to keep pushing.*

Nurses acknowledged the limitations of their advocacy role, partly through a perceived lack of available one-to-one time spent with patients. A few participants spoke highly of the role of a mental health charity advocacy worker who was able to offer patients more time to get to heart of their ongoing issues and concerns. Unlike nursing staff, it was perceived that the

advocacy worker could be viewed completely independently of the hospital by patients, as they had no other potentially conflicting responsibilities for them. Hannah's story provides an insight into how nurses may sometimes struggle to engage patients in being completely open.

*Hannah 327/335:*

*...Oh, it's quite (1.0), quite interesting (1.0)... This guy ((the MIND advocate)) comes out with amazing things we didn't know about the patient... Yeah, he's a brilliant person, teasing out what the issues are. Really finding out what's bothering the patient that week. Also, I think they hold back ((the patient)) from us sometimes. Cos they don't really wanna tell us. Then at ward round, it just all comes out ((Laughs)). And it's like 'Oh, I didn't realise that,' ((laughs))!*

### *Ward rounds*

In contrast with nurses' holistic philosophy of care, liaison with colleagues in ward rounds were regarded by some nurses as unhelpfully orientated to the medical model. Although ward rounds were generally attended by a range of allied health professionals including nurses, pharmacists and occupational therapists, they were led by consultant psychiatrists. The focus was mainly on medication prescribing and review of their therapeutic and side-effects impacting on patients' progress towards discharge. Nurses' holistic approaches to patient needs were perceived by participants to be viewed as less important in ward rounds.

*Hannah 282:*

*... The ward rounds are quite heavily medical. Obviously. They're very, very medical. And em, the emphasis is obviously on (1.0) the drugs, mainly. You know, the charts, the drug charts are (1.0) stared at. So, you know, for such a long time ((laughs)). And, you know. You will be talking about what patients do. And they're sort of going ... 'Eh, What drugs she on?' So it's a different (1.0). We come from different perspectives. And I think the medication is very important. But, em, I don't see it as the, the whole point of their admission.*

Some nurses regarded the traditional ward round process as an unnecessary imposition on patients when they were asked to attend the meeting to give an opinion of their progress to health professionals there. Different ways of multidisciplinary working on a one-to-one basis with

patients were viewed as preferable to the traditional ward round approach, and Natasha demonstrated very strong views:

*Natasha 427:*

*...The thing I'd most like to get rid of is a ward round. I think it's utterly pointless. I think if a doctor wants to go and have one-to-one time with his client, that's fantastic (1.0). But I don't think that there should be this kind of (1.0) 'throne room' atmosphere. You know, with the patient being brought forward to account for themselves and their lack of ((laughs)) progress! And the nurse being sent around to blooming fetch people and carry things...and nurses do it!*

Participants' stories and the literature support that although nurses value one-to-one time with patients, managing the competing demands of shift coordination, documentation, administration, risk assessment and management, and insufficient time, all can lead to a medically driven model of care provision. This shifted the focus of care towards medication giving, de-escalation, and use of control and restraint as primary interventions. It is clear from participants' stories that nurses held some awareness of these problems and how they characterised the context of their nurse-patient relationships.

#### **4.4 SUMMARY**

This chapter has presented the first of three key emerging themes in this study. In this chapter, I have discussed the essential components of nurses' reported experiences of the context of the nurse-patient relationship. These were considered in relation to the literature and interlink with the remaining two key emerging themes presented in the two chapters which follow. Findings about the characteristics of the nurse-patient relationship and nurses' skills and qualities brought to the nurse-patient relationship are discussed next.

## **CHAPTER FIVE: CHARACTERISTICS OF THE NURSE-PATIENT RELATIONSHIP AND NURSES' SKILLS AND QUALITIES BROUGHT TO THE NURSE-PATIENT RELATIONSHIP**

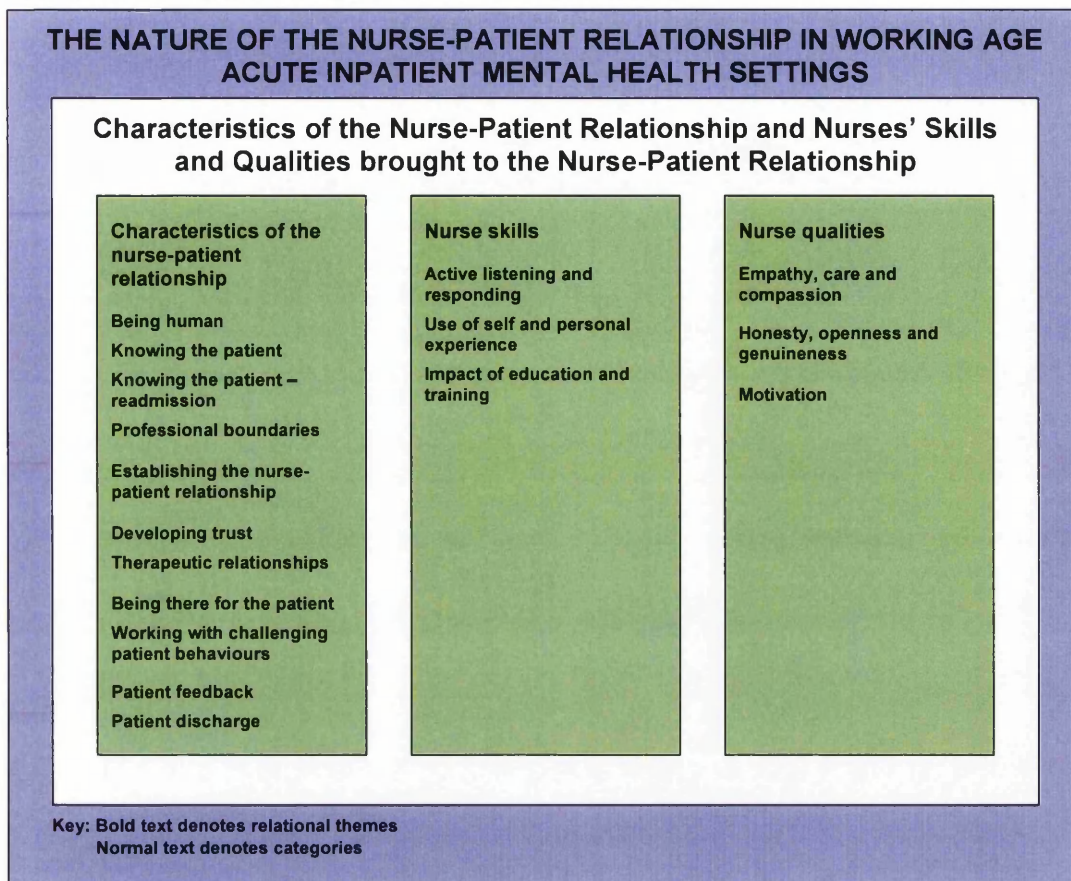
Key findings obtained from 14 in-depth interviews are presented in three findings chapters:

1. The context of the nurse-patient relationship;
2. Characteristics of the nurse-patient relationship and nurses' skills and qualities brought to the nurse-patient relationship; and
3. The impact of the nurse-patient relationship on nurses.

This second chapter presents the key findings obtained concerning the essential components of nurses' reported experiences about the characteristics of the nurse-patient relationship and nurses' skills and qualities brought to the nurse-patient relationship, related to the literature. This is discussed within three major relational themes which emerged from this study: Characteristics of the nurse-patient relationship; Nurse skills; and Nurse qualities.

A conceptual framework of the characteristics of the nurse-patient relationship and nurses' skills and qualities brought to the nurse-patient relationship, is provided in the diagram overleaf, illustrating links between relational theme and their subthemes. The chapter concludes with a brief summary.

Figure 4. Data analysis conceptual framework: Characteristics of the nurse-patient relationship and nurses' skills and qualities brought to the nurse-patient relationship



## 5.1 CHARACTERISTICS OF THE NURSE-PATIENT RELATIONSHIP

### Being human

All participants believed that a key characteristic of the nurse-patient relationship was to recognise and acknowledge the fundamental human nature of one person interacting with another. A caring, compassionate, accepting approach towards working with patients to address their needs and concerns was at the heart of psychiatric nursing. The humanistic nature of the nurse-patient relationship was further reflected in nurses' qualities brought to the relationship, which are discussed later.

*Adam 347:*

*So, as soon as you meet them, the relationship begins. ... I start all my relationships on the one human being to another human being em (1.0), point. And work from there (1.0) onwards. So, I do think it's important. I think it's probably the most important eh thing of all, because em (1.0), that's what psychiatric nursing is. It's one human being (1.0), most of the time, talking to another human being. I think that probably comes first.*

The notion of the nurse-patient relationship being the cornerstone for psychiatric nursing, first developed by Peplau (1952), has existed for almost six decades. The literature continues to support this view, shared by participants. Hem and Heggen (2003) argue that being human and being professional are integral to the nurse-patient relationship. This involves nurses demonstrating empathy and openness with patients, exposing themselves to vulnerability in use of self as agents in the therapeutic relationship. Vulnerability in itself is an essential human quality and may be regarded as fundamental to all human caring.

Hem and Heggen (2003) assert that nurses may present a professional persona to protect their vulnerabilities, equating professionalism with control and safety. This need for control may lead to tensions between what patients want and how nurses portray themselves professionally. Patients want to be understood and listened to by nurses who are available, friendly, and perceptive. Paradoxically, nurses are tasked with being both intimate and distant in therapeutic nurse-patient relationships, presenting professional role and human conflicts. Nurses must balance external demands for effective care delivery and high patient turnover, whilst also expressing their own humanity and vulnerabilities in therapeutic nurse-patient relationships. Further challenges arise owing to the paucity of one-to-one therapeutic contact, owing to a disproportionate amount of nursing time being taken up by administrative activities (Cameron et al., 2005). These views fit well with the lived experiences of participants in this study. Cameron et al go on to suggest that a human relations model of the therapeutic relationship could provide psychiatric nurses with a helpful dialectical framework to support their better understanding of patients' mental health predicaments. They assert that application of Barker's (2003) Tidal Model of mental health which takes a human relations approach, could help nurses better focus on interpersonal nurse-patient relationships, to discuss patients' experiences of their mental health problems.

In the present study, participants appear to acknowledge the relevance of expressing their humanity in the nurse-patient relationship, but there may be



inconsistencies in what nurses say about their professional practice and what they actually do. Whilst some participants' stories acknowledged use of human self in the nurse-patient relationship, in other examples, nurses presented a more controlled 'professional' approach in their interactions with patients.

### Knowing the patient

All participants cited 'knowing' the patient as important in order to understand their needs and concerns. This is a constitutive pattern running across all participants' stories. The extent to which nurses were actually able to 'know' their patients varied, and nurses interpreted the term differently.

For some nurses, 'knowing' the patient meant having developed a rapport with them, and an in-depth knowledge of their mental health problems and concerns. Nurses would also have awareness of the patient's character, their family, friends, significant others and general interests, but as Hannah discussed, not know patients as closely as they would a friend:

*Hannah 258:*

*>But I think I got to know her quite well, I suppose<. ...Her character is quite nice. But em (1.0), in terms of knowing her, no, I don't think I really got to (1.0). You're dealing with the 'here and now' ((current presenting mental health problems)). ...I know she's got a pet. And I know she hasn't got any friends. ...So I can't say I know her (1.0), as well as I know a friend. But then I knew her as well as I could, to help with the stuff that was problematic for her (1.0).*

As Sophie described, sometimes 'knowing the patient' could be of narrow scope:

*Sophie 795:*

*... But then you can have a bizarre combination of really knowing nothing about somebody, ... but, you kind of have quite an intense knowledge of them, when all their inhibitions have gone. And all their normal boundaries have disappeared and em. And maybe they tell you information about, very, very private information, about themselves or, you kind of see them in a different light.*

'Knowing' the patient in the context of their presenting behaviours could mean a detailed knowledge of a specific individual's behaviours, or a collective knowledge of common presenting patterns of behaviours such as self-harm in which the nurse believed their relationship had somehow

reduced risk. Adam believed the quality of the nurse-patient relationship could have a powerful influence of patient risk behaviour but found it difficult to explain why this should be:

*Adam 417:*

*I formed the best relationships, working relationships with people who self harm, who cause dramas ... and most of the time, it works. Most of the time, these patients with me, don't do the slashing. When I'm nursing them that day, they usually save it for someone else, who they don't know so well. ... It can't be a coincidence [that, on the shifts I'm working with them, they don't cut, don't strangulate, don't set fire to themselves. But on other shifts, they do, in the same admission. That can't be a coincidence. It must be something to do with the nurse-patient relationship.*

Bonis (2009) argues that nurses may better understand patients' health experiences through awareness and reflection. This can enable nurses to interweave objective empirical knowledge with subjective practice knowledge, drawing upon multiple levels of awareness and reflection on nurses' and patients' experiences. Cameron et al (2005: 69) conclude from their review of the literature that nursing '... is an interpersonal transaction committed to getting to know and understand the predicament of the patient using reflective practice.'

Whilst reflective practice is embedded in nursing educational curricula, the practice of reflection among nurses in healthcare is less evident, highlighting a theory-practice gap (Ruth-Sahd, 2003). In the present study, just under half of participants evidenced reflective practice in their stories, which may suggest that the ability to get to know and understand patients' mental health experiences may be problematic for some nurses.

### **Knowing the patient – readmission**

For the majority of participants, it was particularly useful in getting to 'know' individual patients when nurse-patient relationships had been established and built upon over successive readmissions to hospital. Nurses who had worked in the hospital service over a number of years were best placed to come to 'know' their patients in this way. A common understanding of one another, and a recognition and respect for the implicit professional boundaries that had been established over time, helped the nurse-patient

relationship to quickly re-establish when the patient was readmitted. Adam talked about the advantages this could bring to the relationship over less developed nurse-patient relationships between the patients and less familiar staff:

*Adam 363:*

*But I think most, especially with patients that are in and out like yo-yo's. It's like a business relationship really. [Some of the patients I've known for years and years. It's almost like ... 'You know who I am. I know who you are. You know what I'm gonna do. ... And you'll see them behaving with, with nurses who they don't know, or new nurses, or agency staff, winding them up, and playing games with them. Em, or em (1.0), being stubborn or whatever. And thinking 'They're doing that because they know that they could possibly get different reactions from this nurse who doesn't know them. Whereas with us over here, who've known this patient for years and years, it's just a matter of fact 'Hello. Here I am. I'll be here for the next few weeks and then I'll be out. And, I'll see you again next year.' It's almost like a transaction. ... We both know what we're talking about. We don't need to waste time. Let's get to the important bit (2.0).*

Natasha was able to articulate an understanding that whilst some patients were known to staff through their readmissions over a period of time, the changing nature of increased risk thresholds for patient admission to inpatient care had seen new patients unknown to services admitted. Established relationships with readmitted patients presented a risk in that nurses might make assumptions of their current risks, needs and presenting problems, based on their historical knowledge of them. On the one hand, nurses may believe they know their readmitted patients well, but on the other, patients' circumstances and concerns may have changed, and the reasons for their admission on this occasion could be different from the past. Whilst nurses might claim to know their patients' presenting problems well, some like Natasha, acknowledged that they did not truly know these patients well in terms of fully appreciating their potential capabilities, hopes and aspirations.

*Natasha 192:*

*... You'll see a cluster of people that you know, and for a little while, perhaps, you'll see a lot of new presentations. But then, people will come back. So (1.0), it depends. I think it's a mistake to assume you know someone, just because you've seen them on five admissions though. Because all you know is the illness. You don't know the person (1.0), at that time. You know what that person can be like under stress and under pressure. But you don't*

*know all the things that they're capable of, and their potential, because you're only ever seeing the things that we think are important. ...But we don't know what their hopes, their dreams are. We don't ask the right questions, I think.*

From the literature reviewed, participants' desire to 'know' patients to address their needs and concerns may not always be possible, as some nurses may lack sufficient awareness and reflective skills to draw upon their own and patients' experiences.

## **Professional boundaries**

### *Professional versus personal relationships*

All participants indicated that maintenance of professional boundaries was a fundamental feature of their nurse-patient relationships. Managing this boundary successfully took skill and judgement. On the one hand, nurses were expected to develop a close therapeutic relationship to gain access to sometimes intimate, highly personal details of the patients' current circumstances leading to their admission. On the other hand, a professional distance had to be maintained whilst establishing closeness and rapport, without overly disclosing personal information about themselves. Nurses acknowledged that this was sometimes difficult for colleagues to adhere to, when they chose to disclose some personal information about themselves. The inherent risks to nurses in doing so are discussed in the next chapter.

Natasha was aware of the need to develop closeness without compromising her focus on the needs of the patient, and as Henderson (2004) discussed, Natasha was also mindful of the challenge for junior staff to achieve this:

*Natasha 210:*

*...And although it's an intense relationship ((the nurse-patient relationship)), it cannot be em (1.0), a personal engagement that you would have with a friend. ...I think that that's something that we do struggle with, putting over to our staff. We tell them 'I want you to be very close to that person.' 'I want you to understand them.' 'I want you to ask them about them.' Em, 'I want you to do this.' 'I want you to do that.' 'But I don't want you to share yourself.' And that's actually quite a difficult thing to do. To be open and available to a client without actually being overly disclosing (1.0). You know, without skills I think, people do struggle. Because the way people engage by nature, is swapping information. 'What do you like?' 'This is what I like, de de, de de.' And by its very nature, this relationship has to be solely*

*focussed on the patient, and the patient's needs, or the client's needs, or the service user's needs.*

The development of the therapeutic nurse-patient relationship in acute psychiatric inpatient care requires both a professional closeness and distance to be maintained by the nurse. This may be challenging to achieve for some nurses, particularly those who are newly qualified, and inexperienced. In developing closeness and patient trust, professional relationships can be a source of great support to patients, and paradoxically, profound distress for both patients and nurses when professional boundaries are transgressed (Henderson, 2004).

Whilst all participants spoke about professional boundaries, there is a dearth of literature addressing the issue of intimacy in nurse-patient relationships (Holder and Schenthal, 2007). In a survey of registered nurses in Canada, a significant number of mental health nurses commented on their sexual attraction towards patients. Very few nurses had developed intimate sexual relationships with patients, and those who did tended to be young men prepared at pre-registration diploma level. A small number of nurses believed it was acceptable to have a sexual relationship with patients whilst in hospital, though none reported having done so.

Given the lack of research into this area, and the inherent vulnerability of patients, the Nursing and Midwifery Council (2009a) guidance to help nurses understand the need to maintain clear sexual boundaries with patients and their immediate families in their care is helpful. Whilst nurses may legitimately share personal information, feelings and vulnerabilities with patients and their families, this professional closeness should not be confused with social intimacy. Patients are likely to disclose personal information in order to inform their treatment and care, and nurses have a duty to monitor and influence the level of closeness and intimacy during professional interactions. This power differential results in patient vulnerability, and the nurse is responsible for deciding what constitutes appropriate, professional behaviour. When professional boundaries are

transgressed, then patients' trust in the nurse-patient relationship is lost, which will most likely have negative patient outcomes.

Findings from the present study found that all participants acknowledged the maintenance of boundaries as a fundamental feature of the nurse-patient relationship. This finding was generally supported in the literature.

### **Establishing the nurse-patient relationship**

Almost all participants indicated that great care and attention was required to establish the nurse-patient relationship at first point of contact with the patient. Nurses' first approaches to newly admitted patients were crucial in establishing therapeutic nurse-patient relationships. For some nurses, this was on the day of admission of the patient, and for others, it was at the first opportunity to informally meet the newly admitted patient when they had returned to work following leave or allocated rest days.

#### *Patient admission*

Zoe described the importance of setting the right tone for patients from the outset of their admissions:

*Zoe 151:*

*Mm. .Hhhhhh. Well, you know, as you gain experience, you become hhhh, more equipped (0.5), to, to (1.0) developing those interpersonal relationships with people. Em, and it's about (1.0), you know, a really important point, I think, is when people are first admitted to the ward. And that can kind of set them up for the rest of their admission. If they have a bad experience when they are admitted to the ward, then that's going to do a lot of damage for the rest of their admission. And so that, I think, is a really important part, and that needs to be done very mindfully. And, you know, you need to be quite conscious of, of settling them in, and giving them good induction onto the ward. And making sure all their questions are answered (1.0). So I think that point is really important. Em (1.0) and I think it's important that they feel listened to from the word go, and that you're not there to judge. Em (1.0), and that you can be (1.0), you know, you need to be able to adapt yourself as a person to be able to relate with each individual. Em (1.0), you know, you need to be able to respond differently (1.0), depending on people's needs (2.0).*

As with Zoe, nurses recognised the patients' first days of admission afforded valuable opportunities to meet the immediate needs of patients, to offer comfort and reassurance, and develop rapport with them. Nurses were mindful of patients' needs and concerns when establishing relationships, to

give patients a good experience that would foster positive collaborative working relationships with them in the future. Prioritising one-to-one time with patients during this period seemed important for many nurses, to begin to get to know their patients. This patient-centred approach was promoted as a way to avoid 'bad' patient experiences, which could damage the prospect of developing therapeutic relationships with them. Some nurses valued this one-to-one time during patient admissions, as it seemed to be 'mentally ring-fenced' and free from distractions from other staff. As Sophie described, this could help nurses to spend quality time with patients, making 'connections', and beginning to establish ongoing therapeutic relationships:

*Sophie 267:*

*Em, I often find that (2.0) you can actually connect quite well with somebody when they're admitted. Em, because the admission, the time of admission, is one of the times that you're almost allowed, as a nurse, to spend time with a patient. And you don't (1.0), you can actually devote yourself to doing that admission and you don't get distracted by other people. It sort of seems to be mentally ring fenced [in the minds of, of all the people on the ward. That, if somebody's being admitted, then, you're doing that admission, and it's ok for you to be devoting yourself to that person (1.0). Em, so, I, I really, that's something I always enjoyed, and I found that if I did an admission with somebody, then I often felt I had a good connection with them after that (1.5).*

This was not a universal view among participants. Two nurses conversely viewed the admission process as a hindrance to establishing therapeutic relationships. These nurses took a task-centred approach, where completion of admission documentation appeared to be prioritised over taking time to develop rapport with patients. Surprisingly, they acknowledged that the admission period was crucial in establishing therapeutic nurse-patient relationships, yet opted for a task-centred approach to the admission process. Others preferred not to be directly involved with patients during the admission process, leaving this to unqualified health care assistants, as nurses focussed on completing admission documentation. Steph described feeling constrained by the admission paperwork:

*Steph 221/381:*

*... I don't think the admission process is very good, ...[because it is just this list of paperwork questions (1.0) that are very set. ... You're just following a script. And I find it really difficult with patients that (1.0). Cos sometimes*

*they'll open up and you have to stop them because you need to get the admission done.*

Paula also spoke about the difficulties presented by demands for recording admissions:

*Paula 254:*

*... Em, most of the time, I tend to get bogged down with documentation (1.0), when someone's coming in. Eh, cos there's lots of paperwork to sort out and things like that first. So actually, making initial contact with the patient is very difficult when they very, very first come in. ...So (1.0), quite often, the nursing assistants tend to be there, you know.*

### *Patient vulnerability on admission*

A majority of participants cited responding to patients' fear and distress as a key nursing intervention. Patients arrived on the ward often anxious and distressed, in part through their own mental health issues and circumstances leading to the admission, and their response to the admission process, and the busy ward environment itself. Patients were sometimes compulsorily admitted under the Mental Health Act 1983, amended 2007 (Department of Health, 2007a) without their consent, accompanied by various professionals including the police and an approved mental health practitioner. Nurses recognised it was important to use this time to establish with patients that they were there to work with them, to assist and reassure them, and to help to meet their immediate needs.

*Adam 110/136:*

*You're the person who's taken away their liberty. You're just an extension of the police, or the social workers, or whoever brought them in. You are the same. ...Until you establish your own identity with them. ...If it's em, a first admission, em, I'm very aware that I've got to make the patient as comfortable as possible. Not be scared about what's gonna happen, what, what kind of place it is. ... I explain what the processes are, and understand how they might be feeling.*

Sometimes, nurses decided that the administration of oral or intramuscular medication, with or without the patient's consent, was required to manage risks. This could be very distressing for vulnerable patients, but where possible, nurses used active listening and responding skills to reassure and support the patient. As in Colin's example, nurses generally included the patient in discussions to accept oral medication in preference to use of



control and restraint techniques to administer medication by intramuscular injection by force.

*Colin 424:*

*We approached him with his medication. He refused, and then eh, we got a team ((control and restraint team)) together,...but then he became very scared. ...poor thing. ... he sort of, asked me 'What can I do to avoid this?' I said 'Well, you know, you have to take this ((oral medication)) really.' And he said 'I don't want to?' You know. But he did, because he could see what, unfortunately. It's not nice to have to do that, but, you have to. We don't want to restrain anyone at all. So we managed to avoid it, and he took his medication, which was good.*

Nurses also were conscious of protecting newly admitted vulnerable patients from developing inappropriate 'connections' with others who might present risks to them. These risks could include unnecessary distress, aggression, and possible violence from other patients.

*Sophie 275:*

*Em (1.0), often, if you get somebody coming in who's very elated, they'll be out there in the public areas of the ward, talking to all and sundry. Em, establishing connections with perhaps the em (1.0), most, the least appropriate sort of other patients. The people who perhaps you would be concerned might be em, be a risk to somebody who's very vulnerable. Em (1.0), and they'll be very visible about the ward. They might be very, very emotional. They might be aggressive. Em, they might be very demanding. So you're having to deal with that.*

Nurse adopted respectful, courteous, gentle approaches to patients at this time, to foster and establish a therapeutic nurse-relationship. This approach was extended to any relatives and significant others present at time of admission.

*Jackie 312:*

*Em, I think (2.0) particularly if it's somebody's first admission. Em (1.0) hhhhh, it's orientation. Em, information, but not too much. That, that initial period can be absolutely crucial, and can taint, or colour somebody's perspective of a mental health service for the rest of their lives. And their relatives as well. Em, it's (1.5) it's, it's being fairly gentle with people, but giving, trying to give them information. Saying who you are, and showing them the practical things. Showing them where things are. ...It's looking to their family, you know, their carers as well. ...So, it's about treating someone as an individual.*

### *Family and carer relationships*

Just under half of participants discussed the significance of developing positive relationships with family and carers. There was a fine balance between involving family and carers and maintaining confidentiality, respecting patients' personal health and social information. Involvement of family and significant others in discussions with health professionals at ward rounds and other meetings was normally undertaken with patient consent. Some nurses, like Nick, extended their therapeutic approach to incorporate patients' families:

*Nick 427:*

*Eh, most patients, you would have a certain degree of involvement with their family. Eh (1.0), when their families come to visit. You know frequently, some more frequently than others. They come to the ward rounds (1.0). Eh, 117 meetings ((to discuss aftercare arrangements for detained patients)). Whatever it happens to be. There will be, usually there'll be a degree of family involvements. Over the course of time, you, you begin to form a relationship with the, the family as well (2.0).*

Sjöblom et al (2005) argue for more family-oriented approaches to mental health care. Findings from focus groups with carers indicated that they would like more compassion for, and understanding of, their needs in supporting family members with mental health problems. Common needs included addressing feelings of shame and embarrassment expressed through infrequent hospital visits; loneliness through loss of contact with the family member with mental health problems; and a need for support and information from someone who listens. Nurses' awareness of carers' needs may be raised through training to help them build relationships with carers and provide appropriate information and support (Gall et al., 2003). As suggested in the literature, this may be difficult to achieve in reality given the work pressures that mental health nurses face in meeting their day-to-day responsibilities (Goodwin and Happell, 2007).

Family needs require nurses to assess the situation from both patients' and family/carers' perspectives (Glick and Dixon, 2002). Nurses' duty of confidentiality towards the patient may sometimes place them in a difficult

position to address family/carers' needs, as patients may not wish private information to be shared.

From the literature reviewed, the fact that less than half of participants mentioned significance of families/carers needs may suggest either a lack of awareness in this regard, or that patients themselves had limited family/carer involvement.

### **Developing trust**

Most participants cited the development of trust within the nurse-patient relationship as important. Failure to establish and maintain trust could have a detrimental impact on the nurse-patient relationship, and some nurses found it frustrating when patients did not engage with them to work collaboratively together. Like Zoe, some nurses viewed patient non-engagement as a poor reflection on them, suggesting they had somehow failed to engage with the patient, despite their best efforts.

*Zoe 217:*

*... You can put a lot of time and energy into it, ...trying to adapt yourself to be a person that they can feel they can trust. And if they don't feel that they can trust you, ...you can come away with that sense of feeling that you've failed.*

The development of trust in the nurse-patient relationship could be beneficial in engaging patients therapeutically in their prescribed treatment plans and other aspects of care, as described by Nick:

*Nick 379/387:*

*... Very often (1.0), you will try and (1.0) exploit the relationship you've got with a patient unwilling to accept their medication, or if they've got misgivings about it, or (1.0) any sort of issues. ... You've already established a sense of trust so you would hope that the patient would be (1.0) more amenable to something that they had a degree of trust in than somebody they had a lesser degree ((of trust)) or none at all (3.0).*

Trust initially relates to patients' confidence in the health care institution and its staff, but later may become individualised as patients and nurses come to know one another (de Raeve, 2002). This work is challenging in a mental health care inpatient context, as patients may enter the healthcare system against their wishes, thereby presenting potential barriers for the

development of trust in the organisation and in the nurse-patient relationship itself.

In a review of the literature, Bell and Duffy (2009) identified patients' expectations of nurses' professional competence and goodwill to act in their best interests, as defining characteristics of trust in the nurse-patient relationship. In considering the nature of trust in the nurse-patient relationship, de Raeve (2002) argues that the nature of patients' trust in nurses in such relationships requires the nurse to care about patients, not just for them. She argues that nursing work is intrinsically moral in nature, in which patients trust nurses to act in their best interests. Caring about patients requires some active moral commitment on the part of the nurse to act in the best interests of patients.

Further characteristics included recognition of human vulnerability and risk in developing the relationship, in that established trust may be lost if ill will is demonstrated by either nurse or patient. Establishing trust between nurse and patient can lead to both positive and negative outcomes for nurses and patients, and loss of trust can destroy the nurse-patient relationship.

The literature supports this study's findings that nurse participants acknowledged trust to be important in nurse-patient relationships, but that this may not always be possible to establish in practice.

### **Therapeutic relationships**

Participant experiences of establishing the nurse-patient relationship were discussed earlier in this chapter. The ongoing development and maintenance of therapeutic nurse-patient relationships allowed nurses and patients to work collaboratively together. This was cited by a majority of participants as being essential in order to assist patients to progress and move forward with their care.

*Janet 515:*

*...And the important thing in that relationship is that you're goal is actually to move them out of that relationship. Is to help them with their recovery and to get them back to where they want to be, with their family, their friends, and to their own home without you there.*

Nurses valued therapeutic relationships with patients in their care, regarding them first and foremost as people. The purpose of the nurse-patient relationship, to move people towards recovery and independence at home, was a primary focus for nurses' relationships with patients. This needed to be founded on valuing patients as people, as Nick describes:

*Nick 483/491:*

*I mean, if you've got a relationship with somebody, regardless of whether it's negative or positive, you would, you would aspire to try and initiate and maintain a positive relationship because, without that, it would be very, very difficult, if not impossible, to achieve anything, certainly anything therapeutic. ... It's just about how you (1.0) relate to other people. And em, you have to value them first and foremost as people.*

### *Patient collaboration*

The development of therapeutic nurse-patient relationships in which nurses and patients worked collaboratively in partnership together, was cited by a majority of participants as being essential in order to assist patients to progress and move forward with their care.

For patients to be active participants in their care, they need to have relevant, accessible information (Henderson, 2006), but mental health nurses working in acute inpatient care tend to communicate with patients using medico-scientific knowledge rather than everyday knowledge. This may impede patients' understanding and participation in sharing responsibility and purposefully engaging in managing their lifestyle and mental health problems. McCann et al (2008) found in a small survey of 47 mental health professionals from two inpatient psychiatric units, that most participants had favourable attitudes towards patient participation in service delivery, care, care planning and treatment, but that they were less supportive about patient participation which related either directly to professionals' individual spheres of responsibility.

Barker and Walker (2000) found that whilst nurses in acute inpatient wards claimed to collaborate with patients in planning care, in reality, this often amounted to patients signing care plans with little collaboration in their construction. Patients themselves have expressed some concerns over lack

of information, poor communication, and lack of involvement in planning their care (Walsh and Boyle, 2009). On a positive note, patients acknowledged experiencing a sense of safety and sanctuary, developing friendships, enjoying some activities, and referring to staff with good qualities. Patients' insufficient involvement in their nursing care is not solely restricted to mental health nursing, but is a common problem in nursing care in general (Sahlsten et al., 2009), and services are still far from being adequately patient-centred (Bradshaw, 2008; Roper and Happell, 2007).

Horsfall (2003) argues that mental health nurses have a responsibility to facilitate patients in managing their life challenges, which may include problems concerning unemployment, poverty, insecure accommodation and stigma. In order for such collaboration to be successful in acute psychiatric care settings, Borge and Hummelvoll (2008) found that patients need both time for self-reflection, and pleasant surroundings, for learning to occur.

In the literature discussed above, it is likely that many patients do not receive adequate one-to-one therapeutic time or sufficient time throughout their short inpatient stay for self-reflection. It may be unlikely then that many patients are afforded sufficient opportunities to develop further skills and insights to self-manage their mental health problems and adapt their lifestyle to better promote their mental health. The changing nurse-patient relationship towards a model of partnership working could benefit both patients and nurses, and may offer opportunities for nurses to make visible the emotional labour of nursing (Staden, 1998).

#### *Patient empowerment and responsibilities*

Some nurses discussed patient empowerment as an important focus of their relationships, to help patients to identify and achieve goals for themselves, to promote their own recovery. The nurses' role was to offer support and work with others in the team to facilitate the patient to take some responsibility to help to resolve their issues.

*Jackie 328:*

*It's empowering people. Enabling them, by doing something quite small, so that they realise that, that they can. And hhhh, and (1.0), yeah. It's about*

*trying to help them find what they want. And, >just trying to help them achieve it<, really. ...It's trying to put in place things that are going to enable them to live back out in the community.*

*Steph 661:*

*Em, the ward ((team)) priorities are, generally, just to find out what the issues are that brought the patient in. Then trying to look at ways to tackle them and resolve them. But to get the patients probably to resolve them, and not us to resolve them. So, it's about empowering them. Cos a lot of them seem to come in, and just expect you to do it. And it's just like, 'Well you can do it. You're capable of doing it.' It's, it's just giving them the support that they need.*

For participants, patient empowerment implied collaboration on the part of the patient to work with the nurse towards their goals. Nurses expected patients to be active participants in their care, to the best of their ability. The nurse-patient relationship required collaboration and effort by both parties, in order to be therapeutic in working towards patients' independence and hospital discharge.

*Natasha 704:*

*...So I think that therapeutic relationships and inpatient stays need to be two way. Even when somebody is em, on a section and here against their will. I think they need to be as engaged in the process as they can be. And to understand the benefits that can bring. It's not just a one way street.*

Some nurses in the present study discussed patient empowerment and responsibilities as an important focus of their relationship, to help patients to identify and achieve goals for themselves, and to promote their own recovery. Nyatanga and Dann (2002) state that the term empowerment is used to describe most human activities and is ambiguous as a concept. They suggest that the dominant medical model and hierarchical structure of current healthcare mitigates against the development of patient empowerment. Whilst service user empowerment is constantly flagged as important in national and local policy, its implementation in practice is difficult to define (Lloyd, 2007). The authors suggest strategies to develop empowering practice including positive risk-taking, reflexive practice, and negotiation with other professionals to include service users in decision-making. Nyatanga and Dann (2002) suggest that if empowerment is to become a reality in nurse-patient relationships, then patients need to be treated as equals, with proper collaboration in developing care plans; that

learning between nurse and patient is reciprocal and valued; that nurses develop empathic understanding of patients; and that patients perceive a sense of control, competence and goal internalisation.

### **Being there for the patient**

Just over half of participants in the present study indicated that 'being there' for the patient was important in the nurse-patient relationship. In this study, nurses aspired to be approachable for patients. Some, like Janet, reported informing their primary and allocated patients that they were around and available at the beginning of each shift:

*Janet 278:*

*...A lot of it's just being there. When they need you. That's em, I think it's important to make sure that, at the beginning of each shift, that they know that you're the one that's there for them for that shift. You know, if you've been allocated that particular patient, not just the ones you're primary nurse for, but any of them. You know, you're there and I always say, you know, 'If there's anything you want just come up and see me, but I'll catch up with you later on.' Or something like that.*

However, just over half of participants cited lack of time as being a major constraint on spending time with patients to work together to address their concerns. The busy nature of the ward environment often negated honouring planned time set aside for patients at the beginning of each shift. These constraints were discussed more fully in the previous findings chapter, but Susie's comment reminds us of this challenge to 'being there':

*Susie 582:*

*But quite often, the time just (1.0) goes, ...You really do not have the time to develop the therapeutic relationship to the extent that you should. There's absolutely no doubt about that at all. You're fire fighting.*

In a small ethnomethodological study with 10 mental health nurses working in an acute admissions unit, Lloyd (2007) found that participants identified their main role as 'being with' patients, working towards developing empowering therapeutic relationships with them. Nurses spent one-to-one time with patients, focussing together on their recovery needs.

There is some evidence from participants in the present study that some nurses did work collaboratively with patients, using both medico-scientific



and everyday knowledge. Some participants had a clear understanding of the nature and purpose of the nurse-patient relationship, to assist patients to move forward in working towards collaborative goals.

### **Working with challenging patient behaviours**

A majority of participants described working with challenging, more prominent patients on the wards. The term 'challenging' captured a variety of more complex patient issues which nurses could find difficult to manage. A minority of patients could cause either intentional or unintentional disruption through inappropriate, sometimes distressing behaviours towards others on the ward. Nurses attributed these behaviours to patients' personalities and own mental health problems. Behaviours seen as challenging invariably demanded much time and attention from nurses at the expense of meeting less prominent patients' needs, as Adam described:

*Adam 267:*

*...Sometimes you can have one or two very disruptive patients, and that's it. All the other patients. Really, you just have to hope that they understand that you haven't got time to see them. ...I will go and tell them. 'I'm your nurse today, but you can see, things are a bit ...' And nine times out of ten, that patient will go 'No, it's ok.'*

This echoes Stockwell's (1984) findings in her study of general ward patients in the early 1970s, that it is patients who are regarded as neither popular or unpopular by virtue of their behaviours who receive least attention from nurses. Most participants in my study continued to try to develop and maintain therapeutic relationships in the face of challenging behaviours, but this was often draining on the individual nurses concerned. With perseverance and patience, nurses felt that they could make progress to work collaboratively with such patients, to begin to address their underlying issues and disruptive behaviours. Some nurses perceived that some patients could covertly choose not to work collaboratively and honestly with their primary nurse towards the same ends. This could lead to what some nurses perceived as 'team splitting' on the part of the patient, with some nurses believing that the primary nurse was therapeutically engaging with the patient, with others in the team believing that the patient was manipulating and misleading the primary nurse. This seemed to be a matter of different

staff perceptions, and could lead some nurses to actively dislike particular patients. This, in part, was because of the adverse effects patients could have upon nurses whilst attempting to maintain a therapeutic relationship with them. The theme of the unpopular patient was discussed in the previous chapter. Sophie recalled a difficult nurse-patient relationship:

*Sophie 596:*

*...I became her primary nurse at the time that she lost custody of her child, em, and sort of went through that process with her. And I think that kind of cemented our relationship in a way, because I'd supported her through that. ...Em (2.0), but then, I think we were trying to work towards two different goals. Because her goal really was to stay in hospital and to abdicate responsibility for her life. And my goal was to encourage her to leave hospital and to work towards regaining her normal life. [And I think, em, she was quite untruthful about a lot of things. Em, and was a very difficult person to nurse because she was very team splitting as well. And em, a lot of the people in the nursing team found her very difficult to work with, and actively disliked her. And em, I think, for a long time, I always felt quite hopeful about her. I felt that she was reasonably intelligent. That, just before coming into hospital, she'd been holding down a job, and looking after her child. And so I felt, I always felt a sense of optimism about her. And it wasn't until really the end of six months that I completely lost that. I gave up being her primary nurse cos I felt really burnt out with it.*

Sophie's account of this touches on the emotional labour of nursing, discussed in the previous chapter.

Half of participants indicated the challenging nature of persevering with patients to attempt to work positively with them, when some patients did not seem to engage and interact with nurses. A sense of powerlessness on the part of nurses could develop when there appeared to be no forward movement in addressing patients' needs, and this could lead to negative nurses' attitudes emerging with particular patients. Nick spoke about finding his positivity for a patient beginning to wane:

*Nick 499:*

*...It becomes difficult to spend time with people, consistently, over a period of time, when you don't really feel that there's an enormous amount of progress being made.*

*Zoe 210:*

*...And there are some people that we just feel that we cannot engage with (1.0), em, because they're not willing to. ... There'll be very little interaction.*

## Patient feedback

An overwhelming majority of participants expressed their perceptions of what patients might say about the quality and significance of their nurse-patient relationships. Some nurses measured the 'success' of a nurse-patient relationship by considering the overall patient experience. A successful admission was judged by some nurses to be when patients believed that their overall experience had been therapeutic and helpful.

*Zoe 224:*

*If they feel that they've had (1.0) a therapeutic and helpful experience (1.0), then I think that, that would be successful. And, you know, if it's helped to make a difference to their (1.0), to their life, you know, compared to how it was when they first came into hospital. Em (1.0), I think that's (1.5), that's how I would term 'successful' in that context. They feel that it's been (1.0) a positive experience.*

Most nurses held mixed opinions about what patients might actually say, ranging from 'best thing ever' to 'indifferent' to 'nothing good'. Nurses perceived this to reflect the range of patients' admission circumstances and inpatient experiences. Some nurses expressed a view that the inpatient admission had kept patients safe and managed their acute mental health problems, but had not changed the patient's life circumstances. There was a view this could have an adverse impact on their future mental health and possible readmission to hospital.

*Nick 515:*

*... You're not really doing anything to (1.0), to fundamentally tackle the, the issues that have given rise to that person's bad experience. ...People get admitted. ...To be crude, you dope them up. You keep them safe for a few weeks, a few months. And then discharge them back into exactly the same situation which led to their admission in the first place. So, you know, you recognise your impotence really.*

In contrast, some nurses commented that patients sometimes sent 'thank you' cards in appreciation of being cared for during their stay, and seemed to acknowledge that the nurse-patient relationship had been helpful in some way.

*Adam 363:*

*... Quite a lot of people at the end of it ((their inpatient stay)) go away and say 'Thanks for looking after me.' We get quite a lot of cards. Nice little things said, you know, 'Thanks for that.'*

*Sophie 803:*

*When people write thank you cards, they often name em the nurse that they feel they particularly had a relationship with.*

Some nurses measured the 'success' of a nurse-patient relationship by considering the overall patient experience. Most nurses held mixed opinions as to what patients might actually say, ranging from 'best thing ever' to 'indifferent' to 'nothing good'.

In the national NHS Trust survey 2009 (Care Quality Commission, 2010), 90% of staff in mental health/learning disability Trusts felt that their role made a difference to patients, with 87% reporting being satisfied with the quality of care they provided. This included staff in both community and hospital settings.

As suggested by the participants in this study, patient satisfaction with services provided by nurse practitioners in community mental health teams is reportedly high (Wortans et al., 2006). Patient satisfaction with inpatient experiences is mixed. Whilst most patients are generally satisfied with nurse-patient relationships, they express dissatisfaction in relation to access to information, the ward environment, restrictions placed upon them, and compulsory care (Kuosmanen et al., 2006; Woodring et al., 2004).

This literature supports this study's finding that nurses held mixed opinions of perceived patients' views, which likely reflect the actual views of patients as a group.

### **Patient discharge**

Some nurses believed discharge arrangements were relevant to ending nurse-patient relationships. A few participants, including Zoe, discussed planning patient discharge as part of an ongoing process from the start of the patient's admission. Whilst arrangements for possible follow-up with care

coordinators in the community were being made, the impact of ending the nurse-patient relationship itself could be given more consideration.

*Zoe 180/182:*

*Em (1.0), these days, we start planning people's discharge at a very early point in their admission. ...Em, and making sure that they're introduced to their care coordinator whose gonna follow them up. ... In terms of ending the relationship, em, cos obviously a lot of patients find it a really difficult transition, especially if they've been in hospital for a long time. They find leaving hospital (1.0) quite difficult, cos it's, you know, such a supportive environment. Em, I don't think we probably give as much consideration to kind of (1.0) ending the relationship as maybe we should do. Em, maybe, you know, we need to give more thought to the importance of doing that (1.0) really.*

A few participants indicated that patients were usually given a week's notice of their planned discharge, but there were times when patients were discharged quickly, with little prior notice. This could happen either with or without the patient's agreement, depending on their circumstances. Patients might be offered early discharge if agreed with the Home Treatment Team, who offered intensive mental health community support. Other patients could be suddenly discharged if their admission was deemed inappropriate, and that they were not deemed to be making best use of the service.

*Zoe 189/196:*

*... And it might be a case of the Home Treatment Team comes and assesses them. 'Right, so we can discharge you tomorrow.' So, they don't have very much time to kind of get used to the idea of going.*

Participants talked of a few patients who experienced delayed discharge, usually as a consequence of difficulties in arranging appropriate accommodation in the community.

In an English postal survey, Lewis and Glasby (2006) found high levels of delayed discharges, affecting 4% to 16% of mental health inpatient beds. Contributing factors were wide-ranging and interlinked, including patients awaiting further assessment elsewhere, lack of available specialist services as an alternative to hospital, and accommodation problems in the community. Ineffective communication between inpatient and community multidisciplinary teams may also delay patient discharge (Fiddler et al., 2007).

There is a paucity of literature regarding the effects of delayed discharge on patients' quality of life whilst in hospital (Megens and Van Meijel, 2006). Patients' limited social networks may place greater emotional demands upon nurses to develop and maintain good therapeutic relationships.

Following discharge, patients may experience difficulties in adjusting to community living, and many former patients may be re-admitted to hospital within a year. Participant concerns regarding sudden ending of the nurse-patient relationship for vulnerable patients were related to inherent service model constraints. Reynolds et al (2004), in a pilot randomised control trial, found that a 'transitional discharge' intervention providing friendship, understanding and support from peers, and continued transitional support provided through an overlap of inpatient and community staff, enhanced their perceived quality of life and reduced patient readmission rates by half. Implementation of such interventions would require significant changes to current service models, but could provide a way forward in best meeting patients' post-discharge needs. Lawn et al (2008) similarly found that people with mental health problems in the community could provide meaningful psychological, emotional and practical support for their peers if provided with adequate support, training and supervision themselves.

## **5.2 NURSE SKILLS**

### **Active listening and responding**

The majority of participants cited active listening and responding as an essential skill to promote successful nurse-patient relationships. Participants acknowledged the distinction between formal counselling approaches with patients, and active listening and responding. The former was largely viewed as inappropriate to apply to patients experiencing symptoms of acute mental illness in the hospital setting where it was impractical to consistently deliver extensive planned one-to-one time. Active listening and responding skills demanded attentiveness and concentration on the part of the nurse, but could be used flexibly and responsively. Nurse believed these approaches were valued and beneficial to patients, to meeting their needs when

appropriately applied. Nurses reported that careful consideration and interpretation of patients' speech content was required in order to understand the stories behind the spoken words, as Jackie and Nick describe:

*Jackie 360/392:*

*...There's a great deal to be gained by somebody just being listened to. A huge amount that it's one of the most powerful tools, as a nurse you have, to actively listen to someone, and hear what they're saying. Acknowledge, what they're saying. ... And, you know, it's so easy to suddenly realise you're not listening. ...It's something that, you know, can be finely tuned and be very effective. And it can mean the difference between somebody being forcibly restrained and, you know, having IM medication ((or not)). You know (1.0), it can make a big difference.*

*Nick 435:*

*It's like, especially when they're psychotic patients, ...it's like learning a foreign language. You know, at the beginning, it's just sort of unintelligible really. But, over the course of time, you start to pick up on more and more factors. Not just, not just the words people are using. But the, contextual clues (1.0) and everything else. And then, very often, things will fit into place. So you can start to hear the story behind the ...psychotic speech content. It's just something that takes time.*

Active listening is critical to providing psychological support and holistic care to patients (Jones and Cutcliffe, 2009), but nurses' participation in such activities is emotionally challenging and may lead to psychological difficulties, including burnout. This issue is considered later. Therapeutic listening is an active, dynamic intervention which requires effort on the part of the listener, to enhance communication and develop better understanding of patients' concerns. This activity requires structured time to help set parameters in which patients feel comfortable to talk. Participants in the present study used active listening skills during one-to-one time with patients, mainly focussing on planning and reviewing care with them.

The development of active listening skills seem essential if mental health nurses are to position therapeutic relationships centre-stage as an integral part of focussing on patients' recovery in mental health care (Hurley et al., 2009). Meeting patients' needs in this way may be difficult to achieve in practice, owing to the organisational constraints placed upon nurses working in acute inpatient psychiatric hospital care.

The finding that an overwhelming majority of participants cited active listening and responding as an essential skill is supported by the literature reviewed.

### **Use of self and personal experience**

Half of participants discussed the skill of appropriate use of self and past personal experiences. These nurses had experienced a variety of significant serious mental health and psychosocial problems in their own lives. These experiences now served to offer them some helpful insights into patients' lived experiences in similar contexts, which likely contributed to their current behaviours and mental health concerns. Nurses' past experiences included living with medical diagnoses of psychosis, obsessive compulsive disorder, anxiety and depression; childhood trauma and physical abuse from a parent with alcohol problems; homelessness; loss of friends through illicit drug overdoses; and self-harm causing serious injuries. Adam described how his experience as a nurse had given him opportunities to reflect on his earlier life experience and develop a greater understanding of adversity faced by others:

*Adam 441:*

*Well, ((coughs)), when I was 17, I was homeless. And em, in ((English city name)), a lot of the people I knew were probably these kind of people anyway. Damaged people on the streets. I wasn't (1.0) homeless for that long. It was only about (1.0) half a year. Well it's two lots of (1.0) six months. Years later, you know. Training and getting to read patients' case files. You find why people, how people get to these positions. And a hell of a lot of people were abused. And em (1.5) seeing why, seeing how em (1.0) some of these people got to the positions they were in (1.0) in the first place. And then, their behaviour became ingrained, and then they can't get out of it. And then, it's all about the behaviour and (2.5), and also (1.0), my belief that, growing up, becoming mature. That we're all capable of it, but it's not so much about (1.0) the (1.0) medicine you take but about the choices we make and the people we can trust. So maybe I feel that (1.0), in pure psychiatric nursing, that is something I can do.*

Graham reflected on how his own difficult experiences had strengthened his nursing:

*Graham 693/701/709/725/733:*

*Mm (1.0). I had my own psychosis ((laughs loudly))! ... I did, yeah. Hands up to that one (1.0). Only a quickie. I think it was drug induced. I got spiked in a pub. A long time ago now. And I went (1.0) bonkers. Very paranoid. I*



*didn't hurt anyone. I was like a little mouse. I was very paranoid. But when I went into hospital, I felt that nobody gave a shit (1.0). I realise now the stress and strains they were under ((laughs loudly))! ... My world was turned upside down by it, really. Eh (1.0) absolutely (1.0). And I just thought 'No, I'm not letting this destroy me. Jesus! These, these professionals, just diagnosing me. These nurses are frightened of me, cos I'm a bit bizarre! I'm getting out of here. Jesus!' As soon as I was a little bit better. I'd come out the fog. I was out the bloody place. ... For me, it was hell on Earth. 'What's happened to me? Shit. I'm crying at the window here, in a nut house ((laughs aloud))! And no-one's giving a shit! ...No-one hardly spoke to me. Which I suppose I could be charged with that occasionally now. Very bizarre. ...But I've got a bit more understanding of what some of these ((patients)) are going through. So I'm not actually as frightened of them, as some of the nurses get (1.0).*

Mental health nurses have consistently identified therapeutic use of self in the therapeutic nurse-patient relationship as a hallmark of their practice (Hurley et al., 2009).

In a review of the literature concerning stigma, negative attitudes and discrimination towards mental illness within the nursing profession, Ross and Goldner (2009) found a lack of literature concerning nurses who themselves had experience of mental health problems. Given the challenging, stressful nature of nursing work, Ross and Goldner reported that nurses may have an increased incidence of stress-related problems above the general population. Lack of investigation into this issue may support their assertion that nurses are most judgemental and stigmatising of their own colleagues about mental illness, so may 'turn a blind eye'. Nurses affected by mental illness may themselves attribute their health issues to a weakness in their personality or character, and may fear discrimination from colleagues, if disclosed. This was not apparent from the participant interviews in this study.

The finding that half of participants have experienced psychosocial and mental health problems in their lives is significant in that health professionals' own problems are not widely reported in the literature. This issue, and its bearing on the nurse-patient relationship, may therefore warrant further investigation.

### **Impact of education and training**

The majority of participants in the present study were educated to pre-registration diploma nursing level, and were not pursuing further formal

studies to develop their professional competence. Lack of preparation of mental health nurses at graduate level has been highlighted as an area of concern, as nurses in practice without appropriate training may lack sufficient skills, which may present barriers to them meeting patients and carers needs (Happell, 2002).

Demographic data revealed that nine participants held a pre-registration diploma in nursing professional qualification; one participant held a pre-registration honours degree in nursing professional qualification; and one participant held a post-registration master's degree in nursing qualification, having gained a pre-registration honours degree in nursing previously. Three participants gained their professional nursing qualification(s) without an academic award (for full demographic data, please refer to tables one to seven in the research design chapter).

Most participants valued their pre-registration nurse training and post-registration nursing courses, and drew upon the knowledge and skills gained there in their everyday nursing practice. Whilst all participants had completed mandatory short in-house training events, most participants, like Colin, referred to their nurse qualifications as their primary source of knowledge and skills development:

*Colin 252:*

*((Discussing the development of the nurse-patient relationship)) ...Em, by being non-judgemental. Em (2.0) by trying to be empathic. The things we're taught really ((on the pre-registration diploma in nursing course)). Eh, and also to use, use the skills, you know, the listening skills, and trying to get an idea, you know, of where this person's coming from. I really learned all that sort of stuff (1.0) on my placement before I qualified, you know. And it's proved to be of great value.*

Nurses who had completed academic nursing studies to at least diploma level commented on how this had enhanced their development of reflection and critical analysis skills. Some nurses commented on how their studies had promoted independent learning skills which had stood them in good stead when faced with ongoing challenges in their professional careers.

Jackie and Sophie discussed their views about the advantages of more academically-focussed nurse training:

*Jackie 553:*

*I, I think, ...nursing training being so academic, as it is at the moment ...has made me be a much better thinker about what I'm doing. And ...why I'm doing things. I, I think if I'd have gone through the old style em, you know, putting in a hospital. You've got a nurse or a sister telling you what to do. And doing the practical stuff. Um, I don't think I would have been as good a nurse. [But, that's made me think about a lot of things that you know, about relationships in particular, I think, em, that (1.0) I may not have done if I hadn't (1.5), hadn't had to put a lot of work into studying.*

*Sophie 779:*

*Em, I think it's em (4.0). I think it made me quite analytical. Em (1.0), and quite critical of, of what I saw, and quite aware of how the institution as a whole is impacting on individuals. And how it kind of put pressure on people to behave in a certain way. Em, and, I think it also made me quite open minded (1.0) about (1.0) em, learning new things. I'm quite confident in my ability to learn new things. Em, and, I think it enabled me to sort of (1.0) come up to speed quite quickly, when I started. Cos when I started, I, during my degree programme, I'd had very little experience on an acute ward. Em, I did (1.0) eight weeks in total. Em, all my other placements were in the community. And the acute ward I was on was a very small district hospital where most of the people were depressed. And then I came here, and it was incredibly shocking ((laughs softly)). And em, and really, very difficult to kind of get to grips with. But I think, in a way, my degree programme helped me, kind of come up to scratch with that.*

Jackie had undertaken an extensive person-centred post-registration counselling course which had further influenced the development of knowledge and skills when interacting with patients, but recognised this approach was not the mainstay of contemporary acute inpatient care:

*Jackie 114:*

*I think probably I'm heavily influenced by the, by the counselling course. I was very lucky to have had a very, very good tutor. It was very, it was person-centred counselling. And, I think having put that into practice in the voluntary sector, it's become part of me. So, I tend to sort of do come from the listening, hearing people's stories (1.0), sort of place, rather than the medical model.*

Adam had gained his professional registration prior to the introduction of the pre-registration diploma in nursing course, and indicated that he did not see any real value in seeking any further formal training or education.

Adam 255:

*... I wasn't a very academic student. I didn't read as many texts as some of my colleagues. Em, and I was worried about that at first. But then the tutor said: 'There are different kinds of students. Some are more academic minded, and they go on to specialise and some are just more human and, you know, do that. That's what we like about the nursing groups we get. We get different skill groups. Different (1.0) kinds of people.' So that reassured me, cos I felt I, I, I had to be really clever, and know all these facts and theories.*

The credibility of nursing seeking professional status has been found to be enhanced through nurses' master's level education and preparation for registration (Ashworth et al., 2001; Gerrish et al., 2003). Nurses prepared at Master's level show enhanced competence in relation to clinical skills, influence and leadership, strengthening the power and status of the nursing profession as a whole.

Specific registered mental health nursing competencies for work in acute inpatient settings include communication, developing appropriate relationships, assessment and observation, inclusion of patients' and carers', working within a team, risk assessment and management, self-awareness, treatment, and management of practice (Patterson et al., 2008). Although it has been suggested that the focus of mental health inpatient care primarily focuses on containment, risk assessment and management, Mullen (2009) argues that the development of psychosocial interventions in inpatient settings could help to meet patients' needs, but that nurses are insufficiently trained and skilled in this regard. A further problem exists in that whilst appropriate specialist educational courses are needed to develop nurses' skills, existing schemes in the United Kingdom have been criticised as being highly selective and limited to senior nurses, and may make no actual difference in clinical practice (Bee et al., 2005).

In a survey of nurses' judgement of their development of professional self, from student nurse to experienced registered nurse, Björkström et al (2008) found that as nurses gain post-registration practice experience over their first three to five years, they lose some of their motivation expressed in the early years for professional development and knowledge acquisition. Nurses' judgements about their leadership skills and general nursing performance

also diminished over time. These issues are of concern as professional development and self-judgement are important to effective nursing performance.

Nurse participants in the present study may therefore lack sufficient knowledge to best meet patient/carers' needs, owing to lack of formal knowledge and skills developed at pre-registration and post-registration levels.

### 5.3 NURSE QUALITIES

#### Empathy, care and compassion

An overwhelming majority of participants demonstrated empathy towards the patients they worked with. They discussed putting themselves in the place of the patient, imaginatively experiencing what it might be like to live with acute mental health issues. They sensitively considered how their interactions and language could impact on patients, and how a non-judgemental, considered, respectful approach to care was needed. As discussed at the beginning of this chapter, participants acknowledged the value of a common humanity with their patients. They also gave thought to the possibility that it might well be them one day that may experience acute mental health problems and be in need of care, as Nick discussed:

*Nick 547:*

*You know (2.0), anyone can be a patient, you know. Anyone. That could be you or I in (1.0) six month's time or a year's time or whatever. And em, if you were in that situation, would you prefer to be nursed by somebody who (1.0) at least attempted not to be judgemental. ... You know, just a bit of respect, a bit of decency.*

Janet and Natasha described the thought, care and compassion, shown in their relationships with particular patients:

*Janet 257:*

*... It's just having the right words to say. ... I mean, it's very much individual with the individual person. ... I know that if I said to her (2.0), ... 'I think you're psychotic.' Em, that would just blow her away really. ... One of the things she's really scared about is being labelled schizophrenic and you know, ... I just wouldn't mention that word in front of her. Because ... it would just destroy her really.*

Natasha 631:

*... I remember, ...a man who (1.0), who took his wife out for their anniversary. ...They were both (2.0) of limited income, and both a little bit unwell still. ...They'd gone to Kentucky for their wedding anniversary. ... You just think, 'Oh my God!' 'Cos they were talking for ages about where they would go, and what they would do. And they went to Kentucky in the end, and had a bargain bucket each and coleslaw. I felt like, just like, 'Oh my God, this is terrible!' And part of me just thought 'Sod it! If you like Kentucky, it's the best meal in the world, isn't it! Not necessarily the most nutritious or the best on the planet. But, you know, people ...value the things they value. And if you want to be part of their world, then you have to understand that and accept it.*

In a systematic review of the literature, Yu and Kirk (2008) found that whilst considerable importance is attached to the concept of empathy in nurse-patient relationships, there is no consistency of the development of reliable, valid measurement tools to assess this. They argue that application of a rigorous tool to measure empathy could help to highlight this quality in nursing. Although dated, Kristjánisdóttir's (1992) exploration of the concept of empathy in nursing care concluded that too little is understood of the phenomenon itself. This still appears to hold true today, and further theory development on the concept is required.

Reynolds and Scott (2000: 226) define empathy as '... the ability to perceive and reason, as well as the ability to communicate understanding of the other person's feelings and attached meanings.' Kirk (2007) argues that understanding and shared meaning through use of empathy are central to the development of therapeutic nurse-patient relationships. Reynolds et al (2000) argue that a key to respecting and meeting individual patient perspectives is consideration of the role that empathy has to play in helping nurses to perceive moral aspects and issues in practice. Nurses require the clinical environment and organisation of care to be supportive, if they are to perceive and act on moral aspects and issues. In poor environments, patients are likely to receive less appropriate care. Nurses who are able to empathise with patients are more likely to engage them in sharing responsibility for their own health, to facilitate them to say what they want from their care, and to be treated as individuals, not 'cases'. Nurses who fail to empathise with their patients may leave them misunderstood, meaning

their patients may not receive sufficient emotional support. This may contribute to unfavourable health outcomes (Reynolds and Scott, 2000).

Findings from participants in the present study suggest that most mental health nurses demonstrate some ability to empathise with their patients to meet their needs, sharing responsibility with them. This is contrary to findings from the literature, which suggests that many professionals in the helping professions are unable to offer empathy to patients (Reynolds and Scott, 2000). An overwhelming majority of participants indicated that the ward environment was unsettling and not always conducive to the development of therapeutic nurse-patient relationships, and this in part may be explained because the environment may not always support nurses in perceiving and acting upon moral aspects of nurse-patient relationships in practice.

It was apparent in a majority of participants' narratives that care and compassion were espoused qualities within their nurse-patient relationships. These qualities were closely linked with empathy, discussed above. Such qualities appeared to be fundamental to good nursing care where fellow-feeling for patients was evident. Adam clearly understood the meaning of caring to be a deep emotion which was not dependent on what he could or could not do for a patient:

*Adam 355:*

*Eh, well I can't not care, ...If someone's there and they're obviously suffering, then I can't think well, there's nothing I can do about it. Because at least, I can care, even if I can't do anything about it (1.0).*

Similarly, Jackie's example shows the maintenance of care and compassion, despite patient behaviours which might challenge such emotions:

*Jackie 193:*

*... Maybe it's just the fact that there'd been many times that he'd pushed me away. That he'd pushed everybody else away. But it's (1.0) consistency. It's still going back. And still acknowledging him. And (2.0) just treating him with respect. And, thinking that, hopefully, one day (1.0). And, there was a point when (1.0) we had to take him off and de-escalate the situation and spend some time with him, on a one-to-one basis. And he sat there and sobbed. You know, over events that had gone on in his past. It was so heartbreaking. He was a really troubled, deeply distressed young man who,*

*you know, his past life experiences had, you know, taken its toll. And his defence and his way of dealing with it was the hostility and aggression.*

The concept of caring is considered to be at the heart of nursing (Huynh et al., 2008). Caring itself is underpinned by invisible internal regulation on the part of the nurse, and has been referred to as emotional labour. This concept is complex and relatively undeveloped within nursing, but recognition of its existence may facilitate the development of authentic nurse-patient relationships in which the application of caring is evident. The concept of emotional labour may help to differentiate between the theoretical 'ideal' emotions which nurses should feel and those which they actually feel in practice, but may not be able to express. Experiencing emotions is considered essential when faced with morally difficult practice incidents, yet most healthcare organisations may undervalue this aspect of nursing care, which may contribute to nurses' emotional exhaustion and professional burnout. Chambers and Ryder (2009) assert that modern healthcare organisations, closely aligned to business models of efficient care delivery, are unlikely to recognise and take account of moral virtues like compassion, as they are difficult to define and measure, yet compassionate care almost certainly will enhance nurses' abilities to meet patients' needs. Nurses need time to reflect and discuss their emotional labour of caring. In the present study context, this may be difficult to achieve given nurses' limited awareness of the concept and the busy ward environment, which may not support nurses' time for reflection. Mazhindu (2003) found that the emotional dimensions of caring may expose nurses to undue stress which may adversely impact on care delivery, patient satisfaction; and nurses' job satisfaction, professional burnout and retention.

The concept of compassion in the nurse-patient relationship is similarly complex in nature to empathy and caring. In an exploration of the concept and its application to moral dimensions of nursing care, van der Cingel (2009) suggests that compassion is an altruistic emotion which may be used as a means to an end, to acknowledge another's suffering. Compassion is '...the deep feeling of connectedness or emotional response to the



experience of human suffering' (Peters, 2006: 38). This requires imagination and reflection on the part of the nurse. It is a process involving thinking as well as feeling, and can evoke conscious as well as unconscious choices. This complex phenomenon is a means to offer comfort to others by exposing and acknowledging their personal suffering. Van der Cingel argues that making another's suffering visible makes clear to them that they are not alone in addressing their issues, though compassion in itself will not make the person's suffering disappear.

Chambers and Ryder (2009) identify six key concepts central to the delivery of compassionate care: empathy and sensitivity; dignity and respect; listening and responding; diversity and cultural competence; choice and priorities; and empowerment and advocacy.

Many of these concepts emerged as relational themes in the current study and are discussed in more depth elsewhere in this chapter, but a theme which united them is their roots in the ordinary, everyday encounters in the nurse-patient relationship, which feature in nursing practice.

### **Honesty, openness and genuineness**

A majority of participants indicated that an honest, truthful approach was needed in interactions with patients. A sense of fairness was recognised as significant in working with patients, to ensure that they had realistic expectations of what nurses and the service in general could and could not provide for them. An honest approach also facilitated realistic patient expectations in terms of their hopes and aspirations for recovery, and what nurses expected of patients in working collaboratively towards this end.

*Nick 291:*

*...It's just being quite honest with someone. You know, a lot of people, I think, come into hospital with this idea that em, you know, psychiatric nurses are sort of psychotherapists or have a huge array of skills and tools at their disposal and, they're gonna be somehow healed or cured. It's being honest with people and telling them, you know, that that's unlikely to happen (2.0).*

It was important that patients could rely on nurses to tell them the truth, keeping patients' best interests at heart, even when this could be unwelcome on the part of the patient.

Natasha 537:

*... I will do my absolute best (1.0) to help them, and to, to be honest with them. And I think most of the clients know that, whether they like it or not.*

Hodkinson (2008) asserts that whilst truth-telling is an important issue in the nurse-patient relationship, decisions regarding information disclosure can be complex. Nurses may choose to answer sensitive questions using intuition based on previous experiences of similar conversations with other patients, or with reference to their own moral compass and best intentions for patients. Being honest means telling the facts as one knows them, and Rumbold (2000) suggests that it is questionable as to whether health professionals always have a duty to tell the truth, as there may be times when the truth could be withheld if judged to be in the patient's best interests. If truth-telling is taken to mean 'telling no lies', then non-disclosure may be acceptable (Collis, 2006).

The Nursing and Midwifery Council set out standards for conduct, performance and ethics for nurses and midwives, which states that registered nurses must '...be open and honest, act with integrity and uphold the reputation of your profession' (Nursing and Midwifery Council, 2008: 1). This raises an ethical debate as to whether nurses should ever decide to non-disclose information to patients, even if telling the truth may cause avoidable suffering.

Collis (2006) argues that it is widely accepted that deception occurs in everyday healthcare, and is justified by some nurses on the basis that patients are protected from harm. In making such decisions, individual patients' preferences and circumstances should be taken into account, and where possible, nurses should be deciding 'how to tell' rather than 'whether to tell'. Most patients want to know the truth about their health circumstances (Glass and Cluxton, 2004) and withholding information from patients may lead to lack of informed choice over their treatment and care. They argue that health professionals may non-disclose information on the basis of fear of taking away a patient's hope, but that this fear is unfounded if patients are informed in culturally sensitive ways that preserve hope. More open

discussion of the ethical issues involved with patients, their relatives, and health professionals, may help in the resolution process (O'Sullivan, 2009). Begley (2008) argues that whilst the ethical rules and principles of truth-telling are useful guidelines for practice, health professionals' expertise and experience, drawing upon virtues such as compassion, should take priority over rule-following, in the best interests of patients.

There is a paucity of literature regarding truth-telling and non-disclosure with people with enduring mental health problems. In the present study, a majority of nurses suggested that honest, open interactions with patients were important for genuine patient care, but that careful consideration was given as to choice of explanations given to patients when information-sharing, to avoid undue harm or distress.

From the literature reviewed, this approach is advocated, but actual practice among mental health nurses working in psychiatric acute inpatient settings may warrant further investigation.

Being 'open' was another important factor for just over half of participants. Openness was needed in maintaining positive working relationships, where nurses were mindful about interacting with patients on an equal footing, insofar as that was possible, in order to promote dialogue, build rapport and develop mutual respect. Jackie spoke of the skill required to manage this on an individualised basis:

*Jackie 273:*

*...That they're informed. ...you're open to them, in so much that they don't feel in any way intimidated by you. ...>You always have to be a bit of a chameleon<. Because you have to adapt you know, to each individual that you're dealing with.*

Rachel spoke about what being open meant in her nurse-patient relationships:

*Rachel 446:*

*...I think it's being quite open isn't it, [about how you are, who you are, and what you're there for. And what you're not there for (1.0)].*

Genuineness was important to just under half of participants, who expressed the intention to be genuine in their interactions with patients. Such sincerity

was seen as important to establish credible, authentic nurse-patient relationships.

*Colin 564:*

*...sort of non-judgemental attitude. And forgiving and open approach, you know, with genuine caring, try and put across our genuine cares and concerns about them as individuals. And, it's my hope that they experience that, and they realise that. And I think a lot of them do, you know. And that's valuable.*

Klein et al (2001) suggest that genuineness and congruence enhance therapeutic relationships. These concepts can be seen as personal characteristics of the therapist as well as a mutual, experiential quality of the relationship. Congruence may be imparted to the patient through a number of factors including the therapist's self-confidence and better mood. From a patient perspective, congruence and genuineness have better outcomes, including better mood, enhanced relationships, and lower levels of manic or schizophrenic symptoms, where applicable. Davis and Gibson (2000) have shown that people with paranoid schizophrenia are more sensitive in recognising genuine facial expressions of negative emotions and surprise than others, challenging previous research evidence which suggested that schizophrenia is associated with a deficit in emotional perception. Negative affect may also decrease some patients' perceived genuineness of facial expressions (Forgas and East, 2008) which may affect their ability to develop trust in others. Low mood could significantly increase some patients' scepticism about non-verbal communications, which could adversely impact on the development of therapeutic relationships.

Congruence and genuineness involve the therapist being in touch with and receptive to their experiencing of the patient, and plays a major role in developing the therapeutic relationship, where empathy and positive regard may be communicated.

Congruence and genuineness may be considered a central element to therapeutic nurse-patient relationships. Almost half of participants in the present study explicitly stated that these qualities were important in developing nurse-patient relationships, and this is supported in the literature.

Some participants indicated that a non-judgemental, accepting approach towards patients was required in order to develop therapeutic nurse-patient relationships. This was especially important as nurses perceived that many patients were sensitive to stigma and negative attitudes experienced from others in the wider community. Any judgemental attitudes from nurses perceived by patients on the wards could therefore become a barrier to developing positive relationships with them.

*Colin 290:*

*... Probably because they've experienced em, eh judgemental attitudes out in society that when, you know, we work with them as nurses in a non-judgemental way, they really respect that.*

## **Motivation**

### *Positive motivation*

A majority of participants expressed positive motivation and a sense of optimism towards working with patients. The challenging nature of understanding patients' problems and concerns seemed to be a positive motivating factor in situations where nurses felt competent and able to meet their needs. Hannah used her experience of such nurse-patient relationships to maintain her motivation:

*Hannah 586:*

*... >You always have to remember the good ones. It keeps you going, doesn't it<! ... I've been lucky in the last six months that I haven't had to deal with that much challenging patients. But they aren't really challenging, are they? It's just different needs. Slightly more complex really. Em (1.0), I've got a lady at the moment who's quite challenging. Because she's, she's em (1.0), she's not quite telling us the truth. She tells everyone different stories. Various injuries that she's sustained. So, she's a bit of a challenge at the moment. But, no, they've all been equally challenging. But like, some, you know, some are the most amazing people ((laughs)) in the world!*

Just under half of participants indicated that their own individual personality was important in having a positive outlook towards working effectively with patients. Nurses discussed how important their personal manner was when interacting with patients, when they adopted an acceptable professional persona.

Rachel 542:

... What personality traits does a person need to be good at being a psychiatric nurse? I've always fundamentally believed it's a lot about the personality. And it's about that openness, willingness to, to learn, to empower patients. That I think is so much part of the therapeutic relationship is, is, is about role modelling (1.0).

Sophie revealed how she developed a professional persona through which she could sustain motivation, and deal with things she would otherwise have been unable to cope with:

Sophie 699/707:

Em, I think em, I think your personality is very important. Em, I feel there's a difference between your (1.0), who you are, and your nursing persona. I think I feel that I have a nursing persona that I adopt when I'm working. And (1.0) which improves certain qualities that I don't have in real life if you like. Em (1.0), [I think. ... Em, I think examples (1.0) in the inpatient setting would be dealing with (1.0) aggression (1.0). Em (2.0), being able to cope with somebody shouting in your face and abusing you and being very intimidating and being able to remain calm and not run away and deal with the situation and remain focussed upon em, that person's needs. And be patient, I think, that's a very unnatural thing to do. I think it's something personally I've had to develop as a kind of part of my nursing persona.

### Negative motivation

A majority of participants talked about negative motivation (demotivation) in the workplace as a factor influencing the nurse-patient relationship. This could arise following incidents with patients, such as verbal threats or physical assault directed towards nurses. Such serious incidents could adversely impact on the nurse-patient relationship, when either or both parties could become defensive and dispirited. Hannah provided insights of her experiences of this:

Hannah 642:

...I think, getting punched, or getting threatened. That really does ruin a relationship. And it ruins the relationship with everyone. Because you just, you come don't you, to protect yourself. ... If something happened to me. If I got hurt or something. I think I'd probably say, 'Oh, I hate them all!' ((laughs))' Not in a bad way. It's just I think, circumstances can really affect your impression on the relationship.

Some nurses appeared to have a general disinterest in maintaining a patient-centred approach to care, and appeared to colleagues to choose to focus on meeting their own needs instead. Others recognised poor motivation in

themselves, and attributed this in part to the long-term stress of the job and likely burnout. Natasha recognised the detrimental effects that negatively motivated colleagues could have on nurse-patient relationships:

*Natasha 280:*

*... You see some people who sit, who just appear to turn up for the money, and their output is appalling, really terrible, and they are there for themselves. Things like turning the TV off, you know, at one o'clock at night, when the film finishes at 1.20am (1.0). I mean it's (1.0) ridiculous on one level, how petty is that? Where is their understanding of what's appropriate and what's not?' 'Where's their humanity gone?' You just don't do something like that.*

Steph reflected on her own motivation and perhaps how this had reduced over time:

*Steph 819/1051:*

*...When new people come in, and they're enthusiastic, it's funny watching them. Cos I think 'God, I used to be like that.' (1.0). They can spend loads of time, they find the time, ... talking to the patients (1.0). And I don't. And I'm just like 'God!' ...Part of me probably doesn't even try now. ...Some people are admitted, and you're told they're gonna only be in for like three days. And it's like well, what am I gonna do in three days? ...Other times, people come in and we have fantastic relationships and it's really rewarding. But they're a minority now. Or seem to be a minority. So (2.0), there you go!*

It was evident that participants could hold simultaneous contradictory positive and negative attitudes towards patients in their care. Half of participants indicated the challenging nature of persevering with some patients, to attempt to work positively with them when they did not seem to want to engage and interact. A sense of powerlessness on the part of nurses could develop when there appeared to be no forward movement in addressing patients' needs, and this could lead to negative nurses' attitudes emerging with particular patients. This was particularly so with 'unpopular', more prominent patients with substance misuse problems and those with a diagnosis of borderline personality disorder.

This finding is consistent with the literature where patients' experiences have indicated that some nurses do not display liking towards them, in terms of their friendliness and behaviours (Rydon, 2005; Sainsbury Centre for Mental Health, 2006). In a survey of mental health staff attitudes, Munro and Baker (2007) found that nurses generally liked their patients, and acknowledged

their role in developing therapeutic relationships with them. The authors acknowledged the realities of restricted resources and inadequate staffing, which adversely impacted on patients' experiences. Medical views of mental illness were associated with negative nurse attitudes, as was working predominantly with patients in crisis with acute illness. Nurses sometimes found it difficult to engage and collaborate with patients in emotional distress. Less well trained nurses generally held poorer attitudes towards patients, with untrained and unqualified support staff having poorer attitudes.

Mental health nurses generally hold more pessimistic attitudes towards patient prognoses than the general public (Munro and Baker, 2007). This may be explained as nurses are likely to develop their attitudes from their professional experiences (Schulze, 2007; Thornicroft, 2007). Many such experiences concern interactions with patients with serious mental health problems, who may have relapsed and become acutely unwell. Nurses may only see patients at this acute stage in their recovery, which may adversely skew their perceptions of patients' long term prognoses.

Nurses' negative attitudes were more evident when adopting a medical model approach to patient care. Patients with a diagnosis of borderline personality disorder were viewed by nurses as more difficult to care for (Deans, 2006; Filer, 2005; James and Cowman, 2007) as were patients with substance misuse problems (Harling et al., 2006).

Patients with mental health problems may experience social exclusion and may lack supportive relationships with others. Lack of human attachments has been associated with ill-health effects, adjustment and well-being (Baumeister and Leary, 1995). In a study of social exclusion, Baumeister et al (2007) found that human needs to belong provide a powerful motivational basis for interpersonal behaviour. Socially excluded people tend to experience emotional distress and may exhibit increased aggressive behaviour and reduced helpfulness towards others. Twenge et al (2007) found that rejection through social exclusion may interfere with emotional responses, so patients in these circumstances may experience an impaired



capacity for empathic understanding of others. This may undermine their motivation to cooperate with nurses to develop therapeutic relationships.

Holmes et al (2006) suggest that nurses often experience feelings of disgust and repulsion in their practice, but the 'unclean' side of nursing is rarely reported in the academic literature. These feelings occur in relation to abject objects, for example, marginalised patient groups, according to their diagnoses or behaviours, where nurses may perceive a personal fear or threat of manipulation or physical harm. Nurses are expected to reject their own anxieties to maintain their professionalism, yet on a personal level, they may wish to remove themselves from challenging situations. Stigma may be experienced on the part of the marginalised patient, adversely impacting on the nurse-patient relationship. Holmes et al argue that the concept of abjection should be brought into the open in nursing practice in order to address patients' vulnerability, and to reduce anxiety and hostility potentially evoked from nurses.

The issue remains as to how nurses can maintain positive attitudes to foster therapeutic relationships, when the context of care delivery in acute mental health settings may not support this. Nurses may sometimes be unwilling to acknowledge their untherapeutic practice in terms of judgemental attitudes which stigmatise patients (Rydon, 2005), and may tend towards more biomedical models of mental illness, which may increase patient boredom, lack of choice and disempowerment.

The finding that the majority of participants in this study simultaneously held positive and negative attitudes and a sense of optimism towards their patients is supported by the literature that nurses are exposed to a variety of situations that require them to present their professional persona whilst holding back their personal feelings, that may not always support the development of therapeutic relationships. The literature supports that nurses should hold a broad, holistic understanding of patients' needs, as biomedical-orientated approaches may foster stigma, patient boredom, lack of choice and disempowerment.

#### **5.4 SUMMARY**

This chapter has presented the second of three key emerging themes in this study. In this chapter, I have discussed the essential components of nurses' reported experiences about the characteristics of the nurse-patient relationship and nurses' skills and qualities brought to the nurse-patient relationship. These were considered in relation to the literature. Findings about the essential components of nurses' reported experiences about the impact of the nurse-patient relationship on nurses, and its effects on the nurse-patient relationship, are discussed in the final findings chapter which follows.

## CHAPTER SIX: THE IMPACT OF THE NURSE-PATIENT RELATIONSHIP ON NURSES

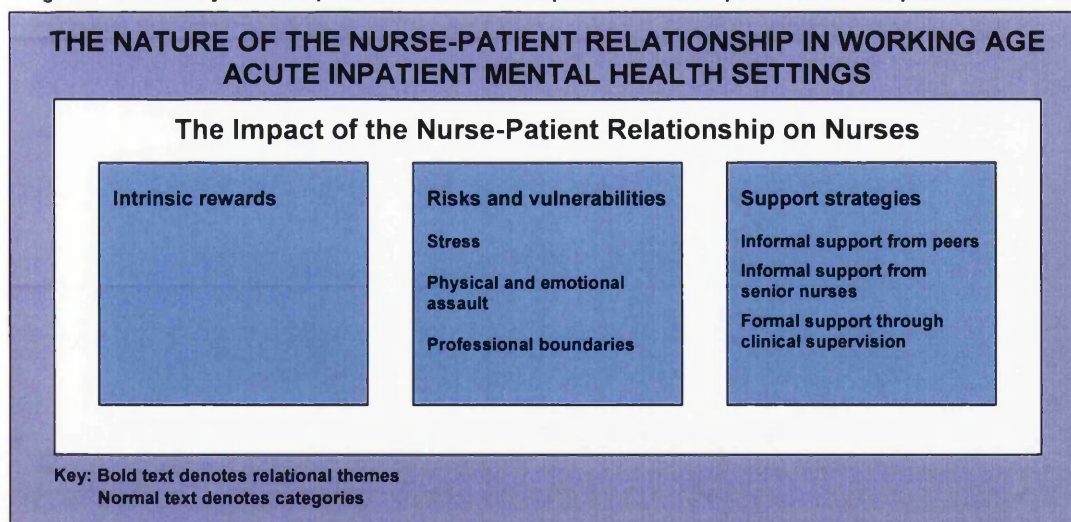
Key findings obtained from 14 in-depth interviews are presented in three findings chapters:

1. The context of the nurse-patient relationship;
2. Characteristics of the nurse-patient relationship and nurses' skills and qualities brought to the nurse-patient relationship; and
3. The impact of the nurse-patient relationship on nurses.

This third chapter presents the key findings obtained concerning the essential components of nurses' reported experiences about the impact of the nurse-patient relationship on nurses, and its effects on the nurse-patient relationship, related to the literature. This is discussed within three major relational themes which emerged from this study: Intrinsic rewards; Risks and vulnerabilities; and Support strategies.

A conceptual framework of the impact of the nurse-patient relationship on nurses is provided in the diagram below, illustrating links between relational theme and their subthemes. The chapter concludes with a brief summary.

Figure 5. Data analysis conceptual framework: The impact of the nurse-patient relationship on nurses



## 6.1 INTRINSIC REWARDS

How nurses are impacted upon by the nurse-patient relationship can be a powerful experience (Peplau, 1988). A majority of participants described developing a sense of personal satisfaction in their interactions with many patients. This was gained when they felt connected with patients, to understand their problems and concerns. Nurses perceived they had helped patients, often achieving small changes to move forward in their lives, to make a difference for the better, as Colin and Jackie illustrate:

*Colin 542:*

*... really reaching them is a great thing. And that's the rewarding part, you know. When we can actually do that, it's really nice.*

*Jackie 162:*

*I do get a lot of positive feedback. It can be just somebody sort of smiling that previously hasn't smiled for (1.0) weeks ... It might just be a small change like that. Really, that motivates me.*

The literature supports that nurses benefit from higher job satisfaction, when one-to-one contact with patients increases (Staden, 1998; Tyson et al., 2002), and when they feel empowered by the organisation (Lautizi et al., 2009). However, the caring or emotional labour at the centre of nursing presents challenges and risks to them. Nurses could make their emotional investment in caring more visible to colleagues, patients, and those providing mental health services, in order to highlight the need for appropriate support and supervision. Empowering nurses to do this may be challenging in current healthcare contexts, where principles of efficiency and public accountability may limit nurses' control over their practice (Lautizi et al., 2009). Whilst nurses could be empowered through further development of their knowledge and skills, organisations too need to review structures and systems to support them to develop their practice. Peplau's (1988) work provides a salient reminder of the benefits of recognising the reciprocal nature of the nurse-patient relationship.

Participants' stories and the literature support that nurses gain intrinsic rewards through direct one-to-one interactions with patients, but competing demands placed upon them may limit opportunities to connect meaningfully with them.

## 6.2 RISKS AND VULNERABILITIES

### Stress

Almost all participants reported stress as a major impediment to the development of effective nurse-patient relationships. Key contributing factors included the general stress of the job, nurses' inexperience, patient complaints, challenges about professional competence, shift work patterns and harassment from patients in the community. These are discussed below.

#### *General stress of the job*

Participants reported the general busyness of the wards, high patient illness acuity, patient demands, their relatives, and those of colleagues, were a major cause of stress. This was particularly so for inexperienced nurses new to the acute working age inpatient environment, although other staff were also affected. As Steph commented, stress sometimes impeded communication with patients when nurses were occupied with other duties:

*Steph 907:*

*When I qualified, it was just a shock. ... it's just, it's busy! You never get a chance to sit down or (1.5). It's just constant >on the go, on the go, on the go<. You're just about to leave on time, and something just happens .. that's when your frustration comes out on the patients as well (1.0). ... I'm just not 'Oh no!' Just because I'm frustrated; I'm stressed (1.5). And I think they know as well. ...*

Jackie spoke of the effects of stress from multiple demands and responsibilities:

*Jackie 209:*

*It's not because staff don't want to engage. ... People are human. People are tired. They're run down. It's the paperwork! ... the fact that there's so much going on. ... multidisciplinary team, working. ... so many different phone calls, different people to liaise with. Different meetings to set up. It's, it's quite overwhelming!*

Nurses sometimes took refuge in their back office during quieter periods, out of sight of patients, to cope when feeling particularly overwhelmed with their duties.

Nurses, like Graham, were aware that, eventually, persistent exposure to stress in the workplace became intolerable for some who chose to leave working age acute inpatient care services to work elsewhere:

*Graham 163:*

*... I've seen nurses come and go. They've ...found it too stressful. It's not suited them. Em, they've come (1.0) and they've gone ((laughs)) (1.0)! I've seen managers come and go (1.0).*

Psychiatric nurses in hospital settings tend to report significantly lower levels of job satisfaction than community-based mental health nurses (Ward and Cowman, 2007). This is attributed to rigid work routines and related nurse disempowerment in the hospital setting, poor physical environments, low professional status, and exclusion from attendance and decision-making in multidisciplinary team meetings.

Jackie and Graham's views echo findings in the literature. Nurses in acute mental health settings report significantly higher workload stress levels than unqualified staff, with inadequate staffing being the main stressor (Jenkins and Elliot, 2004). Having a choice of work location improves job satisfaction, but 90% of nurses working in hospital settings had no choice in the decision to work there.

In this study, the majority of participants felt they had not chosen to work in an acute inpatient setting, but had no other opportunities of employment elsewhere. Hospital ward-based nurses perceived community-based nurses as having more autonomy and greater input into patient care, with more scope for patients to move to a state of wellness. Nurses in acute psychiatric inpatient environments experience high levels of stress and burnout (Happell et al., 2003) with more than half of nurses expressing a willingness to leave the profession should employment opportunities arise elsewhere. This is typified by Graham's point above and correlates with the fact that almost half of nursing staff in acute mental health settings show signs of high burnout through emotional exhaustion (Jenkins and Elliot, 2004). In a recent national NHS staff survey 2009 (Care Quality Commission, 2010), 30% of staff

working in mental health/learning disability Trusts had suffered from work-related stress.

The emotional labour of mental health nursing, discussed previously, is a prominent feature, and is positively correlated to daily stress levels. Increased emotional labour is associated with increased intensity of nurse-patient interactions and the wider range of emotions experienced (Mann and Cowburn, 2005). Increased emotional competency is strongly correlated with increased years of practice experience (Humpel and Caputi, 2001). Nurses with at least six years' practice experience have higher levels of emotional competency, and nurses with less than two years' practice experience express more self-doubt than their peers. This is particularly relevant for participants in the present study, as many were newly qualified, and had accepted their first post-registration employment in acute care settings, which they found stressful and distressing at times.

In its most recent fitness for practise report, the Nursing and Midwifery Council (2009c) cited that they had received the highest number of complaints about nurses since 2005. Of those, 47% were received from employers; 16% from members of the public; and 2% from the police. Many complaints directly involved patients, most commonly involving incidents of physical or verbal abuse, and failure to communicate respect for dignity. In the present study, a few participants discussed concerns about possible patient complaints which were a source of stress for them. This was particularly so for inexperienced nurses when working with patients with challenging behaviours, who could be perceived by nurses to be manipulative and undermining.

As Steph reported earlier, stress and frustration could lead to irritability with patients. The concept of 'compassion fatigue' was developed in the early 1990s, as a more user-friendly construct than stress, which is pathologised as secondary traumatic stress disorder (Sabo, 2006). Compassion fatigue is described as the stress brought about through helping or wanting to help people experiencing trauma or suffering. As we have seen, nurses' stress

may be brought about by a wider range of factors in the workplace, which may explain its common citation in the literature.

Continued exposure to patients with serious mental health problems and distress may lead nurses to emotional fatigue and eventual burnout (Jones and Cutcliffe, 2009). Burnout, characterised by emotional exhaustion, depersonalisation, and reduced sense of personal accomplishment in people who work with others (Bakker et al., 2000), is associated with a perceived effort-reward imbalance among staff. Unconscious methods of managing anxiety may lead nurses to establish emotional distance from patients, which conflicts with patients' needs and the goals of the organisation (Megens and Van Meijel, 2006). I have also explored the potentially damaging nature of nurse reticence and incongruent communication behaviours on the nurse-patient relationship.

Nurses exposed to enduring exhaustion in the workplace tend to withdraw psychologically from the environment. What may help individuals' capability to cope is emotional intelligence. Staff with higher emotional intelligence levels tend to experience less emotional exhaustion, and are less cynical towards their patients (Megens and Van Meijel, 2006). Given that a significant number of participants in the present study lacked extended clinical experience and post-registration knowledge development, and experience stress in their work, this would appear to be an important cause for concern for nurses, employers, and educators.

There is a plethora of literature discussing the sources and impact of stress on nurses, but little evidence about effective strategies to support them in addressing this issue. Nurses may benefit in reducing their stress levels if offered stress management techniques and workshops, relaxation techniques, training in behavioural techniques, and training in therapeutic skills (Edwards and Burnard, 2003).

#### *Nurses' inexperience*

Some participants discussed inexperience and uncertainty, particularly among newly qualified nurses, as a major factor contributing to staff stress.



Newly qualified nurses were concerned about the onerous patient care responsibilities of their new roles, and developing competence in shift coordination activities where they often found themselves left in charge of the ward, but seemed less aware of the issues of emotional intelligence discussed above. Colin was able to talk about feeling anxious:

*Colin 496/534:*

*...it's quite anxiety provoking. Eh, being responsible for the care of 23 patients. Eh, what happens to them in the seven and a half hours every day. Eh, especially when ... there's lots and lots going on ... potential for stuff to go wrong. Quite easily. ...I'm quite an anxious person, and I think you know, I've suffered a little bit from, eh, stress, but I'm learning to manage my anxiety now. And it's a good thing for me. ... I was dropped in here initially. And, you know (2.0). But it's only because I wanna be proactive in, in managing my anxiety, my stress. I wanna do the best I can for the patients.*

Unlike staff who felt comfortable in their roles, and able to 'bend the rules' to help patients feel valued, inexperienced nurses' anxieties could have an adverse impact on nurse-patient relationships, with their interactions becoming more rigid and inflexible. Graham was aware this sometimes led to conflict with patients, as nurses tended towards more defensive practice, failing to meet patients' needs:

*Graham 509/789:*

*... The more kind of anxious you are (1.0), the more kind of rigid you are (1.5). And the more rigid you are with that lot ((patients)), the more likely you are to come into conflict with them (2.0). ... >And it affects the relationships. The ward, the environment, and everything<.*

### *Risks and harassment from patients in the community*

When discussing stress at work, a few participants discussed concerns for their personal safety with patients in the community as a source of stress. This was an unusual circumstance, but could have a profound adverse effect on the nurse when it occurred, as discussed by Janet:

*Janet 243:*

*[Yeah. Sometimes you are very careful about your own personal safety ... We had a man on the ward who was very much into the drug scene ... psychosis ... as well. ... very paranoid about people following him on the street ... He lived not too far away from me. And I would come across him occasionally. So I was always aware that, you know, I never wanted him to know where I lived and things like that. Because, even just seeing me on the street could feed into his paranoia.*

Steph discussed an experience of stalking, and others were aware of the risks of self-disclosure in this regard:

*Steph 987:*

*I had a patient that em, stalked me for a year, and was harassing me... I had the police picking me up. They had to take me home. The patient was absconding and, so that kind of started the overspill. And I just (1.0). ((City name))'s big, but it's small (1.0). [And you walk down town, and you can see your patients. You see them looking really well, and you'll kind of go 'hello' and walk on. And other times, you can see them really deteriorating. You're just like, I've got to just go hide somewhere cos I just don't want this person to see me. I remember I was in Tesco's once and this woman, she just chased me round giving me so much abuse. And it's an ex-patient!*

The literature on mental health nurses' reported experiences of stalking is limited. In a recent small scale survey, Ashmore et al (2006) found that 50% (n=56) of mental health nurses had been stalked, of whom just over three-quarters were women. Stalkers were mainly men. Victims were threatened, followed, physically assaulted and received unwanted communications. Stalkers came from different social groups including mental health patients, but also mental health nurses. Although this study has limited generalisability, stalking of mental health nurses could be a significant, under-reported phenomenon requiring further research. Findings may have implications for nurses' self-awareness and use of self-disclosure in therapeutic nurse-patient relationships.

### **Physical and emotional assault**

#### *Physical assault*

A majority of participants discussed stress associated with risks of, or actual, physical assault by patients. This was particularly so for inexperienced nurses with limited skills and confidence to intervene, some of whom were fearful of patients who presented such risks.

Experienced nurses generally worked well together to successfully intervene to manage the risks, but as Steph's story illustrates, sometimes this did not always go to plan, and nurses were physically assaulted. This could

subsequently adversely affect the ongoing relationship with the patient concerned.

*Steph 803:*

*...it has backfired once, and I got quite badly assaulted! ... But I will still try and do it ((talk to the patient to de-escalate the situation)). And I work with someone else who started the same time as me. ... I think the person that assaulted me. He was just gonna assault anyone, whatever happened. He was just (1.0) very, very angry. Kind of just shouting and bawling. When we took him down the end, he just completely let loose and (2.0) so (2.0). And that broke down our relationship completely.*

Some experienced nurses commented that the development of ongoing therapeutic nurse-patient relationships over the years with some patients who had had several hospital admissions, had served to build a positive reputation with them. As in Natasha's account, this was seen, to some extent, as a protective measure, reducing nurses' likelihood of future assaults:

*Natasha 167:*

*[Mm. I think (1.0) most of the senior staff have worked on more than one ward, so you do know em, regular clients (1.5). ... You're wise to get to know as many people as possible. ... I think it reduces my assault rate. If I know people, I know their risk. I'm a face, I'm a name. I'm not just a nurse. I think I'm less likely to get into trouble. That's been my experience. It's much easier to assault a stranger (1.0), than it is to assault somebody who you know has helped you in the past.*

The incidence of physical assault on nurses has been discussed previously. Natasha's experience is positive, but males and younger, inexperienced nurses are particularly vulnerable to threats from patients. These include verbal threats, verbal sexual harassment, physical intimidation, physical assault and stalking from patients (McKenna et al., 2003). Mental health nurses who are less socially engaging and less tolerant with patients with serious mental health problems, are more likely to experience physical assaults from them. This could be taken as an indicator that increased engagement would reduce risk, however, there is evidence that those who do engage with patients tend to experience more aggression and verbal assaults, which makes them more fearful of potential physical assaults (Bilgin, 2009). Nurses should therefore consider these conflicting findings and be self-aware of their interpersonal communication styles and patterns of

engaging with patients, and how this relates to the likelihood of them becoming a victim of assault.

Unsurprisingly, the psychological effects of physical assault impact negatively on nurses. In a systematic review of the literature, Needham et al (2005) found that nurses' predominant responses to physical assault were anger, fear or anxiety, post-traumatic stress disorder symptoms, guilt, self-blame, and shame. This brought about a complex interplay of contradictory feelings and past related experiences. Further research is required in relation to the prevention of patient violence and aggression, as well as better preparation for nurses to cope with the psychological impact of physical assault (Delaney et al., 2001; Needham et al., 2005).

#### *Emotional assault*

Just under half of participants indicated that emotional assaults from patients were a significant source of stress. This generally occurred when nurses had established a positive, collaborative working relationship with the patient, and involved them developing a sense of trust and understanding of the patient's ongoing problems and concerns. Where nurses believed that the patient was making positive steps forward to address these concerns, the unexpected psychological trauma triggered by sometimes life-threatening patient behaviour, suddenly shattered this sense of optimism. Some nurses were traumatised by such incidents, interpreting these as a betrayal of their trust, and regarded them as an emotional assault from which their ongoing nurse-patient relationship was severely threatened. A multidisciplinary team de-brief was usually offered to staff following such incidents, and this is discussed later. Natasha and Zoe described such experiences:

#### *Natasha 135:*

*... they're making good strides forward with their mental health, and taking back their own responsibility. And the nurse starts to feel good about what's happening, starts to feel their input is valued, and, that they're a success at their job. Then, for whatever reason, be it the client's own mental state, the pressure (1.0). It goes wrong. ...And then the next thing, the next input they had, the next communication between them, was the said nurse walking in and being frightened to death by seeing a blue patient ((the patient was hanging in their bedroom)). And it is very frightening (1.0), you know. And they all thought she was dead (1.0). And it's, you know, you then get the kick back on that, that you know, the nurse feeling that (1.0) 'I'm not good at*

*my job; why didn't I see this coming; should I have put her on levels without her permission?' You know, 'Why, why isn't she getting better?' (1.0). You know, you've got all this self doubt coming back, and it was something we had to talk through as a group, and look at, you know. ...We basically talked it through from the position that this is an emotional assault, and it's just as harmful as being punched or being sworn at ...*

Whilst having similar experience to Natasha, Zoe went on to talk about the implications for the nurse-patient relationship in more detail:

*Zoe 369:*

*You know, it's an emotional and psychological assault. Em (1.0), so I've kind of been through, you know, all those emotions and it has damaged our relationship. Em (1.0), and I haven't been able to communicate with her since the event, as I would have done before. [And (1.5), and I'm left thinking, 'How could I fix this?' 'How can I sort out my feelings so that I am able to continue (1.0) a therapeutic relationship with her?' 'Am I able to do that?' You know, 'Is it mendable?' [Em 'Does she care?' Em (2.0) ((participant seems upset)).*

Nurses working with patients with complex mental health needs such as self-harm may feel burdened by feelings and heavy emotions which can be draining on them (Wilstrand et al., 2007). These feelings can include fear for the patient's potentially life threatening actions, feelings of overwhelming frustration, feelings of abandonment, and lack of support from peers and managers. Nurses may commonly feel a sense of understanding, engagement and hopefulness about the patient's situation, whilst acknowledging the challenges and complexities of best meeting their needs. Nurses have to manage their personal feelings in such relationships, and may 'shut off' their feelings in order to cope with the patient's challenging circumstances and behaviours. Nurses may be so overburdened that they may not always be able to deliver professional care to patients, and negative attitudes towards them may develop. Participants in the present study seemed to simultaneously hold both positive and negative attitudes towards some patients with complex needs, which may in part be explained by the challenging nature of their work with them, and the emotional impact of patient behaviours on nurses themselves. Failure to address these issues

may lead to ineffective patient care, compassion fatigue, and burnout among staff.

## Professional boundaries

### *Developing patient closeness*

Just under half of participants cited the development of closeness in the nurse-patient relationship as beneficial to assist patients in moving forward towards achieving their goals. Whilst nurses generally recognised the need to maintain professional boundaries with patients, this was sometimes challenging to achieve in practice, particularly for less experienced staff.

Steph articulated her experience of developing a sense of connectedness:

*Steph 748:*

*So I guess it is just a supportive role ((the nurse-patient relationship)) (1.0). But, you can only support them if you have a good relationship with them, cos a lot of them aren't gonna tell you (1.0) that they need help if they aren't (1.0, aren't gonna get on with you. It's very difficult to answer. It's making the balance between (1.0). Cos some people, if they are in for a while, well you do get to know them more in depth and it's (1.0). Suddenly, quite often, patients suddenly kinda look on you as your friend. And you're like, it's getting the balance between being warm and friendly and getting information, and (1.5), at the same time, you've got to keep that distance, that you're the nurse; they're the patient. [But that, straight away is a power thing as well. So that causes problems. It's, it's finding the balance that's really hard. Really hard.*

In developing closeness with patients, inexperienced nurses were sometimes exposed to risks of being drawn in by manipulative patients under the pretext that other nursing staff did not somehow understand them as well as the inexperienced nurse in whom trust and rapport were being fostered. This led to a sense of enhanced worth and self-esteem on the part of the inexperienced nurse, but under false pretences. Inevitably, the nurse-patient relationship was challenged when the reality of the situation finally emerged that staff were being 'played off' against one another. Jackie reflected on her own experiences of these challenges:

*Jackie 400:*

*... It's very easy to get hooked in by somebody who's manipulative. And I know I can be a bit naive, and I tend to take people initially at face value. And, I think, you know, a few times, I've got hooked in (1.0), em, to*

*somebody playing somebody else off against (1.0). ... I was having a discussion with one of the staff nurses about these types of situations. And she did say something which I thought was quite interesting. She was saying that it was very easy to, you do get hooked in, and develop a rapport with someone who does tend to say 'you're the only person that listens to me.' She said it's very easy to think that your colleagues are less skilled. That, it can be that you begin to think that they haven't got the patience. They haven't got the understanding that I have. And it's very easy to start thinking things like that. And in actual fact, it's probably not the case at all.*

Maintaining professional boundaries involves nurses meeting patients' needs through relating and engaging with them, whilst managing their personal feelings about patients and their circumstances (Wilstrand et al., 2007).

Balancing professional/personal boundaries is challenging for nurses, who need appropriate support, clinical supervision and debriefing, to facilitate this process. Nurses may also experience a lack of knowledge to work effectively with patients in their care. Patients' trust in the nurse-patient relationship is lost when professional boundaries are transgressed, which will most likely lead to negative patient outcomes.

#### *Personal disclosure*

Some participants discussed use of personal disclosure as a means of developing rapport and trust with patients. This could happen when the nurse recognised some commonality between them and a patient in their care. Such disclosures were usually made to help the patient address their ongoing problems in some way:

*Paula 615/647:*

*I myself am a transsexual. I don't get questioned on it, very much. Occasionally, I do. Occasionally, someone will say something to me. But it's not really, it's not really an issue. ... If I feel it's appropriate, then I will disclose something, if I feel it will help the client. But (1.0), this client, em, the transsexual lady. I was quite happy to talk to her about being transsexual. Because it was an issue that was causing her problems (1.0).*

Sometimes, disclosure of personal issues, either intentionally or unintentionally, caused problems for nurses, including discrimination, harassment and threats of violence, as Paula illustrates:

*Paula 718:*

*...One client, em, said, they didn't want a transsexual as a primary nurse. But then came up a while later and apologised (2.0). Em (1.0), and then em, obviously males can be quite discriminatory. I find males to be more discriminatory than females (1.0), but nothing, nothing really major. I've had one threat of violence. But that was when I was a student.*

Self-disclosure can involve communication about intimate aspects of oneself (Ignatius and Kokkonen, 2007). The tendency towards self-disclosure differs from person to person according to their 'baseline'. Interpersonal interactions in an everyday social context foster matching of disclosures between people to develop trust. Reciprocating disclosing behaviours may also fulfil unconscious needs for social integration or identification, but personal disclosure also may leave the individual vulnerable. Zoe talked of patients using personal information against nurses:

*Zoe 252:*

*If you disclose some personal information about yourself, they ((patients)) might kind of hold onto that and, and use it at a later date. Cos I've known that to happen. ...the patient has known my colleague has got a child. They kind of (1.0) have said things about their child (1.0) to hurt them (1.0). You know, they've said horrible things about (1.0), my colleague's child. Em (2.0), you know, ...because they're angry with us, or (1.0), for whatever reason. Or it's part of their illness. Some people, you know, sometimes they can use (2.0) personal information about you, to hurt you.*

In a clinical context, self-disclosure is a debated therapeutic practice (Jeffrey and Austin, 2007), but nurses have contributed little to the debate (Ashmore and Banks, 2003). Self-disclosure may help in establishing, maintaining and ending therapeutic nurse-patient relationships, and may help to promote genuineness and trust. On the other hand, the impact of nurses' self-disclosure on patients is unpredictable, and patients may feel unduly pressured to similarly respond. Self-disclosure may therefore be perceived as helpful or unhelpful in the therapeutic relationship, and lack of skill may be an intervening variable which could determine this (Hanson, 2005).

Whilst this is an ambiguous and complex ethical issue, which requires skill and appropriate judgements (Peterson, 2002), nurses who disclose information about themselves unskillfully, and those who never disclose to patients, run the risk of damaging the therapeutic nurse-patient relationship.



Use of skilled disclosure may highlight nurses' humanness, honesty and openness, helping patients to move forward in achieving their goals.

Findings from the present study suggest that nurses sometimes use self-disclosure as a therapeutic act, but their knowledge and skill in this regard is unclear. More support through training and clinical supervision may likely be helpful to nurses to develop safer skills for self-disclosure.

### 6.3 SUPPORT STRATEGIES

#### Informal support from peers

Given the wide ranging and significantly impactful challenges which nurses encounter in their nurse-patient relationships, it is important to consider what supports may be in place or useful for nurses. A majority of participants indicated that they relied mainly on their immediate nurse colleagues for day-to-day informal support and decision-making whilst working on the wards. This was the main source of support available to nurses, as Nick and Paula suggest:

*Nick 643:*

*Hhhhhhh (3.0). It's not too bad really. It's em (2.0). The people ((nurse peers)) are generally supportive. Eh (3.0), there's always one or two exceptions in every workplace but, generally, we're all trying to achieve pretty much the same aims.*

*Paula 1031:*

*I felt lucky on my ward. Because the staff were (2.5) very good. The ward manager was good. Em (1.5), the more qualified nurses were supportive (1.0). So this all helped.*

Whilst this support mainly took the form of informal discussions with colleagues, some nurses also supported their own practice development through close informal observation of colleagues' interactions with patients. Inexperienced nurses were able to differentiate between skilful and poor practice. This helped less experienced nurses to develop their skills and confidence, to work towards becoming capable, skilled practitioners. 'Knowing' individual patients through the development of nurse-patient relationships with them over time was seen as a key factor in learning the

'craft' of nursing in acute inpatient hospital care. Graham and Susie provide examples of this:

*Graham 267/275:*

*At first, I WATCHED. ...I watched the best ones (1.0). And I watched the worst ones as well (1.0)! And see how they relate to the patients (1.0). And see how the patients relate to them. And I picked up a lot from that. ... And, the ones who impressed me the most (1.0), with the results they got (1.0), or with the kind of relationship they developed as a nurse with the patients. ...They knew the patients. They'd grown with them (1.0). They knew them very well (1.0). ...And, I learned a lot from that. I thought, well, actually to get the best relationships, you do need to stay somewhere a while (1.0), and learn your craft (2.0).*

*Susie 574:*

*If you were to list all of the responsibilities, I would really doubt myself. It's only because I look at the others and think, well they, these human beings, who em, don't always make perfect decisions and all the rest of it. They're doing it. And if they're doing it, I can do it. ...Luckily, I can see the faults as well, and so I think, 'Well you know, I won't be perfect. At least I'll be able to be as good as them you know, in a few months time'. But it's only by looking at them, and, the fact that I respect them as well. I think I'll be able to do it. And I think it'll be ok. ...*

Jenkins and Elliot (2004) found that high levels of support from peers related to lower levels of emotional exhaustion. This may be because peers may offer more immediate support than other external sources, and a greater range of support behaviours, including practical help, when dealing with work-related problems.

### **Informal support from senior nurses**

Just under half of participants discussed informal support available from charge nurses and ward managers. Whilst charge nurses mainly worked shifts alongside other nursing staff, ward managers generally worked weekday office hours and were less visible on the 'shop floor'. Senior nurses made themselves accessible to nurses for support when available, generally when more complex issues arose in managing challenging patients' needs on the ward. One ward manager talked about their own availability to provide support:

Ward manager one 680:

*...I've got an open door policy. ...My door key is shared with everyone. Everyone can walk into my office. Anyone who's on the staff can. And I think, part of me would love to change that, and part of me thinks (1.0) that (1.0) I don't ever want to be one of these people you have to knock and come in. Just come in (1.0), you know (1.0).*

Such informal support was welcomed and taken up by nurses from time-to-time. Some inexperienced nurses commented that, whilst on the one hand they felt supported by ward managers, on the other hand, they realised that they had to accept professional responsibility for their actions and often make clinical decisions in isolation when in charge of the ward, in the absence of more experienced colleagues. Colin illustrated this complex dynamic:

Colin 512/519:

*Support's (1.0) sort of there, but sort of not. We've got a very good ward manager who, ((laughs)), she's wonderful. Eh (1.0), she sort of gives you the impression that you're getting supported. And always listens. I think that's her quality. But really, tangibly, I'm not really supported. But she just makes you feel like you are. I think, you, you sort of realise that you're not, really. ... This lady listens to you, and gives you the time (1.0), and makes you feel like you're supported and will listen to what you're saying. But after she's given you this terrific (1.0). She'll tell you various things you can do. ... you can call the senior duty nurse, you can always ask for back-up. Em (1.0), and she'll say all of that. Great, it makes you feel good. It makes you feel reassured. Em, but really, at eight o'clock, when it's kicking off, or, you know, you've got loads and loads of things to do, you might try and get a patient transferred to another ward, and they'll just say 'no.' Or you might ask for extra staff, and there won't be any. So, it's a bit of an illusion. ... But it works. Because it works to make us feel supported. I think, I think this lady would support us if she could, but the reality is she's got lots on as well.*

Senior nurses recognised the day-to-day clinical challenges faced by nurses on the wards, and made themselves present when more complex incidents arose. In such instances, senior nurses discussed role modelling for staff as a strategy to help them to develop and to manage future challenging situations. Senior nurses discussed the dilemma between making themselves available to support their nursing staff in this way, versus addressing their own substantial administrative workloads. Nurses' clinical needs always came first when senior nurses were in the vicinity of the ward.

*Ward manager one 450:*

*...I do try and come onto the ward and cover and be around, and take the heat as well sometimes. ... when a client needs boundaries setting ... I will always back the nurse up. I mean, there are times when I need to step in and role model how you de-escalate or how you say no to somebody, or how you offer other choices (1.0). You know, and I will always be there if an aggressive incident kicks off. And that's not always the case I think, with senior staff. But it's difficult isn't it. [I can't be doing all these reports for my bosses and (1.0) there for the clients and there for the staff. And, I think you just need to try and (1.0) be as judicious with your time as you can. ...*

Senior nurses' roles in supporting staff to reduce stress and increase job satisfaction through effective leadership has been found to be highly significant in acute psychiatric inpatient settings (Ouzouni and Nakakis, 2009). Senior nurses' accessibility to provide immediate support to address nurses' concerns has been found to be crucial in nurses' decisions as to whom to approach when faced with work-related problems (Jenkins and Elliot, 2004).

Findings from the present study suggest that, whilst informal support may be particularly effective in addressing nurses' needs, more support would be welcomed from experienced senior nurses.

### **Formal support through clinical supervision**

In terms of formal supports for nurses in managing their roles and relationships with patients, just under half of participants discussed clinical supervision as a means of receiving formal support from colleagues. The quality and frequency of this was variable, sometimes inadequate, and a cause for concern.

Two senior nurses commented on their roles as supervisors with their junior colleagues. Emphasis was placed on developing nurses' clinical practice and management skills by fostering a supportive, non-punitive supervision culture:

*Ward manager one 419:*

*What I tend to see in supervision, I tend to see the next layer down, because that's how we supervise. But what I do do is talk very clearly with them about how they manage the staff as well, so that we do try and keep things on the kind of (2.0), caring (1.0) em, non-punitive side. Because, there's a*

*lot of mistakes to be made in interactions with other people. And I think that you learn from them. And also putting right things that are wrong is a bigger skill than, you know, a more important skill sometimes, than getting 100% right. Because life isn't like that (1.0). ...*

A few participants indicated that the quality of their supervision from charge nurses did not meet their professional needs and expectations. Whilst nurses sought guidance for their professional development, this was not forthcoming from supervisors, and they were left feeling overwhelmed and inadequate in meeting their professional responsibilities on the wards. They criticised their charge nurse supervisors for a perceived lack of clinical expertise, and lack of relevant further education or training since gaining their initial professional registration:

*Sophie 659/667:*

*Em (1.0), I think the fact that, for example, both the charge nurses on my ward, they'd never worked anywhere but the acute sector, the inpatient wards. [You know, they had no experience of em, of working anywhere else em. They didn't have any qualifications beyond their diploma. Em (1.0), they (1.0) they hadn't been qualified that long. I think one had been qualified five years. And another one had been qualified about six years. Em (1.0), so I think, personally, I just felt they didn't have the knowledge, the experience to em, to provide what was needed really. ...I think other colleagues would feel the same, because, it's something that's quite often discussed really, among the team. Em, the fact that I think, we all felt em (1.0), that we really had a lack of guidance. That the wards are just full of newly qualified or fairly recently qualified nurses. Em, that there's not enough experience, there's not enough knowledge, and I think that people do feel, particularly when they're there as newly qualified nurses, they feel completely adrift, and overwhelmed with the intensity of the work that they're having to do. And a lack of, a lack of kind of guidance really. And we talked a lot about em, about supervision, and the fact that none of us feel like we get adequate supervision.*

The frequency of clinical supervision was raised by a few participants as a cause for concern. Whilst the NHS Trust supervision policy stated that clinical supervision should be undertaken on a monthly basis, participants reported that the reality could be different. Planned supervision could be cancelled owing to pressing clinical needs on the ward. When they did occur, supervision meetings could be held in rooms frequently accessed by other colleagues, negating the possibility of confidential dialogue and support for supervisees. Sophie and Susie described their own experiences:

*Sophie 675:*

*I probably met my supervisor an average of once every four months. ... I didn't find supervision particularly helpful ...they didn't really have a great deal to offer me. ...when you have supervision, it's on the ward. It's part of your shift. So, often it's cancelled because it's too busy to have it. Or else you're having it in the staff room, and there's all this noise going on in the background. And em, people are walking in and out of the room. It's very difficult to get any kind of em, ring-fenced time [to spend doing supervision.*

*Susie 590:*

*Supervision? We just get it on the hoof. Em, and if I'm feeling insecure. I can't get supervision. I need it now. I go to the manager. And eh, or I write a letter to the manager. And say look, I'm very unhappy about this, da de dah, dah. And then the manager comes to me and says, come on, we'll have a chat about it.*

Problematic dynamics between supervisor and supervisee may lead to collusion, suspicion, resistance, tokenism and mutiny, resulting in poor outcomes (Cottrell, 2002). Shared, collaborative working between supervisees, supervisors, managers and the Trust, is suggested as a way forward to develop effective clinical supervision arrangements. A commitment to the appropriate training of supervisors to develop and enhance their supervision skills is also required. The realities of mental health nurses' reported experiences suggest that the quality and frequency of clinical supervision often falls short of meeting their needs and expectations (Scanlon and Weir, 1997) leaving them to resort to maladaptive coping mechanisms, in turn undermining the provision of effective care.

Participant experiences of supervision were variable. One nurse received high quality supervision from an experienced colleague. Time was made available when they worked together during night shifts and the nurse was able to reflect on practice and share experiences in confidence with the supervisee, to help her to develop her clinical competence and confidence in her professional judgements:

*Jackie 400:*

*... I think I've been very fortunate over the last five, six years, that I've had somebody that I've worked with. ... Very experienced. And there'd be informal supervision, in the nights we've worked. And, it's been very beneficial for us both. Because, you know, to be able to talk about work in a confidential manner, has been really helpful. And I've learnt an awful lot. ... Knowing that there will be some times when you, you don't take the best action, but you do the best you can. And accepting that, not beating yourself*

*up. And as long as you can take a step back and say 'Well I did do this, and I did do that. And I've tried that. Next time ...' It's about reflective practice.*

Clinical supervision can reduce nurses' stress and distress caused through emotionally charged incidents, and can contribute to safer, more effective nursing practice (Jones and Cutcliffe, 2009). The process can lead to nurses' self-recognition as professionals and authentic human beings, which can positively affect their well-being (Bé gat and Severinsson, 2006). Patient care outcomes may also be enhanced through nurses' clinical supervision and supervised nursing care plans, leading to improved creativity and a more positive organisational culture (Berg and Hallberg, 1999).

Just under half of participants in the present study discussed formal clinical supervision as a support strategy, but that the quality and frequency was variable and often inadequate. The literature reviewed supports this finding in that nurses working in acute inpatient settings elsewhere report similar experiences.

#### **6.4 SUMMARY**

Key findings about nurses' reported experiences about the impact of the nurse-patient relationship on nurses, and its effects on the nurse-patient relationship, have been discussed here. These interlink with the findings from the two previous chapters. These are synthesised into the discussion and conclusions chapter which follows.

## **CHAPTER SEVEN: CONCLUSIONS**

In recent years, the role of acute inpatient psychiatric services has come under increased scrutiny, during an overall review of how mental health services for people with severe mental health problems should be provided. In the present day context of healthcare modernisation, the development of effective services for people with severe mental health problems has become a national priority. Although the number of acute inpatient beds has and continues to reduce, the role and value of the inpatient service has been recognised as an important aspect of service provision.

The therapeutic nurse-patient relationship is claimed to be central to best mental health nursing practice (Barker, 1999) but the extent to which this is recognised and valued by nurses in the inpatient setting is unclear. Although recent studies offer some evidence about the everyday realities of the roles and skills of mental health nurses, the literature review revealed that remarkably little is known about the present nature of the nurse-patient relationship in the adult acute psychiatric inpatient setting, from the perspectives of nurses themselves.

It was timely that this qualitative study set out to explore nurses' accounts of the nature of their nurse-patient relationships in the acute working age inpatient mental health setting. This thesis presented an interpretive analysis of participants' accounts of their experiences, and discussed the findings in the context of the literature.

In seeking to understand this phenomenon, the principal research question asked 'What are registered mental nurses' reported experiences of the nature of the nurse-patient relationship in working age acute inpatient mental health care settings?'

Conclusions from this study discuss central issues arising in relation to the key emerging themes: the context of the nurse-patient relationship; characteristics of the nurse-patient relationship, and nurse skills and qualities brought to the nurse-patient relationship; and the impact of the nurse-patient



relationship on nurses. Implications for practice, education and research are finally drawn.

## **7.1 THE CONTEXT OF THE NURSE-PATIENT RELATIONSHIP**

Participants' stories revealed that the ward environment was frequently unsettling and not always conducive to the development of therapeutic nurse-patient relationships. Many nurses had experienced aggression and violence from patients. Some patients were labelled as 'unpopular' by virtue of their behaviour or by their medical diagnosis. This included 'personality disorder'; 'substance misuse' and 'psychosis'. Since admission rates for people with a diagnosis of personality disorder are increasing, this is likely to be a growing concern for nursing practice.

Nurses were mixed in their expectations of what they may achieve whilst working with challenging patients with complex needs. Services focused on short term crisis admissions; risk assessment and management; and patient safety. Emphasis was placed on rapid stabilisation of symptoms, reflecting the dominant bio-medical approach there, and planning for patient discharge began as soon as possible. The literature revealed limitations of the physical environment which included little free access to communal space, detracting from the therapeutic milieu. Patients' acuity of symptoms and close proximity living are factors which contribute to potential conflicts, which may lead to violence and aggression. Nurses in this study discussed many of these factors as a challenge, but none-the-less, they reported that it was often possible to develop therapeutic nurse-patient relationships.

Many participants discussed their career path and aspirations in working in working age acute mental health care. Nurses' career choices and expectations were varied. Some staff chose to leave the service within one to two years whilst others had made an active choice to continue working within the field. Just under half of participants were dissatisfied with their perceptions of service purpose to manage and contain patient risk behaviours.

Nurses revealed they are not always adequately prepared in their expectations of the purpose and function of working age acute inpatient mental health settings. This is particularly so for newly qualified nurses, who develop aspirations to engage in highly therapeutic, patient-centred relationships, with opportunities to support patients through their journeys to recovery. For most newly-qualified registered mental nurses, the realities fall short of these expectations, as the service model requires nurses to support patients over a short-term period. Nurses may therefore only support patients in their recovery for brief parts of their journeys. Although patients may later continue towards recovery, inpatient nurses may be disappointed when they are not part of this process.

Most nurses indicated generally positive experiences with their nursing team which were characterised by close team working relationships and the development of trust in colleagues. However, most expressed negative views of the multidisciplinary team, particularly in relation to medical colleagues. The dominant medical model approach was felt to be imposed on nurses who preferred a broader holistic approach to patient care. Many medical colleagues lacked a day-to-day presence on the wards, so were not considered to be part of the team.

It can be concluded that nurses value colleagues more when working regularly in close proximity with them, where a sense of shared philosophy of care, and team cohesion is experienced. Different working arrangements for other professional disciplines meant that some members of the multidisciplinary team were less present than nurses, who were in danger of excluding other colleagues from the team. This may lead to polarised views of competing models of care, instead of acknowledging and valuing the strengths and merits of differing approaches to care.

All participants valued one-to-one patient contact, and planned this into their shift activities on a regular basis. Many expressed concerns over the amount of time spent on shift coordination at the expense of direct patient care. Much of their time was taken up in the day-to-day documentation and administration of patient care.

It is clear that nurses experience difficulties in managing the tension between wanting to spend one-to-one time with patients, and having to attend to the technical aspects of their job roles, such as shift coordination and record keeping. As the literature supports, nurses need to recognise that these technical aspects of care are equally valid and important aspects of their roles as nurses. They need to strengthen their ability to prioritise and effectively manage the competing aspects of their roles, without devaluing less appealing aspects of their role.

Many participants discussed patient risk assessment and management as a key priority. Patient control and restraint was raised as an issue which impacted either adversely or positively on the nurse-patient relationship. Nurses discussed mixed views in their teams about under what circumstances control and restraint should be used.

This suggests that nurses' approaches to managing risk through the use of control and restraint can raise conflict among nursing teams about the appropriateness of control and restraint as an intervention, and its effects on the therapeutic nurse-patient relationship. Nurses should develop greater knowledge and skills about intervening to manage patient risk, to acknowledge the place and appropriate use of control and restraint as one intervention when other less restrictive interventions such as interpersonal de-escalation measures have been unsuccessful. This would enable nurses to practice in a more effective, consistent and capable manner, minimising disputes, distress and confusion with peers.

As in this study's findings, the literature shows that nurses' realities of everyday working practices in acute psychiatric inpatient care may include poor ward environments, increased patients' acuity of illness, and multiple, competing demands placed on their time. These factors may challenge possibilities for the development of therapeutic nurse-patient relationships. Many service users appear to want to experience therapeutic nurse-patient relationships, but this may not always be possible, and significant levels of dissatisfaction are reported of their overall inpatient experiences. The significance of findings in this study is that nurses appear to want to engage

in therapeutic contact with patients, but commonly find that opportunities to do so are hindered by organisational constraints.

## **7.2 CHARACTERISTICS OF THE NURSE-PATIENT RELATIONSHIP**

All participants indicated that a key characteristic of the nurse-patient relationship was 'being human', recognising and acknowledging the fundamental human nature of one person interacting with another, and 'knowing' the patient as important in order to understand their needs and concerns. Most participants cited the development of trust and collaborative working within the nurse-patient relationship as important, in order to assist patients to progress and move forward with their care.

Nurses aspire to recognise patients as fellow human beings, and value the development of nurse-patient relationships with them. Nurses acknowledge the reciprocal nature of working collaboratively with patients. It is evident that nurses believe that the therapeutic relationship is important in helping patients to move forward in their recoveries. Nurses need to promote the characteristics and value of the nurse-patient relationship as a central element of their professional practice.

Half of the participants indicated the challenging nature of persevering with some patients to attempt to work positively with them, when they did not seem to engage and interact with them. A sense of powerlessness on the part of nurses could develop when there appeared to be no forward movement in addressing patients' needs, and this could lead to negative nurses' attitudes emerging with particular patients.

This indicates that nurses need to accept that not all patients may want or be able to engage with them in therapeutic relationships. Nurses should be self-aware in these circumstances, and seek appropriate support in order to ensure that they continue to maintain appropriate approaches to care provision, even in the absence of affirming patient responses.

Most participants cited active listening and responding as an essential skill to promote successful nurse-patient relationships. Half discussed the skill of appropriate use of self and past personal experiences in nurse-patient relationships. These nurses had experienced a variety of significant serious mental health and psychosocial problems in their own lives.

As the literature review discussed, the use of active listening and responding skills is valuable in developing and sustaining therapeutic nurse-patient relationships. The use of self-disclosure is a valuable intervention, but this must be managed carefully by the nurse to avoid unnecessary or harmful disclosures. These disclosures may adversely impact on both nurses and patients. Nurses who are able to draw upon past personal experience of mental health and psychosocial problems in their own lives may empathise with patients on a deeper level.

Many participants discussed the positive impact of education and training opportunities completed by them on their overall development of knowledge and skills. Most participants valued their pre-registration nurse training and post-registration nursing courses, and drew upon the knowledge and skills gained there in their everyday nursing practice. Many nurses relied on their pre-registration education and training, to inform current post-registration practice.

Many nurses lose motivation and interest for further training and education to support their professional practice. However, nurses that do develop post-registration knowledge and skills through further education and training benefit from enhanced reflective and clinical judgement skills. This affords them greater competence and confidence in meeting the emotionally challenging demands of professional practice in working age acute inpatient mental health settings.

Almost all participants demonstrated empathy towards the patients they worked with, and indicated that a caring, compassionate, honest, truthful approach was needed in interactions with patients. Most participants expressed positive motivation and a sense of optimism towards working with

patients, but interestingly, many also cited an awareness of negative motivation in the workplace as a factor adversely influencing the nurse-patient relationship. This could arise following incidents with patients such as verbal threats or physical assault directed towards nurses.

Nurses need to be mindful of the value of their positive nurse qualities. Maintaining these in practice may be challenging owing to the possibility of negative experiences such as exposure to threats or violence from patients. Without keeping these qualities at the forefront of their everyday practice, optimism and motivation may lessen, leading to the development of negative attitudes which may adversely impact on patients.

The characteristics, qualities and skills nurses associated with the nurse-patient relationship were broad-ranging, and centred around a humanistic approach to developing their nurse-patient relationships, reflecting Peplau's model of interpersonal relations in nursing, discussed previously. Application of such approaches was important to nurses, but this was challenged by the competing demands of the organisation and other patients' needs, discussed previously.

### **7.3 THE IMPACT OF THE NURSE-PATIENT RELATIONSHIP ON NURSES**

Most participants described developing a sense of personal satisfaction in their interactions with many patients. This was gained when nurses felt they had connected with patients to understand their problems and concerns and to help them to make a difference in their lives for the better.

Participants in this study needed opportunities to connect with patients to develop an understanding of their problems, concerns, and experiences, in order to maintain their sense of professional validity and worth. This need is supported in the literature. Without such opportunities, nurses are at increased risk of emotional fatigue and burnout.

Most nurses cited stress as a major impediment to the development of effective nurse-patient relationships. Key contributing factors included the general stress of the job, nurses' inexperience, and challenges about their

professional competence by others. Many discussed their awareness of potential risks of physical assault or actual physical assault by patients as a source of stress. Just under half of participants indicated that emotional assaults from patients were a significant source of stress.

The study revealed that nurses face a number of significant professionally and clinically related stressors. Given that these are inherent challenges for nurses working in acute inpatient mental health settings, it is crucial that they receive adequate training and support appropriate to their needs.

All participants indicated that maintenance of professional boundaries was a fundamental feature of the nurse-patient relationship. Just under half of participants cited the development of closeness in the nurse-patient relationship as beneficial to assist patients in moving forward towards achieving their goals.

Nurses need to be clear about maintaining appropriate boundaries in nurse-patient relationships. This is essential to ensure safe, therapeutic practice, placing patients' interests first. Despite the fact that nurses are clear about their professional boundaries, transgressions continue to occur. Nurses need to maintain self-awareness of their feelings within nurse-patient relationships, and challenge themselves to seek and access appropriate support through which to explore their closeness to patients.

Almost all participants indicated that they relied mainly on their immediate nurse colleagues for day-to-day informal support and decision-making whilst working on the wards. Just under half of participants discussed informal support available from charge nurses and ward managers. Whilst charge nurses mainly worked shifts alongside other nursing staff, ward managers made themselves available when more complex issues arose in managing challenging patients' needs on the ward.

Nurses require day-to-day immediate support, but charge nurse and ward manager colleagues with relative expertise are not always sufficiently available to provide such support. This may leave relatively inexperienced

nurses to manage complex and challenging situations with inadequate support.

Just under half of the participants discussed clinical supervision as a means of receiving formal support from colleagues. Participants reported that the quality and frequency of clinical supervision was variable, often inadequate, and a cause for concern.

Whilst nurses value and require formal support for their professional development through clinical supervision, the frequency and quality of this may be inadequate to meet their needs.

#### **7.4 CONTRIBUTION OF THIS THESIS**

The existing literature provides an overview of what is currently known about the care delivery and everyday practices of nurses working in the acute inpatient setting. Whilst attention has been paid to considering patients' own accounts of their experiences of care, including the nurse-patient relationship, the literature revealed that remarkably little is known about nurses' experiences of the nurse-patient relationship from their own perspectives.

The contribution of this thesis is that it places the voices of nurses centre stage in this interpretive study, to explore their accounts of their experiences of the nurse-patient relationship in the acute inpatient setting. Their stories reveal new perspectives to inform our understanding of nurse-patient relationships; how nurses themselves invest in developing these relationships, the challenges they face in doing so, and how these experiences impact on nurses themselves.



## **7.5 IMPLICATIONS FOR PRACTICE, EDUCATION AND RESEARCH**

### **Implications for practice**

Leaders, policy makers, senior managers, ward managers and registered mental nurses in working age acute inpatient mental health settings in the NHS and independent sector should consider the following implications for practice:

1. Ensure that all staff and service users have a clear understanding of the organisation's service model for acute inpatient care. Its purpose and function when working with patients should be made clear.
2. Newly employed nurses should be provided with an orientation and induction to the inpatient service, taking due account of the service purpose and operational realities of service provision.
3. Programmes which allow nurses to rotate between different parts of the service should be considered to expose nurses to the wider range of services providing service user opportunities for recovery.
4. Training programmes should ensure that all multidisciplinary staff are aware of one another's roles and responsibilities, and modes of practice. Annual or six monthly team days should be arranged to foster strong multidisciplinary team cohesion.
5. Multidisciplinary teams should develop shared statements of philosophy of care which acknowledges the strengths and contributions of different disciplines within the team.
6. Nurses need to value both technical and interpersonal aspects of their role, avoiding bias in their preference for role activities.
7. Training programmes and formal educational opportunities should be made available to nurses to ensure an adequate level of knowledge and skills to meet role challenges, duties and responsibilities.
8. Nurses need to promote the positive characteristics and value of being human in the nurse-patient relationship as a central element of their professional practice.
9. Nurses should carefully manage the use of therapeutic self-disclosure from an informed position, to promote patient well-being and to minimise the risk of harm to nurses and patients.

10. Service providers should ensure that operational services are arranged and resourced to allow sufficient time for nurses to engage meaningfully with patients in order to connect with them and develop an understanding of their problems, concerns and experiences. Without such opportunities, nurses will be at increased risk of emotional fatigue and burnout.
11. Service providers should make provisions to support staff exposed to inherent professional and clinical stressors.
12. Supervision arrangements should ensure that nurses are provided with regular and adequate support, through which a range of professional issues can safely be discussed. This should include open discussion about the maintenance of appropriate professional boundaries.
13. Services should be arranged to ensure that senior clinical nurses and team leaders have available time to provide a frequent presence with shift teams to meet their day-to-day support needs.

### **Implications for education**

Educators responsible for pre-registration and post-registration programmes of nursing should consider the following implications for education:

1. Pre-registration nursing education providers should ensure that curricula provide student nurses with a realistic understanding of the nature of service provision in working age acute inpatient mental health settings.
2. Pre-registration nursing education providers should provide career development support to ensure that student nurses have a realistic understanding of the roles and responsibilities of registered nurses employed in working age acute inpatient mental health settings. This should include both the technical and interpersonal aspects of the registered nurse's role.
3. Education providers should ensure that appropriate specialist training programmes and formal educational opportunities are made available to nurses in working age acute inpatient mental health settings, to ensure an adequate level of knowledge and skills to meet role challenges, duties and responsibilities.

4. Education providers should offer appropriate post-registration clinical supervision training and educational opportunities to support the development of reflective and reflexive practice.

### **Implications for research**

Health and social care researchers should consider the following implications for research:

1. Further research is required to investigate the changing role and purpose of working age acute inpatient mental health services.
2. Further research is required to investigate the effects of the design of the physical environment on patient well-being and recovery, taking account of ward population size and physical space.
3. Further research is required to investigate the effects of nursing rotation programmes between different parts of the service, on their professional development and the impact of this on stress, emotional fatigue, and burnout.
4. Further research is required into the impact of the positive characteristics and value of being human in the nurse-patient relationship to increase understanding of this central element of professional nursing practice. This could include research design which includes both patients and nurses.
5. Further research is required to explore whether additional resources to promote therapeutic nurse-patient engagement would reduce stress, emotional fatigue, and burnout among nurses.
6. Further research is required to investigate whether an increased presence of senior clinical nurses and team leaders would have a positive impact on the support needs of shift working nurses, to meet their day-to-day support needs.

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## APPENDIX A

### Anonymised ethical approval main study LREC



**(County name 1) Research Ethics Committee**  
**(County name 2) Research Ethics Committee**

06 December 2005

(Address, telephone, fax, email details)

Mr Ian Taylor  
Senior Lecturer, Institute of Nursing & Midwifery  
University of Brighton  
Westlain house, Village Way, Falmer  
Brighton, East Sussex.  
BN1 9PH

Dear Mr Taylor

**Full title of study:** An exploration of the views of registered mental nurses about the nature of the nurse-patient relationship in adult acute inpatient psychiatric care settings.  
**REC reference number:** 05/Q1907/144

Thank you for your letter of 01 December 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

#### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

#### Ethical review of research sites

The favourable opinion applies to the research site listed on the attached form.

#### Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

#### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application		01 December 2005
Investigator CV		05 September 2005
Protocol	1	05 September 2005
Covering Letter		05 September 2005
Letter from Sponsor		
Interview Schedules/Topic Guides	1	20 November 2005
Letter of invitation to participant	2	01 December 2005

## APPENDIX A

### Anonymised ethical approval main study LREC (continued)

05/Q1907/144

Page 2

Participant Information Sheet	3	01 December 2005
Participant Consent Form	3	01 December 2005
Response to Request for Further Information		01 December 2005
Response to Request for Further Information		20 November 2005
Email from (Clinical Nurse Manager name)		21 October 2005
Letter from Research Governance		26 October 2005
Referees' or other scientific critique report		01 June 2004
Supervisor's CV		22 February 2005
Indemnity		13 June 2005

#### Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**05/Q1907/144 Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

**Chair**

Email: .

Enclosures: Standard approval conditions  
Site approval form

Copy to: Dr D Fitzsimmons  
University of Wales, Swansea.  
University of Wales, Swansea  
School of Health Science, Singleton Park,  
Swansea, SA2 8PP

R&D Department for NHS care organisation at lead site

SI-1 list of approved sites

## APPENDIX B

### Anonymised ethical approval main study Trust Consortium

(County name) NHS Research Consortium 

Please reply to:

Telephone:

Fax:

E-mail:

Mr Ian Taylor  
Senior Lecturer  
Institute of Nursing and Midwifery  
University of Brighton  
Westlain House, Village Way  
Falmer, Brighton  
BN1 9PH

20 December 2005

Dear Mr Taylor

ID: 0615/NOCI/2005 **An exploration of the views of registered mental nurses about the nature of the nurse-patient relationship in adult inpatient psychiatric care settings.**

Further to my letter of the 26th October 2005, the Chairman on behalf of the RAMC has considered your response to the issue/s raised by the committee's initial review. The documents considered were as follows:

- \* Response to the RAMC request for clarification letter from Ian Taylor (signed and dated 20/12/05)
- \* NHS REC form Parts A and B (version 3 signed and dated 01/12/05)
- \* NHS REC form part C (signed and dated 01/12/05)
- \* Interview schedule (version 3 NHS REC form dated 01/12/05)
- \* (Local LREC name) LREC approval letter (signed and dated 06/12/05)

I am pleased to inform you that this study has now been approved by 'Chairman's action', and so may proceed. This approval is valid in the following Organisations:

- \* (NHS Trust name)

Your RAMC approval is valid providing you comply with the conditions set out below:

1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application to the committee.
2. You notify the RAMC by contacting me, should you deviate or make any changes to the RAMC approved documents.
3. You alert the RAMC by contacting me, if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.
4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year. Failure to do this will result in the suspension of RAMC approval.
5. You comply fully with the Department of Health Research Governance Framework, and in particular that you ensure that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.

Please contact the Consortium Office if you wish this approval to be extended to cover other Consortium Organisations; such an extension will usually be agreed on the same day. We also have reciprocal arrangements for recognition of Research Governance approval with some other NHS Organisations; such an extension can usually be arranged within five working days.

Please note that if your work involves (NHS Trust name) NHS Trust, this approval means that you now have your Research Passport.

Good luck with your work.

Yours sincerely

Research Governance Assistant

## APPENDIX C

### Anonymised manager approval to access participants

**Taylor Ian**

**From:** *(Clinical Nurse Manager name, email address)*  
**Sent:** Friday, January 13, 2006 1:06 PM  
**To:** *(All Ward Managers, Charge Nurses, Staff Nurses)*

**Cc:** I.Taylor@brighton.ac.uk  
**Subject:** Research Study:An exploration of the views of Registered Nurses about the nature of the Nurse/Patient relationship in adult acute inpatient psychiatric care settings.

Dear Colleagues

You will soon be receiving an information pack from Ian Taylor, Research/Senior Lecturer, University of Brighton inviting you to participate in the above research study. The pack will provide details about the study, what is involved and how to contact Ian if you would like to participate. This email is to let you know in advance that Ian has been given approval to contact you about this study.

Ian plans to visit the nursing teams on *(Ward names)* Wards to explain further about the project.

Ward Managers please forward this message to all qualified members of your teams.

Many thanks  
*(Clinical Nurse Manager name)*

Clinical Nurse Manager  
*(Hospital name)*

\*\*\*\*\*  
Disclaimer

The content of this email are not necessarily the policy or opinion or representative of any policy or opinion of the *(NHS Trust name)* NHS Trust or any person employed by it. This transmission is intended only for the named recipient(s) and is confidential in nature. If received in error, please return it to the sender and destroy any copies immediately.

All messages passing through this gateway are virus scanned and monitored for offensive content.

*(NHS Trust web address)*  
\*\*\*\*\*

## APPENDIX D

### Anonymised participant letter of invitation

Faculty of Health



University of Brighton



Institute of Nursing and Midwifery

12 January 2006

To all Staff Nurses,  
Charge Nurses and Ward Managers  
(Ward names) Wards  
(Hospital name)  
(Address line 1)  
(City)  
(County)  
(Postcode)

University of Brighton  
Westlain House  
Village Way  
Falmer  
Brighton BN1 9PH  
Telephone 01273 600900  
Fax 01273 644010

Extn. 4083

Dear colleague

**Research Proposal: An exploration of the views of registered mental nurses about the nature of the nurse-patient relationship in adult acute inpatient psychiatric care settings**

I am a full time mental health lecturer at the University of Brighton and am currently undertaking a part time Doctorate in Nursing Science programme at the University of Wales Swansea. This is a professional doctorate programme which requires me to undertake original research in practice.

The focus of my research is to explore the views of registered mental nurses about the nature of the nurse-patient relationship in adult acute inpatient care settings. Further details about this research can be found in the enclosed Participant Information Sheet.

The research study requires me to identify 15 registered mental nurses including staff nurses, charge nurses and ward managers who will be willing to participate in an individual interview with me, lasting approximately one hour. I believe that staff working within the acute inpatient wards at (Hospital name) would be ideal for this purpose. I am therefore writing to invite you to participate in this study. In order to inform your decision, I would be happy to discuss the study with you more fully. I shall be arranging informal meetings with ward staff to provide further details and to answer any questions which may arise. I am also happy to see staff individually if preferred.

Formal approval to undertake this research study has been granted by the (Name) Research Ethics Committee and the (Name) NHS Research Consortium Research Approval and Monitoring Committee. Consent to approach nursing staff within (Hospital name) Hospital has been given by (Name), Clinical Nurse Manager. Please note that your decision as to whether or not to participate in this study will be known only by me, and will not be disclosed to anyone else.

Should you wish any further information, please contact me at the above address, by email (I.Taylor@brighton.ac.uk) or by telephone (direct dial 01273 644083). Thank you for taking the time to read this letter. I look forward to hearing from you.

Yours sincerely

Ian Taylor  
Researcher / Senior Lecturer

1 of 2

## APPENDIX D

### Anonymised participant letter of invitation (continued)

#### REPLY SLIP

#### AN EXPLORATION OF THE VIEWS OF REGISTERED MENTAL NURSES ABOUT THE NATURE OF THE NURSE-PATIENT RELATIONSHIP IN ADULT ACUTE INPATIENT PSYCHIATRIC CARE SETTINGS.

All personal details provided by you will only be available to the researcher, and will be stored securely to maintain confidentiality.

Your decision as to whether or not to participate in this study will not be disclosed to anyone else.

Please complete as appropriate

Name:

1. I am / am not (please delete as appropriate) willing to participate in the above research.
2. Please do / do not contact me to give further details about the study and to arrange a convenient time and place for interview.

#### Contact details

Preferred contact address (please complete as appropriate e.g. work/home):

Preferred contact telephone number (please complete as appropriate):

Work:

Home:

Mobile:

Preferred email address (please complete as appropriate):

Work:

Personal:

Signed:

Date:

Please return your completed reply slip using the enclosed stamped, addressed envelope to:

Ian Taylor, Senior Lecturer, Institute of Nursing and Midwifery, University of Brighton,  
Westlain House, Village Way, Falmer, Brighton, BN1 9PH.

Thank you for your interest.

## APPENDIX E

### Anonymised participant information sheet

PRIFYSGOL CYMRU ABERTAWE

Ysgol Gwyddor Iechyd  
Parc Singleton, Abertawe SA2 8PP



UNIVERSITY OF WALES SWANSEA

School of Health Science  
Singleton Park, Swansea SA2 8PP

The N-P relationship in adult acute inpatient settings version 3  
Date: 01/12/05 Ref: 05/Q1907/144

## PARTICIPANT INFORMATION SHEET

Version 3 dated 01/12/2005

### Study title:

#### **An exploration of the views of registered mental nurses about the nature of the nurse-patient relationship in adult acute inpatient settings**

You are being invited to take part in a research study which I am undertaking as part of a Doctorate in Nursing Science educational qualification at the University of Wales Swansea. I am conducting the research in *(City name)*. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Below are some answers to general questions, but please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

#### **What is the purpose of the study?**

The purpose of the study is to uncover the perceptions and experiences of registered mental nurses about the nature of nurse-patient relationships in adult acute inpatient psychiatric settings. I hope that findings from the study will help to inform our understandings about the nature and significance of nurse-patient relationships in these settings, and how they might best contribute to the care of patients in the future.

#### **Why have I been invited to take part?**

If you are a registered mental nurse and have at least six months experience in working age adult acute inpatient psychiatric services, then you are eligible to take part in the study. I would like to include staff nurses, charge nurses and ward managers in this research. You are invited to take part because the nature of your work means that you experience relationships with patients in inpatient services.

#### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw from the study at any time and without giving any reason. A decision to withdraw at any time, or a decision not to take part, will not affect your employment or legal rights, and will remain confidential.

## APPENDIX E

### Anonymised participant information sheet (continued)

The N-P relationship in adult acute inpatient settings version 3  
Date: 01/12/05 Ref: 05/Q1907/144

#### **What will happen to me if I take part?**

If you decide to take part, I will ask you to:

1. Read this information sheet carefully and complete the consent form provided. You will be given a copy of this information sheet and a signed consent form to keep.
2. Take part in an individual interview with me lasting about one hour, at a convenient venue near to your workplace. Consent to conduct these interviews during working hours has been authorised by (Name), Clinical Nurse Manager, (Hospital name) Hospital. However, he will not be informed about who is participating in the study. It is important that you are willing to talk openly and in depth about your experiences of nurse-patient relationships in adult acute inpatient psychiatric services. I would like to audio-record the interview so that I do not miss any of the details. Later, the interview recording will be word-processed into an anonymous transcript. You will be given a copy of this when completed.
3. Read the interview transcript carefully to check its content and accuracy. You may add or remove comments to the transcript if you wish.

#### **What are the possible disadvantages and risks of taking part?**

It is possible, though quite unlikely, that participants could experience some distress during interviews depending on what you decide to share and discuss. These potential risks may be countered by the potential benefits of participating in this study.

#### **What are the possible benefits of taking part?**

I hope that participation in this study will be of benefit to you, but this is not guaranteed. Although there is no intended direct benefit to you by taking part in this study, your participation may be felt to be positive, offering time for self-reflection to make sense of your experiences. The main benefits are likely to be for the wider population through the publication of findings in refereed journals and elsewhere, offering insights into their implications for best patient care.

#### **What if something goes wrong?**

If you have any concerns about how you have been approached or treated during the course of this study, please contact Dr Deborah Fitzsimmons, Head of Post Graduate Research Students, Centre for Public Health and Primary Care, School of Health Science, University of Wales Swansea, Singleton Park, Swansea, SA2 8PP; by telephone 01792 602226; or by email [D.Fitzsimmons@swansea.ac.uk](mailto:D.Fitzsimmons@swansea.ac.uk).

#### **Will my taking part in this study be kept confidential?**

All information which is collected about you during the course of this research will be kept strictly confidential. Only I will know the identities of those participating in the study. Your consent form will be stored separately from your interview recording and transcript which will be given an anonymity code so that you cannot be recognised from them. Interview transcripts and any other information you provide will be anonymised to maintain confidentiality; any references to names, places and people will be removed. All electronic information held on computer will be password protected. All electronic information held on back up computer discs and paper records will be stored in a locked cabinet when not in use.

Your name and personal details will not be disclosed, even when reporting the results of the study. I may wish to use quotes from you in an anonymised form when publishing the results of this study.



## APPENDIX E

### Anonymised participant information sheet (continued)

The N-P relationship in adult acute inpatient settings version 3  
Date: 01/12/05 Ref: 05/Q1907/144

As a registered nurse myself, I am bound by the Nursing and Midwifery Council Code of Professional Conduct. If disclosures are made which raise professional dilemmas, confidentiality may be broken in the interests and safety of patients.

**What will happen to the results of the research study?**

The anonymised results of the study will be published as a university thesis, copies of which will be held in the Library and Information Centre, University of Wales Swansea and the National Library of Wales, Cardiff. Findings may also be published as papers in refereed journals and may be presented to professional audiences locally, nationally and internationally at conferences and training events.

**Who is organising and funding the research?**

I am organising the research as part of a Doctorate in Nursing Science educational qualification at the School of Health Science, University of Wales Swansea, which is the sponsor of this research. Course fees are being paid by my employer, the Institute of Nursing and Midwifery, University of Brighton.

**Who has reviewed the study?**

The (Name) Research Ethics Committee has reviewed and approved this study.

**Contacts for further information**

For further information about this study, please contact me: Ian Taylor, Researcher, University of Brighton, Institute of Nursing and Midwifery, Westlain House, Village Way, Falmer, Brighton, BN1 9PH; by telephone 01273 644087; or by email [I.Taylor@brighton.ac.uk](mailto:I.Taylor@brighton.ac.uk).

For independent information or advice about the rights of research participants in general, or about being involved in this particular research project, please contact Dr Angie Hart, Principal Lecturer, University of Brighton, Centre for Nursing and Midwifery Research, Mayfield House, Village Way, Falmer, Brighton, BN1 9PH; by telephone 01273 644051; or by email [A.Hart@brighton.ac.uk](mailto:A.Hart@brighton.ac.uk).

Thank you for taking the time to consider whether or not to take part in this study. I look forward to meeting you should you decide to accept this invitation.

Ian Taylor  
Researcher

# APPENDIX F

## Anonymised participant consent form

PRIFYSGOL CYMRU ABERTAWE

Ysgol Gwyddor Iechyd  
Parc Singleton, Abertawe SA2 8PP



UNIVERSITY OF WALES SWANSEA

School of Health Science  
Singleton Park, Swansea SA2 8PP

The N-P relationship in adult acute inpatient settings version 3  
Date: 01/12/05 Ref: 05/Q1907/144

Participant identification no:

### PARTICIPANT CONSENT FORM

Version 3 dated 01/12/2005

**Title of research project:**

**An exploration of the views of registered mental nurses about the nature of the nurse-patient relationship in adult acute inpatient settings**

**Researcher: Ian Taylor**

**Please Initial**

1. I confirm that the researcher has explained to my satisfaction the purpose of the research and the possible risks involved.
2. I confirm that I have read the participant information sheet version 3 dated 01/12/05 for the above study, and that I have had the opportunity to ask questions and address any concerns.
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my employment or legal rights being affected.
4. I am aware that I will have to answer questions in a one-to-one interview with the researcher, and that the interview will be audio-recorded for later transcription with all identification removed.
5. I agree for direct quotations from this transcript in anonymised form to be used in any publication from the study.
6. I agree to take part in the above study.

\_\_\_\_\_  
Name of participant  
(please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

1 for participant; 1 for researcher

## APPENDIX G

### Anonymised arrangements for participant support

PRIFYSGOL CYMRU ABERTAWE  
Ysgol Gwyddor Iechyd  
Parc Singleton, Abertawe SA2 8PP



UNIVERSITY OF WALES SWANSEA  
School of Health Science  
Singleton Park, Swansea SA2 8PP

#### ARRANGEMENTS FOR PARTICIPANT SUPPORT

Version 1 dated 23/02/2008

**Study title:**

**An exploration of the views of registered mental nurses about the nature of the nurse-patient relationship in adult acute inpatient settings**

Should you require further support as a result of your participation in this study, the following services may be helpful.

Should you wish to make a complaint about the conduct of this research, please refer to the complaints procedure outlined in the Participant Information Sheet (version 3 dated 01/12/2005).

1. (Name) NHS Trust Occupational Health

(Name) NHS Trust provides a confidential self-referral service for its staff for counselling and support.

Tel: \*\*\*\*\* extn. \*\*\*\* (Nurse adviser)

2. (Name) NHS Trust Clinical Supervision

Participants may access clinical supervision to discuss professional issues through their line manager in (Name) NHS Trust.

3. Nursing and Midwifery Council (NMC)

The NMC provides all registered nurses with free and confidential professional advice on the Council's standards.

Website: <http://www.nmc-uk.org>  
Tel: Professional adviser 020 7333 6550  
Email: [advice@nmc-uk.org](mailto:advice@nmc-uk.org)  
Address: Nursing and Midwifery Council, 23 Portland Place,  
London., W1B 1PZ

Tel 01792 295789 Fax 01792 295487 [www.healthscience.swansea.ac.uk](http://www.healthscience.swansea.ac.uk)

## APPENDIX G

### Anonymised arrangements for participant support (continued)

#### 4. Royal College of Nursing (RCN)

The RCN is a professional union for nurses. RCN members have access to professional and confidential counselling by appointment, either by phone or face-to-face, at various RCN offices throughout the UK. Counsellors can help with any work-related or personal problems.

Website: <http://www.rcn.org.uk/members/direct/>  
Tel: RCN Direct 0845 772 6100  
Email: Local RCN representative email address to be advised via RCN Direct  
Address: Royal College of Nursing Headquarters, 20 Cavendish Square, London., W1G 0RN.

#### 5. UNISON

UNISON is a trade union for people delivering public services. Its members have access to confidential support through 'Unison Welfare', a registered charity.

Website: <http://www.unison.org.uk/welfare/services.asp>  
Tel: 020 7551 1620  
Email: [welfare@unison.co.uk](mailto:welfare@unison.co.uk) (local steward email address to be advised via Unison Welfare)  
Address: Unison Welfare, 1 Mabledon Place, London., WC1H 9AJ.

#### 6. Samaritans

Samaritans is a charity providing local and national confidential emotional support.

Website: [http://www.samaritans.org/~\(city name\)](http://www.samaritans.org/~(city name))  
Tel: Local branch \*\*\*\*\* (24 hours)  
National 08457 90 90 90 (24 hours)  
Email: (name)@samaritans.org  
Address: (Local name and address)

Ian Taylor  
Researcher

## APPENDIX H

### Transcription process timescale summary

Participant pseudonym	Interview duration (hr, mins)	No. of pages (pp)	Transcription 1 <sup>st</sup> draft time (hr, mins)	Refinements/ final draft time (hr, mins)	Transcript returned by participant? Comments
Adam	1, 33	36	7, 40	4, 58	Yes. Nine minor corrections/clarifications.
Colin	0, 50	28	4, 30	2, 32	No.
Graham	1, 25	38	7, 01	3, 19	No.
Hannah	0, 49	33	6, 05	4, 12	No.
Jackie	1, 33	29	6, 52	4, 11	Yes. Twenty-four minor corrections/clarifications
Janet	1, 31	38	7, 04	8, 45	No.
Natasha	1, 35	51	10, 01	8, 40	Yes. Demographic details: minor amendment.
Nick	1, 06	34	4, 48	4, 41	Yes. No changes.
Paula	1, 30	48	7, 10	5, 27	No.
Rachel	1, 00	30	5, 15	5, 11	No.
Sophie	1, 35	40	6, 24	4, 54	Yes. Three minor corrections.
Steph	0, 49	42	6, 20	8, 15	Yes. No changes.
Susie	1, 43	46	9, 29	5, 21	Yes. Seven minor corrections/clarifications.
Zoe	1, 01	26	5, 49	4, 20	Yes. Two minor corrections.
<b>Total</b>	<b>18h 0min</b>	<b>519pp</b>	<b>94h 28 min</b>	<b>74h 46 min</b>	<b>8 returned: 46 minor amendments</b>
<b>N = 14</b>	<b>Mean = 1h 17 min</b>	<b>Mean = 37pp</b>	<b>Mean = 6h 45 min</b>	<b>Mean = 5h 20 min</b>	<b>6 not returned: no changes</b>

## APPENDIX I

### Transcribing conventions adopted during transcription process

[	Interviewer: quite a [while? Nurse: [Yeah	Left brackets indicate the point at which a current speaker's talk is overlapped by another's talk.
(2.0)	Nurse: Well (2.0), I suppose	Numbers in parentheses indicate elapsed time in silence in seconds.
–	What's <u>up</u> ?	Underscoring indicates some form of stress, via pitch and/or amplitude.
WORD	I've got ENOUGH TO WORRY ABOUT	Capitals except at the beginning of lines, indicate especially loud sounds relative to the surrounding talk.
.hhhh	I felt that .hhh	A row of h's prefixed by a dot indicates an inbreath; without a dot, an outbreath. The length of the row of h's indicates the length of the inbreath or outbreath.
( )	Future risks ( ) and ( ) life	Empty parentheses indicate the transcriber's inability to hear what was said.
(word)	Would you see (there) anything positive	Parenthesized words are possible hearings.
(( ))	Confirm that ((continues))	Double parentheses contain author's descriptions rather than transcriptions.
.	That's that.	Indicates a stopping fall in tone.
,	One, two,	Indicates a continuing intonation.
><	>so that's it<	Shows talk that is noticeably faster than surrounding talk.
?	What do you think?	Indicates a rising intonation.

Adapted from Silverman (2001: 303)

# APPENDIX J

## Interpretive plan

Raw Category / Participant Name (N: Nurse SN: Senior Nurse)	Colin (N)	Paula (N)	Susie (N)	Jackie (N)	Graham (N)	Adam (N)	Janet (N)	Nick (N)	Sophie (N)	Hannah (SN)	Natasha (SN)	Rachel (SN)	Steph (SN)	Zoe (SN)
Admission – crisis team		X												
Admission – detained									X					
Admission – emergencies and crises						X								
Admission – fear and distress	X	X				X								
Admission – inappropriate		X	X											
Admission – inappropriate substances		X					X							X
Admission – patient comfort/reassurance		X				X								
Admission – planning / documentation		X												
Admission – situational crisis		X					X		X					
Admission – success														X
Admission criteria – challenges powerlessness						X				X				X
Admission criteria – risk	X	X	X						X					X
Assessment – collateral information						X							X	
Assessment – eCPA									X					
Assessment – observation	X	X		X	X	X			X					
Assessment – observation - unofficial		X			X				X					
Assessment – patient history									X				X	
Assessment – patient liberty									X					
Assessment – physical health				X		X				X				
Assessment – risks				X		X			X	X			X	
Communication – appropriate			X	X			X	X			X			
Communication – availability accepted							X							
Communication – availability denied							X							
Communication – barriers		X								X				
Communication – equal power	X			X										
Communication – explaining to pt							X	X						
Communication – inappropriate					X				X					
Communication – listening and responding	X	X	X	X		X	X	X	X		X	X	X	X
Communication - nurse - non-verbal comm.			X									X		
Communication – nurse disempowerment			X					X			X			
Communication – nurse-nurse power and control			X						X	X			X	X
Communication – nurse-patient power and control			X						X		X			X
Communication – offering reassurance / comfort		X		X	X	X		X	X					X
Communication – patient influence											X			
Communication – patient power and control			X						X		X			
Communication – positive			X				X	X						
Communication – protecting staff							X							
Confrontation							X							X
Demographic – age	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Demographic – current post	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Demographic – ethnicity	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Demographic – further study	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Demographic – qualification	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Demographic – time in WAMHS IP	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Demographic –time registered	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Demographics – PICU													X	
Description – summary	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Discharge – delayed									X			X		
Discharge – patient difficulties														X
Discharge – patient recovery											X			
Discharge – planned						X							X	X
Discharge – sudden														X
Discharge consequence – early positive		X									X			
Discharge consequence patient deterioration										X			X	X
Environment – locked door										X				X
Environment – bed occupancy												X		
Environment – budgetary / financial constraints	X											X		
Environment – inappropriate			X								X		X	
Environment – negative	X	X	X	X	X	X			X		X	X	X	
Environment – number of beds														X
Environment – nurse space				X					X					
Environment – office boundaries				X	X				X					
Environment – patient acuity of illness		X					X						X	
Environment – private sector +ve/ length stay / client gp				X	X									
Environment – pt dynamics					X		X					X		

# APPENDIX J

## Interpretive plan (continued)

Raw Category / Participant Name	Collin	Paula	Susie	Jackie	Graham	Adam	Janet	Nick	Sophie	Hannah	Natasha	Rachel	Steph	Zoe
Environment – shift pattern	X	X			X	X		X	X				X	
Environment – staffing levels											X	X		X
Environment – therapeutic / positive		X			X				X		X			
Environment – ward busyness	X						X	X	X		X	X	X	
Inpatient client groups		X	X	X	X	X	X	X	X		X	X	X	X
Intervention – 117 meeting								X						
Intervention – appropriateness for client group				X										
Intervention – assessment								X						X
Intervention – bed man/admission/working the system						X								
Intervention – care / shift coordination	X	X	X	X	X	X	X	X		X	X	X	X	X
Intervention – care plan	X		X	X	X				X	X		X	X	
Intervention – consistent approach				X										
Intervention – control and restraint	X		X	X	X		X	X	X	X	X		X	
Intervention – counselling	X			X										
Intervention – demanding pt. / prominent behaviour						X			X			X		X
Intervention – denying liberty				X			X		X					X
Intervention – documentation	X	X	X	X		X	X	X	X		X	X	X	
Intervention – documentation – unofficial									X					
Intervention – eCPA		X		X					X		X			
Intervention – emergencies and crises						X						X		
Intervention – escort patient					X									
Intervention – ethics				X						X				
Intervention – family/carers				X	X	X	X	X		X				
Intervention – handover								X	X					
Intervention – heavy handedness							X			X				
Intervention – information giving				X		X				X		X		
Intervention – legalities													X	
Intervention – MDT liaison						X		X					X	
Intervention – meal times								X						
Intervention – meaningful activity		X									X			
Intervention – medication enforcing		X				X				X	X			
Intervention – medication giving	X			X	X	X		X	X	X		X	X	
Intervention – medication monitoring			X							X				X
Intervention – meeting patient needs					X				X	X		X		
Intervention – mental health review tribunal	X													
Intervention – MHA detention and reading rights		X		X		X			X			X	X	
Intervention – nurse in charge			X											
Intervention – off/on response											X			
Intervention – patient leave early												X		
Intervention – police	X			X		X	X			X	X		X	
Intervention – prioritising / time management				X										
Intervention – pt empowerment and responsibilities	X			X				X				X	X	
Intervention – realistic expectations	X				X				X					
Intervention – referral on	X	X								X				X
Intervention – role modelling		X		X								X		
Intervention – senior nurse – complex care									X	X	X	X		
Intervention – social interaction		X											X	
Intervention – supporting staff							X			X	X	X		
Intervention – tasks							X				X			X
Intervention – use of self / personal experience		X		X	X	X	X	X					X	
Intervention – ward round						X		X		X	X			
Intervention- advocacy					X	X	X		X	X	X	X		
Intervention- physical exercise				X										
Interview debrief	X	X	X	X		X	X	X			X	X		X
Management – service expectations								X				X		
NP relationship – acuity of illness	X			X									X	
NP relationship – admission induction		X		X		X		X	X			X	X	X
NP relationship – assault	X			X	X								X	
NP relationship – being human	X	X	X	X	X	X	X	X	X	X	X	X	X	X
NP relationship – boundaries	X	X	X	X	X	X	X	X	X	X	X	X	X	X
NP relationship – breaking bad news							X							
NP relationship – challenges diverse needs							X			X				X
NP relationship – challenges frustration									X				X	X
NP relationship – challenges length stay				X					X				X	X
NP relationship – challenges unwell pt	X					X	X			X			X	X
NP relationship – challenging pt	X		X	X		X		X	X	X	X			X
NP relationship – closeness			X								X			
NP relationship – collaborative				X	X					X		X		X
NP relationship – complex needs										X	X	X		X



# APPENDIX J

## Interpretive plan (continued)

Raw Category / Participant Name	Colin	Paula	Susie	Jackie	Graham	Adam	Janet	Nick	Sophie	Hannah	Natasha	Rachel	Steph	Zoe
NP relationship – constraints – time		X	X	X		X	X		X			X	X	
NP relationship – control and restraint								X						
NP relationship – damaged														X
NP relationship – defining / definition				X	X					X				
NP relationship – ending														X
NP relationship – establishing	X	X	X	X	X	X	X	X	X	X		X	X	X
NP relationship – extended						X							X	X
NP relationship – general								X						
NP relationship – HCA	X	X	X					X		X	X			
NP relationship – imbalance							X				X		X	X
NP relationship – impact of education/training	X	X	X	X	X	X	X	X	X		X		X	
NP relationship – imparting sensitive info.							X							
NP relationship – insignificant						X			X					
NP relationship – knowing pt – limits											X			
NP relationship – knowing pt readmission					X	X	X	X		X	X	X	X	X
NP relationship – knowing the pt	X	X	X	X	X	X	X	X	X	X	X	X	X	X
NP relationship – life experience		X	X				X							
NP relationship – maintaining			X			X	X							X
NP relationship – MHA detention / detained		X		X	X	X	X		X	X			X	X
NP relationship – negative	X	X		X		X		X	X	X	X		X	
NP relationship – negative patient experience	X	X				X	X	X	X	X	X	X	X	
NP relationship – nurse disclosure negative		X					X				X			X
NP relationship – nurse disclosure positive		X					X				X			
NP relationship – nurse powerlessness						X		X	X					
NP relationship – nurse rejection														X
NP relationship – nurse reputation fair											X	X		
NP relationship – nurse responsibility			X											
NP relationship – nurse vulnerability	X	X	X				X				X	X		X
NP relationship – observation negative						X								
NP relationship – observation positive						X								
NP relationship – patient barriers		X					X			X				
NP relationship – patient connection	X	X		X		X			X					
NP relationship – patient dishonesty									X					X
NP relationship – patient engagement									X		X			
NP relationship – patient feedback negative						X		X		X		X		
NP relationship – patient non-engagement	X	X			X			X	X				X	X
NP relationship – patient responsibility						X								
NP relationship – patient views negative													X	
NP relationship – patient vulnerability	X	X	X		X	X	X		X					
NP relationship – patient vulnerability – fear and distress	X	X	X	X	X	X	X	X	X					X
NP relationship – patient vulnerability – physical assault						X								
NP relationship – Peplau/Rogers		X	X		X									
NP relationship – persistence					X									
NP relationship – physical assault	X										X			
NP relationship – positive		X	X	X				X				X	X	X
NP relationship – positive nurse feedback			X	X										
NP relationship – positive patient feedback	X	X	X	X	X	X	X	X	X	X	X			X
NP relationship – positive pt experience														
NP relationship – protecting patient							X							
NP relationship – patient-centred	X		X	X	X	X	X	X	X	X	X	X	X	
NP relationship – purpose/goals	X			X			X		X		X			
NP relationship – rapport		X	X	X		X	X		X					X
NP relationship – respect for patient		X		X	X			X			X	X	X	
NP relationship – restoring														X
NP relationship – senior nurse									X		X	X	X	
NP relationship – significance of	X	X		X				X	X	X				X
NP relationship – supporting – being there for patient		X			X		X		X	X		X	X	X
NP relationship – supporting – help in crisis							X			X				X
NP relationship – team splitting				X					X			X		
NP relationship – therapeutic	X	X	X	X		X	X	X	X		X	X		X
NP relationship – touch			X		X				X					
NP relationship – trust	X	X		X	X	X	X	X	X		X		X	X
NP relationship – untherapeutic/negative					X									X
Nurse – career path	X	X		X		X	X		X	X	X	X	X	X
Nurse – intrinsic rewards		X	X	X			X		X	X	X	X		X
Nurse – low self esteem											X			X
Nurse – own needs											X			
Nurse – own needs – inability to seek support											X			
Nurse – own needs – time out	X								X					

# APPENDIX J

## Interpretive plan (continued)

Raw Category / Participant Name	Collin	Paula	Susie	Jackie	Graham	Adam	Janet	Nick	Sophie	Hannah	Natasha	Rachel	Steph	Zoe
Nurse – positive self esteem														X
Nurse – skills											X			X
Nurse attitudes – poor / negative			X	X	X	X		X	X		X		X	X
Nurse attitudes – positive	X			X	X	X		X	X					
Nurse attitudes – senior management negative	X					X		X	X	X	X	X		
Nurse attitudes – valuing the patient	X			X	X									
Nurse behaviour – dress inappropriate				X										
Nurse beliefs – negative patient intent	X													
Nurse beliefs – positive patient intent	X													
Nurse capability – experienced	X	X		X	X	X	X	X	X	X	X	X	X	
Nurse capability – inexperienced	X	X	X	X	X	X	X		X		X	X	X	X
Nurse motivation – positive	X	X	X	X	X	X	X			X	X		X	X
Nurse motivation –negative	X	X		X	X		X			X	X	X	X	X
Nurse priorities – safety	X					X	X		X	X		X		X
Nurse qualities – accepting		X					X							
Nurse qualities - approachable		X		X										
Nurse qualities - beneficence											X			
Nurse qualities – care and compassion	X		X	X	X	X	X	X	X	X	X			
Nurse qualities – coping							X				X			
Nurse qualities – emotional strengths									X		X			
Nurse qualities - empathy	X	X	X	X	X	X	X	X	X	X	X			X
Nurse qualities - genuine	X		X	X		X				X				X
Nurse qualities – good listener							X				X			
Nurse qualities – high expressed emotion					X							X		
Nurse qualities - honesty	X	X	X	X	X	X	X	X			X	X		X
Nurse qualities - humour			X											
Nurse qualities – keeping promises				X			X							
Nurse qualities – motherly/parental			X	X					X					
Nurse qualities - negative											X	X		X
Nurse qualities – non-judgemental	X			X			X				X	X		
Nurse qualities – openness		X		X	X	X		X			X	X		X
Nurse qualities - patience				X					X			X	X	X
Nurse qualities – personality negative														X
Nurse qualities – personality positive					X	X	X		X			X		X
Nurse qualities – positive														X
Nurse qualities – selfishness											X			
Nurse qualities - unapproachable				X								X		
Nurse qualities – valuing diversity		X												
Nurse rewards – being human	X													
Nurse rewards – financial/employment terms						X								
Nurse rewards - negative														X
Nurse rewards – positive feedback family							X							
Nurse rewards – positive patient engagement	X									X			X	
Nurse skills – CBT	X			X										
Nurse skills – common sense											X			
Nurse skills - de-escalation					X				X				X	
Nurse skills – emotional				X							X			
Nurse skills – insight interpretation					X			X			X			
Nurse skills – intuition							X	X	X				X	
Nurse skills – judgement poor			X								X			
Nurse skills – judgement positive									X		X		X	
Nurse skills – learning from others			X											
Nurse skills – practical										X	X			
Nurse skills – rapport		X		X			X	X	X					
Nurse skills - reflection and analysis			X	X	X		X		X		X			
Nurse skills – self-awareness - limitations			X	X							X		X	
Nurse skills and values – crisis management												X		
Nurse skills and values – one to one												X		
Nurse story – motivation positive			X	X						X	X			
Nurse support – formal - MDT debrief														X
Nurse support – formal supervision	X		X	X		X			X		X			
Nurse support - inexperience			X								X			
Nurse support – informal family					X	X								
Nurse support – informal management	X	X		X							X	X	X	
Nurse support – informal peers	X	X	X	X	X			X	X		X		X	X
Nurse support – lack of support	X										X			
Nurse values – personal politics/agendas					X			X						
Nurse values – positive	X	X	X		X	X		X			X		X	X
Nurse values – positive personal history		X	X	X					X					X

# APPENDIX J

## Interpretive plan (continued)

Raw Category / Participant Name	Colin	Paula	Susie	Jackie	Graham	Adam	Janet	Nick	Sophie	Hannah	Natasha	Rachel	Steph	Zoe
Nurse vulnerability - assault	X	X	X	X	X	X				X			X	X
Nurse vulnerability - boundaries		X	X		X	X	X						X	
Nurse vulnerability - burnout									X			X	X	
Nurse vulnerability - complaints			X					X	X			X		
Nurse vulnerability – fear and anxiety		X		X	X		X							
Nurse vulnerability – inappropriate dress				X										
Nurse vulnerability – inexperience / uncertainty	X		X	X	X						X	X		
Nurse vulnerability – job security / uncertainty										X		X		
Nurse vulnerability – judgement poor			X		X	X							X	
Nurse vulnerability – own mental health	X	X	X		X	X	X				X	X		
Nurse vulnerability – patient betrayal								X			X		X	
Nurse vulnerability – patient suicide					X							X	X	
Nurse vulnerability - stress	X	X	X	X	X	X		X	X	X	X	X	X	X
Nurse vulnerability – unrealistic expectations				X	X				X		X			
Nurse vulnerability – verbal abuse		X							X			X		
Nurse vulnerability – violation and anger			X				X		X		X		X	X
Observation – continuous						X		X	X		X			X
Observation - intermittent							X					X		
Participant anonymity												X		
Patient – dependence											X			
Patient – labelling diagnosis			X											
Patient – medication concordance		X	X				X	X				X		X
Patient – popular		X				X								
Patient – risk assessment and management	X	X	X	X		X		X	X	X		X	X	
Patient – risks	X					X	X		X	X				
Patient – unpopular	X	X	X	X	X	X	X	X	X		X	X		
Patient – visible / invisible									X					
Patient behaviour – aggression	X	X		X	X	X	X	X	X	X	X	X	X	X
Patient behaviour – self-harm / suicide			X	X	X	X			X				X	
Patient behaviour – violence	X	X	X	X	X				X	X	X		X	X
Patient contact – planned	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Patient contact – unplanned		X	X		X	X	X	X	X			X	X	X
Patient diagnosis/problem – anxiety							X					X		
Patient diagnosis/problem – bipolar	X		X											
Patient diagnosis/problem – complex needs										X				X
Patient diagnosis/problem – depression			X		X		X	X				X		
Patient diagnosis/problem – deserving			X											
Patient diagnosis/problem – elderly							X							
Patient diagnosis/problem – homelessness							X							
Patient diagnosis/problem – mania							X							
Patient diagnosis/problem – paranoid	X		X	X			X					X		
Patient diagnosis/problem – personality disorder	X		X	X	X	X	X	X			X	X		X
Patient diagnosis/problem – physical health							X							
Patient diagnosis/problem – post-traumatic stress			X				X							
Patient diagnosis/problem – psychosis	X		X		X		X	X				X	X	
Patient diagnosis/problem – substance misuse	X	X	X	X	X		X		X			X		
Patient diagnosis/problem – trauma/abuse			X											X
Patient diagnosis/problem – self-harm						X	X				X			
Patient empowerment/advocacy - MIND										X	X			
Patient example - absconding					X									
Patient example - absconding												X		
Patient example – absconding												X		
Patient example – admission anxiety / depression					X									
Patient example – admission complex needs								X						
Patient example – admission emer. miscommunication						X								
Patient example – admission schizophrenia									X					
Patient example – advocacy							X							
Patient example – anxiety / depression							X					X		
Patient example – bipolar observation						X								
Patient example – boundaries one						X								
Patient example – boundaries transgressed													X	
Patient example – boundaries two						X								
Patient example – challenging			X									X		X
Patient example – challenging boundaries				X										
Patient example – challenging PD nurse unsupported	X													
Patient example – challenging untruthful										X				
Patient example – control and restraint/self-harm			X											
Patient example – demanding patient									X					
Patient example – detained pt v service need				X										

# APPENDIX J

## Interpretive plan (continued)

Raw Category / Participant Name	Collin	Paula	Susie	Jackie	Graham	Adam	Janet	Nick	Sophie	Hannah	Natasha	Rachel	Steph	Zoe
Patient example – disruptive patient				X										
Patient example – enforcing medication / patient choice						X					X			
Patient example – first admission						X								
Patient example – florid psychosis admission													X	
Patient example – forensic / sexual abuse				X										
Patient example – formal complaints												X		
Patient example – giving nurse feedback											X			
Patient example – hearing impairment / PD				X										
Patient example – hearing impairment / psychosis				X										
Patient example – manic dep/physical - hydrocephalus										X				
Patient example – mute patient													X	
Patient example – non-engagement									X					
Patient example – nurse safety							X							
Patient example – nurse vulnerability			X									X		
Patient example – paranoid acutely ill	X													
Patient example – paranoid schizophrenia												X		
Patient example – paranoid schizophrenia - threatening				X										
Patient example - Parkinson's disease							X							
Patient example – patient death												X		
Patient example – patient disclosure sexuality		X												
Patient example – patient power and control	X		X											
Patient example – PD self-harm positive experience						X								
Patient example – personality disorder													X	
Patient example – primary nurse substance misuse									X					
Patient example – private hospital transfer					X									
Patient example – psychosis							X							
Patient example – psychotic hostile					X									
Patient example – pt safety							X							
Patient example – readmission 'attention seeking'						X								
Patient example – schizophrenia							X							
Patient example – schizophrenia / alcohol problem				X										
Patient example – seeking readmission					X									
Patient example – self-harm			X											
Patient example – self-harm overdose							X							
Patient example – share hobbies/interests		X												
Patient example – staff manipulation						X								
Patient example – stigma				X										
Patient example – suicide attempt											X			
Patient example – therapeutic relationship														X
Patient example – transsexual female		X												
Patient example – unpopular forensic	X													
Patient needs – unmet											X	X		
Patient observation of nurses					X									
Patient qualities – honesty											X			X
Patient restrictions							X							
Patient risks - absconding	X			X	X	X	X		X			X	X	
Patient seclusion							X							
Patient story – feeling safe														X
Patient/relative complaints			X							X				
Patient-patient risks	X					X	X		X	X				
Primary / associate nursing / pt allocation			X	X	X	X	X	X	X	X	X	X	X	X
Public attitudes – negative stigma	X		X		X						X			X
Safety – patient			X			X	X			X				X
Safety – public														X
Safety – staff						X	X							X
Senior nurse – leadership negative									X					
Senior nurse – leadership positive										X				
Senior nurse capability - inexperience									X				X	
Staff power hierarchy			X			X								
Staff role – senior nurse								X				X	X	X
Staffing – agency	X		X			X						X		
Staffing – available resources poor			X											
Team working – MDT challenges											X			
Team working – MDT negative	X	X	X	X	X	X			X	X	X	X		
Team working – MDT positive	X	X		X		X			X	X				X
Team working – nurses negative	X		X	X	X		X			X		X		
Team working – nurses positive	X	X	X	X	X	X	X		X	X	X		X	X
WAMHS – service purpose	X	X		X						X	X		X	