Facilitating Recovery-Oriented Practice in Acute Inpatient Psychiatric Care Settings through Appreciative Inquiry

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Abstract

Significant efforts have been made to incorporate recovery-oriented practice (ROP) throughout the mental health service arena; however, implementing ROP in acute inpatient psychiatric care settings has proven to be challenging. The purpose of this research study was to explore how psychiatric nurses best engage in ROP in acute inpatient psychiatric care settings through the lens of Appreciative Inquiry. Four acute care psychiatric nurses who identified as practicing from a recovery-oriented lens were interviewed using semi-structured interviews designed to elicit best practice experiences. Interpretive phenomenological analysis was used to understand the nurses' experience of providing ROP. Data analysis revealed superordinate themes of (1) recovery-oriented practices and (2) barriers and recommendations. The findings demonstrated that the practices described by participants reflected the recovery literature to an extent, but appeared to be more in line with the ideals of relationship based psychiatric nursing practice. Further, the barriers and recommendations for ROP in acute inpatient psychiatric care settings suggested the need for a larger system change in order for psychiatric nurses to engage in practice that supports recovery. Themes that emerged hinted at a recovery-oriented practice dream, perhaps through the fostering of relationship based psychiatric nursing practice.

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Chapter 1: Introduction

Acute inpatient psychiatric care settings are rich with a variety of health care disciplines and models of care. There are very few health care settings where a nurse can be involved with both the forced injection of a chemical restraint to one patient and the collaborative discharge planning meeting with another patient and their family in the same shift, sometimes in the same hour. Given the obvious negative repercussions to both the nurse and the patient involved in a forced injection, efforts to support the latter approach to nursing practice are imperative.

Recovery-oriented practice (ROP) is an approach to care that is based on the belief that people with mental health challenges can live meaningful and fulfilling lives even with ongoing symptoms of illness (Anthony, 1993). Deriving from a strengths-based perspective, ROP focuses care on instilling hope, respecting individuality, and empowering personal choice (Mental Health Commission of Canada [MHCC], 2015). Recovery philosophy has been discussed for decades, yet the translation of recovery principles into clinical care has been slower to realize.

In contrast to the biomedical model's focus on diagnosis, symptom reduction, and risk management, the recovery model focuses on promoting choice and self-management and encouraging positive risk taking (Anthony, 1993; Gordon, 2013; Kidd, et al., 2015). Personal recovery has been differentiated from clinical recovery; while personal recovery is about getting one's life back on track and becoming a functional member of the community, clinical recovery is focused on reducing incapacity and achieving symptom relief and self-management strategies (Rosen & O'Halloran, 2014). The biomedical model and clinical recovery are prominent in acute inpatient psychiatric care settings, creating unique challenges to the full integration of ROP.

Appreciative Inquiry (AI) is an approach to organizational change that builds upon the strengths and positive core aspects of an organization (Hennessy & Hughes, 2014). AI and ROP share several distinct philosophical assumptions: they both focus on empowerment, they are both strength-based, and they both emphasize a positive, hopeful vision for the future (Clossey et al., 2011). AI empowers organizations and the staff within it, igniting a shift from a blame ideology to one which emphasizes strengths and opportunities (Hennessy & Hughes, 2014).

Purpose of this Research

In the spirit of AI philosophy, this research explores the positive, quality experiences of psychiatric nurses providing recovery-oriented care to patients in acute inpatient psychiatric care settings. This research explores how an AI approach demonstrates the strengths and successes of psychiatric nurses implementing ROP in acute inpatient psychiatric care settings.

Research Question

This research is intended to reveal insights into the following question: How do psychiatric nurses best engage in ROP in acute inpatient psychiatric care settings? This question was explored by interviewing psychiatric nurses who provide recovery-oriented care in acute inpatient psychiatric care settings. Psychiatric nursing has been identified as the largest professional body working in acute psychiatric care settings (Hanrahan et al., 2010). Psychiatric nursing has also been described as sharing similar values and philosophy to recovery (Barker, 2001). More details on methodology are provided in the methodology section of this proposal.

Benefits of the Proposed Research

Recovery and ROP are well-established and are recommended across the globe as essential to supporting people with mental health challenges (MHCC, 2015). However, there are significant gaps in translating this knowledge into practice and care. These gaps appear to be

more significant in acute care settings, where several barriers exist, such as the prominence of the biomedical model of care, challenging unit cultures, and a climate that is risk averse (Cleary et al., 2013). In fact, the literature points towards a need for a cultural shift for the adoption of a recovery-orientation to be substantial (Clossey & Rheinheimer, 2014).

With its focus on strengths and its shared values with recovery, AI may be useful in the incorporation and facilitation of ROP in acute inpatient psychiatric care settings. AI could help support the adoption of ROP by psychiatric nurses by building connections between the values of recovery and the values of psychiatric nursing. AI informed research could aid in the identification of practices that support ROP in acute inpatient psychiatric care settings, which can be built upon to further implement ROP.

Definitions

People receiving psychiatric care have been given several titles: people with lived experience, service users, consumers, clients, and patients. In acute inpatient psychiatric care settings, the title patient is more likely to be used. In a recovery-oriented approach, the choice should be given to the individual as to which title they prefer to hold, if any. However, in this research, the writer uses the title that is used in the literature to more accurately represent the literature as well as remove any bias towards one title.

The term recovery has also had many names including recovery movement, recovery model, recovery paradigm, recovery philosophy, and recovery-oriented services. For the purpose of this research, the term recovery is used to describe the concept of recovery (i.e. recovery philosophy) and the terms recovery-oriented services or recovery-oriented practice are used when describing the systems and approaches that are based on the principles of recovery.

Chapter 2: Literature Review

There is a vast array of literature around recovery and recovery-oriented services. This literature review begins with the broader concepts of recovery, including the history of recovery, varying definitions of recovery, and the importance of lived experience. Literature surrounding recovery-oriented services will be described and include the impact of the biomedical model and the characteristics of a recovery-oriented workforce, with special attention given to psychiatric nursing. Both community and inpatient services are discussed, however, emphasis will be placed on inpatient care settings due to the unique obstacles inherent in developing a recovery-orientation in these areas.

Finally, the literature focuses on the system transformation that is occurring as recovery is being incorporated into mental health and substance use systems. The literature described provides an overview of the approaches that have been tried to move such services toward a recovery-orientation. Here, the concept of AI is introduced, the unique similarities to recovery are explained, and how AI has been used to support system change in health care is explored.

While much of the literature describes the challenges with implementing ROP, the writer has integrated the spirit of AI throughout the research process and draws upon the positive aspects in the literature. Through this process, the writer anticipates eliciting hope for a fully integrated recovery-oriented mental health system.

Recovery

The recovery movement derived, in large part, from the grassroots consumer/survivor movement of the 1980s and 1990s. It pertains to a shift from viewing serious and persistent mental illness as a life sentence, to something that is one aspect of a quality, meaningful life (Anthony, 1993). Its most recognizable description is by Anthony (1993):

> Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (p. 15)

Anthony (1993) broadens the recovery concept to be a *human* experience that is beyond the notions of illness and disability. This is truly fundamental as it lays the groundwork that recovery can be experienced by helpers and those with lived experience alike; whether one is facing the impact of mental illness, the impact of trauma, the impact of marginalization, or the impact of a stroke, recovery is a universal experience.

History of Recovery

The recovery movement was prompted by the impact of deinstitutionalization, when the diverse needs of people with mental illness required more than mere symptom relief, but a complete reconceptualization of mental health care delivery (Anthony, 1993). Anthony (1993) explains that with the help of the World Health Organization's classification of the consequences of disease (i.e. disability), mental health services shifted away from treating the illness to treating the consequences of the illness. This is commonly known as psychiatric rehabilitation or psychosocial rehabilitation (PSR).

Today, recovery is recognized by many first world nations across the globe. In addition to Canada subscribing to a recovery-oriented approach to mental health and substance use services (Kirby & Keno, 2006), the United Kingdom, the United States, Australia, New Zealand, and other countries across the world have adopted a recovery framework to mental health care. More recently in Canada, the *Guidelines for Recovery-Oriented Practice: Hope, Dignity,*

Inclusion, has been developed to support mental health services adopt a recovery-orientation (MHCC, 2015).

In Canada, mental health recovery was born out of the consumer-driven movement of the 1960s and 1970s (Piat & Sabetti, 2012). Canadians with lived experience have been promoting recovery through a self-help network for over 25 years. According to Piat & Sabetti (2012), there have been three conceptualizations of recovery by Canadian researchers: (1) personal recovery, or the notion of living a full life despite mental illness; (2) recovery as personal empowerment, or the notion of a minority group breaking through the barriers of a constricting mental health system; and (3) recovery and social equality, or the notion that people with mental illness deserve the same opportunities for housing, employment, and other social determinants of health as other citizens.

While the Kirby report laid the groundwork for recovery in Canadian mental health policy, Piat and Sabetti (2012) explain that health care is under provincial jurisdiction. Each province has different historical, socio-cultural, and economic backgrounds, as well as different political leanings, populations, and service priorities. In spite of the provincial differences, Canada is one of many countries that views recovery as important to mental health.

Gordon (2013) described how recovery is based in two origins: (1) longitudinal studies of people with mental illness and (2) personal experiences of consumers through the consumer-survivor movement. Kirkpatrick (2008) recognized the quantitative (Harding et al., 1987) and qualitative (Deegan, 1988) evidence as the driving force behind recovery. These different backgrounds have caused confusion around the concept of recovery. Longitudinal studies resulted in the notion of ‘recovery from’ mental illness, also viewed as the elimination of symptoms, while the consumer movement resulted in the notion of ‘recovery in’ mental illness,

when one retains control and meaning in life despite present or recurring symptoms (Gordon, 2013). As Gordon (2013) described, the misperception arises when one group believes that those who 'recover from' the symptoms of mental illness, do not need to 'recover in' the distress caused by the *consequences* of mental illness. Recovering from the social consequences of mental illness has been identified as more important and more challenging than recovering from the illness itself (Bonney & Stickley, 2008). According to Harding et al. (1987), only some of those recovered were actually symptom free.

Gordon (2013) offered an alternative model of viewing the two constructs of recovery: viewing one as an outcome (longitudinal studies) and one as a process (consumer-survivor movement). Interestingly, Gordon (2013) cautioned that exclusive focus on process implies that there is no end to the journey, likening process to the experience of 'chronicity' and hopelessness experienced by consumers. She challenged that outcome is just as important as process and that this is unconsciously recognized in consumer recovery, despite the conscious rejection of outcome. Gordon (2013) provided several examples of this, including Anthony's (1993) definition of recovery as a *process* of growing beyond the catastrophic effects of mental illness towards an *outcome* of living a hopeful, satisfying, and purposeful life.

Defining Recovery

Much of the literature described the challenges in defining and measuring recovery; some have stated that this is the reason for the disjointed uptake in the mental health care arena (Anthony, 1993; Gordon, 2013; Leamy et al., 2011). Bonney & Stickley (2008) described six themes in British literature on recovery: "(1) identity, (2) service provision agenda, (3) the social domain, (4) power and control, (5) hope and optimism, and (6) risk and responsibility" (p. 141).

Bonney and Stickley (2008) emphasized that people need to recover from the effects of illness, diagnosis, and treatment, not merely from the illness itself. Further, personal power and self-responsibility are essential parts of a service user's recovery, but the reality of a rigid practice system does not always reflect that philosophy (Bonney & Stickley, 2008). Several articles described how power is given back to the service user through user-centred initiatives, while one author (Jacobson, as cited in Bonney & Stickley, 2008) warned against giving the illusion of power where none really exists (i.e. tokenism).

Leamy et al. (2011) developed a framework for personal recovery in mental health to inform recovery-oriented research and practice. Their systematic review resulted in a conceptual framework with three superordinate categories: (1) characteristics of the recovery journey, (2) recovery processes, and (3) recovery stages. The recovery processes resulted in the CHIME framework, which stands for "connectedness, hope, identity, meaning, and empowerment", and has the most impact on clinical research and practice (Leamy et al., 2011, p. 449). The CHIME framework provides clarity to the ambiguous concept of recovery; characteristics of the recovery journey provide clarity about the philosophy, recovery processes provide measurable dimensions of change, and recovery stages provide a framework for implementing stage-specific clinical interventions and evaluation strategies (Leamy et al., 2011).

Stuart et al. (2017) described four additional themes to the CHIME framework in their best-fit framework synthesis: (1) difficulties, (2) therapeutic input, (3) acceptance and mindful awareness, and (4) returning to, or desiring, normality. The *difficulties* theme is distinguished as important since all other themes consider only positive aspects of recovery (Stuart et al., 2017). Failing to acknowledge the challenges in the recovery experience can result in people feeling like they are 'failing at recovery' if they struggle with the other concepts (i.e. lack hope or

connectedness). Further, failing to acknowledge the difficulties can promote a neo-liberal view of responsibility where individuals can always succeed, regardless of financial or social circumstances (Stuart et al., 2017; Vandekinderen et al., 2014). There appears to be a fine line between individual empowerment and off-loading of societal responsibility.

While some literature identifies the challenge of defining recovery as a key barrier to implementation or ROP, the last decade of research in this field has shown significant breakthroughs in clearing up the concept of recovery. This literature includes both qualitative and quantitative studies as well as a rising number of studies driven by people with lived experience.

Importance of Lived Experience

Lived experience is highlighted as an essential component of recovery and should be interwoven throughout recovery-oriented mental health services. Kidd et al. (2015) shared that participatory approaches are necessary in the development of recovery-oriented services. As discussed by Slade et al. (2012), these services are inherently collaborative and partnership-based, and take direction from the 'experts by experience'. Participatory action research has been described to share similar principles as recovery, including the principles of inclusion, empowerment, and social change (de Wolff, 2009). In Kidd et al.'s (2015) participatory study, people with lived experience described recovery as "an ongoing quest in life" and other key themes included finding meaning, an invisible disability, empowerment and agency, connection, and recovery takes time (p. 185). Predominant in participants' discussions was the importance of moving forward and finding meaning and hope while managing mental illness (Kidd et al., 2015).

Local mental health services can be influenced by consumers by "systematically integrating lived experience perspectives … [and challenging] a paternalistic biomedical approach and hierarchical organizational structures" (Anthony & Huckshorn, 2008). Transformation occurs in the exchanging and combining of different knowledge bases between consumer, caregiver, and clinician. Health professionals supporting people with mental illness must support and encourage self-management approaches, much like clinicians treating people with chronic disease; a better balance must be established between following clinical guidelines and supporting recovery (Kidd et al., 2015). This can be done through collaborative partnerships where consumers are empowered to become experts by experience.

Hungerford and Fox (2014) asked consumers about ways of improving services in a community setting. Interestingly, solutions did not necessarily involve a need for additional funding, rather they involved a change in commitment of health professionals (Hungerford & Fox, 2014). One participant plainly stated: "Three words. Listen to us" (Hungerford & Fox, 2014, p. 212). For consumers, when health professionals actively listen to what they have to say about their experiences, this leads to an increase in confidence and feeling of support in their journey towards self-determination. This approach is aligned with the psychiatric nursing aspirational practices of active listening and compassion. Participants also suggested greater collaboration and cooperation between various services and for improvements in continuity of care between hospital and community settings (Hungerford & Fox, 2014).

Including a peer workforce is another powerful way to ensure that lived experience perspectives exist in mental health services at all times. Peer workers are individuals with lived experience of mental health or substance use disorders who are trained in the peer worker role and hired into a variety of healthcare settings (Gagne et al., 2018). Their personal experience

with mental illness or substance use and their experience in navigating the health care system is invaluable to both clients in care and the professionals providing care.

The knowledge of those with lived experience is an essential component of ROP. Mental health services can embrace lived experience in many ways: by collaborating around care, by respecting individuals as experts in their own life, by acknowledging the knowledge base and experience of individuals, and by incorporating the expertise of peer workers in the health care team.

Recovery-Oriented Mental Health Services

The recovery movement has shaped the services for those with mental health challenges. This section will review and describe the characteristics of a recovery-oriented mental health service, the impact of the biomedical model, the role of medication in recovery, and the characteristics of the workforce. Emphasis will be placed on the psychiatric nursing workforce and inpatient care settings.

Anthony (1993) described how the recovery vision guides a recovery-oriented mental health system. Existing services can provide a more holistic approach by shifting beyond the objectives of symptom relief, for example, and toward including subjective outcomes such as self-esteem and empowerment. Rosen and O'Halloran (2014) urged the need for a full, wholesome range of mental health services for people with mental illness. Since mental illness has a multifaceted etiology, its most effective treatment is multimodal and can include pharmacological, psychological, social, and cultural approaches (Rosen & O'Halloran, 2014). The complexity of mental illness can lead to a fractured understanding around what should be a holistic treatment model.

The findings of research, practice-based evidence, and the perspectives of people with mental illness and their families all point toward a need for a comprehensive and integrated system of care that is centred in the community (Rosen & O'Halloran, 2014). Described another way, Rosen & O'Halloran (2014) stated that the centre of gravity of mental health services must shift from being 'hospital-centric' to being 'outreach' and community based, with 'in-reach' to hospital only as needed. This means that the relationship and collaboration between community and acute care partners is integral to supporting the people who use these services. It is also integral for the care approach in the acute care environment to be consistent with that of the community environment.

Vandekinderen et al. (2014) sharply criticized the approach to recovery where individual responsibility is prioritized, as it does not consider the lack of choice and resources available to people seeking to make a life for themselves. The authors further demonstrated this paradox in the following statement:

> When the concept of recovery is grounded in the idea of holding individuals with mental health problems accountable for their own recovery, their entitlement to proper care and support is easily denied; … scarce resources are covered under the veil of autonomy, choice and empowerment. (Vandekinderen et al., 2014, p. 1427)

Recovery-oriented mental health services must understand that empowerment and the promotion of personal choice does not equate to less need for services. Rather, the resources and services are needed more than ever and they need to be defined by the people who are receiving them.

Biomedical Model

Jacob (2015) challenged psychiatric medicine by describing the 'failed promises' of psychotropic medicine, that this form of treatment has not successfully helped people get their

'life back on track'. He described how recovery can be supported by helping people develop healthy relationships, financial security, and employment, and by providing a safe and supportive environment in times of crisis (Jacob, 2015). Several suggestions on how to support recovery are offered in the conclusion of Jacob's (2015) article, with emphasis placed on engagement, empowerment, and community involvement. He also included specific tools (i.e., WRAP and Recovery Star) and websites, which mental health professionals can (and should) add to their repertoire of practice tools.

People need to find their own meaning for the experience of mental illness and this needs to be supported and accepted by clinicians (Kidd et al., 2015). Further, the invisibility of mental illness makes finding recovery more challenging. Clinicians need to facilitate the knowledge and skill of self-management and focus less on pharmaceutical interventions (Kidd et al., 2015). This pharmaceutically based focus of treatment in acute care causes consumers to progressively lose hope through their contact with mental health services and increased use of medication. Jenkins and Carpenter-Song (2005) reflect this sentiment in their study where participants had to grapple with the paradox of 'recovery without cure', choose between 'being fat and drooling or being crazy' and experience the enjoyment of life being taken away by medication, while at the same time being told by health professionals to 'enjoy their life'. Consumers voice that the biomedical model continues to dominate health service organization as a whole, while undermining the consumer-centred approaches to service delivery (Hungerford & Fox, 2014).

Medication. With regards to recovery and medication treatments in psychiatry, Stratford et al. (2013) noted that recovery encourages careful thought on the impact of medication, such as side effects, and emphasized the importance of person-centred assessment on the benefits of medication use. Some challenges around shifting medication practices to a recovery-orientation

include the use of medication as a first line treatment and the frustrating and potentially dangerous side effects of these medications (Stratford et al., 2013). While these challenges might raise questions around the use of medication within the recovery paradigm, Stratford et al. (2013) proposed that medications can be used when the person receiving them is given a choice that is supported with informed consent.

Stratford et al. (2013) described how medication aligns with personal recovery with the promotion of knowledge, self-care, and taking responsibility for one's life, and with tailoring treatment approaches to the individual's unique preferences and needs. The authors then took a deeper look at the challenges. For instance, the fact that medication has been the central focus of psychiatric treatment has resulted in professionals lacking skills in other mental health treatment strategies (Stratford et el., 2013). Stratford et al. (2013) identified that medications are overvalued beyond their effectiveness and too-heavily relied upon. Further, medication adherence has been closely linked to safety and risk management, resulting in involuntary treatment approaches where "coercion [is] used as currency for engagement and treatment" (Stratford et al., 2013, p. 551). The emphasis on medication as the first line treatment for mental illness can exacerbate the power imbalance by relying on the expertise of the professional and by minimizing the consumer's role and knowledge in their recovery (Stratford et al., 2013).

Stratford et al. (2013) explained how the shift to using medication from a recovery-oriented perspective happens when the experience and expertise of consumers and health professionals are equally embraced. This notion is seen with the practice of supportive decision making and in viewing the patient as the expert in managing their own wellbeing. When the consumer and health professional recognize each other's knowledge and strengths, a respectful environment is created where medication and its potential therapeutic benefits can be considered

(Stratford et al., 2013). The role of mental health professional is to support medication use while respecting other interventions and the consumer's personal experience. Rather than viewing non-adherence as the consumer having poor insight, Thorne (1990) urged mental health professionals to view non-adherence as the consumer making attempts to build confidence, feel in control of their health, and address the power imbalances felt between themselves and their medical team. Compliance involves two parties and rarely is the role of the professional scrutinized.

Stratford et al. (2013) concluded their article by offering several strategies mental health professionals can use to support recovery and the use of medication. They powerfully state:

> The freedom to choose is potentially liberating and positive for consumers – it enables greater respect for other evidence-informed interventions, including what peer support workers and family/carer roles might offer. It focuses on the person, how they understand their mental health issues and what they think will help or are prepared to try in the context of their situation and goals. (Stratford et al., 2013, p. 552)

Finally, the authors acknowledge the concerns clinicians may have in their beliefs that they must enforce medication adherence in order to minimize risk, but point out the growing changes in legislative reform that support consumer empowerment and autonomy in these processes (Stratford et al., 2013).

Inpatient Care Settings

As for inpatient care, Rosen and O'Halloran (2014) shared that the recovery approach can be supported by respecting and strengthening individual choice and the therapeutic alliance more systematically, and by ensuring safe and effective treatment and support. The authors stated that "if interventions are based on individual choice, are humane and empowering, evidence-based,

alleviate suffering and distress, and are potentially healing, then they should be included under the recovery umbrella" (Rosen & O'Halloran, 2014, p. 105).

Cleary et al. (2013) described how the attitudes, beliefs, and approaches by health professionals are central to facilitating recovery in mental health services. Employees must act as a guide or a partner, rather than an expert; they must give service users knowledge and empower them to engage in their treatment and prepare for future crises (Cleary et al., 2013). Employees must also respect a person's knowledge of their own needs. Although hospitalization typically occurs for only brief periods in one's life, it is a crucial time during the recovery process and it is an important opportunity for professionals to help them continue the path once discharged (Cleary et al., 2013).

Despite recovery being a guiding principle in mental health settings, there is still a lot of ambiguity around recovery (Cleary et al., 2013). Education and training are needed for nurses to learn practical ways in which nurses and service users can contribute to the recovery process. Further, there are several key aspects of recovery that are not viewed as a function of acute care, such as processing trauma, reintegrating in the community, and developing friendships (Cleary et al., 2013). The authors identified the lack of time and the busy workloads of nurses as a barrier to supporting these recovery processes. ROP in acute inpatient psychiatric care settings requires system wide change, working in partnership with providers, comprehensive training, and ensuring seamless coordination across services, particularly between hospitals and community. Ultimately, nurses are well positioned to develop recovery strategies in partnership with service users so they can make informed choices about their care (Cleary et al., 2013).

Substance Abuse and Mental Health Services Administration (SAMHSA, 2011) developed a list of ten recovery principles:

> Recovery (1) emerges from hope, (2) is person driven, (3) occurs through many pathways, (4) is holistic, (5) is supported by peers, (6) is supported through relationships and social networks, (7) is culturally based and influenced, (8) is supported by addressing trauma, (9) involves individual, family, and community strengths and responsibility, and (10) is based on respect. (p. 4-7)

Davidson et al. (2016) pointed out confusion in SAMHSA's list in that there is no differentiation between recovery and recovery-oriented care. Recovery is the process a person goes through to manage their illness and finding meaning in their life, while recovery-oriented care is what health care providers do to support and enhance a person's own efforts towards recovery (Davidson et al., 2016).

Despite a person having lost some degree of decision-making capabilities, Davidson et al. (2016) urged the necessity for staff to connect with the person behind the illness. One reason is that no matter how restrictive the hospital setting is, the vast majority of people who are discharged, return to the community to make their own decisions and manage their own health. The focus on inpatient care needs to be on how to bolster self-management, rather than on how to reduce the symptoms of mental illness (Davidson et al., 2016). It is essential to focus care around informing, educating, and role modeling self-care strategies. For example, staff should encourage patients to use medication as a tool for recovery, rather than take it because they were told to.

In inpatient care, the literature around patients' experience of psychosis during hospitalization described the need to feel safe, understood, respected, and trusted (Koivisto et al.,

2004). For example, during the acute phase of illness, patients have described their need for safety and support by psychiatric nurses, and that interventions should be tailored towards structure and empathy in line with the patients' distress (Koivisto et al., 2004). Furthermore, psychiatric nurses should engage in continuous discussions with patients, and empower patients sense of being able to manage their daily life (Koivisto et al., 2004).

Barriers and Challenges in Inpatient Settings. While literature identifies some advances in recovery-oriented inpatient care, the reality shows that recovery is far from reaching the corners of acute inpatient psychiatric care settings (Cleary et al., 2013). For a fully integrated recovery-oriented acute inpatient care setting to be realized, the challenges and barriers must be acknowledged. There have been and continue to be injustices done to patients by nurses in these settings (Slemon et al., 2017). Slemon et al. (2017) cautioned that the focus on safety and risk in psychiatric inpatient settings has led to a breakdown of trust between staff and patients. For example, there is a perception that strategies such as seclusion are necessary for safety, however, "this perception eliminates the place of self-reflexivity and ethical reflection in nursing care, creating automatic justification for nursing practice" (Slemon et al., 2017, p. 2). Seclusion and other risk management strategies continue to be justified despite strong evidence that they are harmful to patients (Slemon et al., 2017).

Waldemar et al. (2016) described several other challenges and barriers to facilitating recovery-oriented practice in acute inpatient psychiatric care settings. Increasing acuity levels, capacity challenges, workload pressures, and unpredictable situations all result in staff having less time to engage with patients in their recovery, and more time working from a crisis and problem driven approach (Waldemar et al., 2016). Further, the compulsory and often coercive nature of inpatient psychiatry is paradoxical with the principles of recovery (Waldemar et al.,

2016). Finally, with the misunderstandings of recovery principles and difficulties in translating these into the inpatient setting, there needs to be clarification around what recovery-oriented practice looks like in this setting (Waldemar et al., 2016).

Psychiatric Nursing

Delaney (2010) explained that while psychiatric nurses have been engaging in recovery-oriented initiatives and care models for some time, they are far from fully incorporating recovery into practice and often misunderstand the concept. By engaging in respectful dialogue, however, and by reconnecting with the philosophical roots of the profession, psychiatric nurses might begin to relate with recovery. A prominent theme in Delaney's (2010) article was the notion of dialogue based on respect and equality. Psychiatric nursing is fundamentally about healing relationships and supporting one to redefine their sense of self through personal narrative, which are concepts that align well with recovery. What Delaney (2010) proposes is that psychiatric nurses can come to fully embrace recovery through reconnecting with the relational roots of their profession.

Kirkpatrick (2008) explained how stories are common in the health care system and have the potential to shift the beliefs of the listener and ignite reflective practice. However, stories can also put health professionals in a powerful position (Kirkpatrick, 2008). For instance, when a patient is labelled as aggressive or noncompliant, this can freeze the patient's story line and limit their potential outcomes. A health care provider's stories may reflect negative perspectives of the patient's social worth, not to mention entirely exclude the perspective of the patient themselves. On the contrary, a nursing report describing the strengths and successes of a patient can positively alter the way the health care team views and cares for them.

Storytelling can be a powerful method to support the shift towards a recovery paradigm, both on the personal/individual level as well as in the broader program and societal context (Kirkpatrick, 2008). In the acute care environment, the telling, listening, and sharing of stories can be significant in the relationship between a nurse and a patient; the reshaping of a patient's story has the potential to shift the perspective of the larger health care team and ultimately impact on a system level (Kirkpatrick, 2008). Rosen and O'Halloran (2014) emphasized the need for a workforce that is trained and qualified to provide accessible, welcoming, and trauma-informed services, and that these services are provided fairly and equitably.

Bonney and Stickley (2008) warned that the rigidity of current mental health systems and their focus on risk and outcomes can break a person's identity and destroy hope for a recovery-oriented mental health system. In addition, Cusack et al. (2016) found that nurses believed that the symptom-focused approach to mental health delivery was a key barrier to facilitating ROP. Fortunately, psychiatric nurses can and do practice from a recovery perspective within the confines of rigid health care structures (Cleary et al., 2013). Cusack et al. (2016) described several ways in which psychiatric nurses practice ROP: by engaging in collaborative partnerships with community and peer support; by fostering the caring aspect of their profession; by communicating, listening, and conveying hope; and by engaging in comprehensive assessments and psychosocial interventions.

Davidson et al. (2016) shared that psychiatric nurses are vital in setting the standard for ROP, and in demonstrating respect and collaboration with all patient and staff interactions. Nurses are said to historically have great influence in the milieu of a unit and can influence certain policies and care practices to be recovery-oriented (Davidson et al., 2016). For instance, psychiatric nurses can advocate for less restrictive practices, such as controlling items a patient

may possess, or the people a patient may have to visit. Even within a restrictive environment, psychiatric nurses can influence how safety measures can become recovery-oriented.

Literature points towards a need for cultural transformation in order for inpatient mental health services to fully embrace a recovery-oriented approach to care. Delaney and Lynch (2008) claimed that psychiatric nurses play a key role in this transformation, which must begin with innovation within their role in inpatient care. Inpatient psychiatric nurses must understand how attitudes, practices, and larger organizational structures influence nurses' sense of empowerment (Delaney & Lynch, 2008). A study by Brennan et al. (2008) showed how nurses working on units with high turnover, low staffing rates, and high levels of patient self-harm and violence were extraordinarily vigilant about risk, and subsequently, unable to be curious about potential practice change. On the contrary, inpatient nurses have become empowered through the Safewards model, where nurses initiate ways to improve the staff-patient relationship and, thereby, reduce incidents of conflict and containment (Bowers et al., 2015). Creativity, curiosity, and willingness to take risks appear to be essential staff characteristics for system transformation to be possible.

Appreciative Inquiry

The literature review on AI will explore the utility of AI in health care, mental health services and research, and in the implementation of recovery-oriented practice (ROP) in these services. AI is a model that supports transformational change in organizations; it is a process that helps organizations facilitate change by focusing on the positive core values of the organization, creating a shared vision, and inspiring action for change (Trajkovski et al., 2013). The process involves the '4D' approach where participants *discover* the strengths and best practices of the organization, *dream* of what could be and how to turn problems into innovative

solutions, *design* a future by envisioning the ideal organization, and enact their *destiny* by engaging in positive change (Hennessy & Hughes, 2014).

An essential assumption of AI is that dialogue can either enhance or inhibit organizational growth (Trajkovski et al., 2013). Engaging the workforce through dialogue and empowerment is one reason that this method has been so successful in influencing organizational culture. Dialogues that focus on problems can contribute to a negative and draining culture and thereby reduce the organization's potential for positive change (Trajkovski et al., 2013). Another assumption of AI is that whatever people, groups, societies, or organizations focus their energy on becomes their reality (Trajkovski et al., 2013). This belief is shared by renowned psychiatrist David Hawkins (2009) in the following excerpt:

> Problems are best solved not on the level where they appear to occur but on the next level above them… Problems are best solved by transcending them and looking at them from a higher viewpoint. At the higher level, the problems automatically resolve themselves because of that shift in point of view, or one might see there was no problem at all. (p. 176)

By creating and focusing on a collective vision, organizations can generate change and enhance practice.

Appreciative Inquiry in Healthcare

AI was originally developed to be used in the business sector, but has increasingly been used in other areas, including the health care sector. The literature in this section will describe how AI is used in healthcare and include the successes and opportunities of AI in these settings. Trajkovski et al. (2013) asserted that with the existing public dissatisfaction with poor quality health care, AI is a promising tool that can engage the workforce and facilitate organizational

change. When positive dialogue is used and a collective vision is generated, people tend to bring forward the positive aspects of the past. Cooperrider and Srivastva (as cited in Trajkovski et al., 2013) share that "AI acknowledges that different social realities co-exist within groups and considers people's voice and contributions as equally valid and important (regardless of social status) resulting in a stance of freedom, liberation, solidarity, and social construction" (p. 96). This notion challenges the hierarchy in the health care arena, placing all health care participants' opinions on the same level. Similarly, recovery principles call for service users to be active participants in health care system change.

Participants of AI are considered co-researchers (Trajkovski et al., 2013), much like participatory action research, which has also been used in relation to mental health recovery. Other areas of healthcare where AI has been used are in the evaluation and change of clinical processes, the exploration of professional development initiatives, the creation of team visions, and in the improvement of the work environment (Richer et al., 2010). Cowling (2001) notes that the nursing profession shares similar philosophical values to AI, in that they are both curious about the uniqueness and wholeness of human life. This suggests an opportunity to blend research with practice and supports the use of AI in recovery and psychiatric nursing practice.

Watkins et al. (2016) explored the utilization of AI in changing nursing practice in inpatient care settings. They described a culture of defensiveness, blaming, and denial in current nursing practice, including an overall indifference to human suffering, and proposed that AI's use of engagement and its focus on strengths might liberate nurses to improve and enhance their practice (Watkins et al., 2016). Further, through the dialogue and celebration of peak practice experiences, nurses might shift their perceptions of poor-quality patient care. By stimulating positivity, AI can enhance disciplinary resilience and can assist with understanding group

dynamics (Watkins et al., 2016). The negative accounts of modern nursing practice can become catalysts for change and the focusing on core strengths and values can inspire this change.

Ultimately, Watkins et al. (2016) identified three themes in their study: (1) AI as a democratic process, (2) AI as a knowledge translation strategy, and (3) AI to facilitate and sustain change. In the first theme, the authors described themes of inclusiveness and interaction between different disciplines. The shift away from hierarchical change management was considered refreshing and the focus on strengths was experienced as uplifting (Watkins et al., 2016). Participants established trust, engaged in dialogue and teamwork, and eradicated any existing mistrust, although challenges can occur when the goals of the participants differ from the goals of the organization (Watkins et al., 2016). In the second theme, AI is used as a knowledge translation strategy or as a means of engaging participants in quality improvement strategies (Watkins, et al., 2016). Engaging participants in knowledge translation can lead to successful implementation of evidence-based practice. In the third theme, the studies that focused on facilitating and sustaining change were extensive and used the 4D approach of AI (Watkins et al., 2016). The effectiveness of AI strongly depended on the skill of the facilitator and the organizational follow-up (Watkins et al., 2016).

A study by Scerri et al. (2015) explored how AI could be used to enhance person-centred care in acute care dementia wards. Studies suggest that there are several missed opportunities to employ person-centred care in dementia care wards. In this article, Scerri et al. (2015) sought to explore quality dementia care, including positive experiences, from the perspectives of both staff and family members of inpatients with dementia. All participants were able to describe experiences where they felt satisfied with the level of care provided to patients with dementia (Scerri et al., 2015). Participants shared stories and uplifting experiences of quality patient care

and were also asked what made these experiences possible. Scerri et al. (2015) concluded that personal attributes of care workers, organizational factors, physical environment, and managing resources were all important factors in supporting quality dementia care in these settings. This research is a great example of how AI can support our understanding of improving patient-centred care in hospital settings. By exploring the positive experiences of dementia care provision, participants can help articulate what factors or attributes are connected to person-centred care (Scerri et al., 2015). Having this knowledge can help leadership focus on what is needed to enhance quality of patient care.

AI has also been used to improve approaches to clinical risk in mental health settings. Aggett et al. (2012) did a study at the Child and Adolescent Mental Health Services (CAMHS) in the United Kingdom (UK) following a series of unfortunate high-risk incidents. The goal of this study was to raise awareness and responsiveness to clinical risk, to reframe risk awareness as a positive aspect of the organization, and to create a context where risk might be predicted (Aggett et al., 2012). Following the high-risk incidents, the employees of CAMHS expressed an increased level of fear around risk. In planning this approach, Aggett et al. (2012) discovered two discourses on clinical risk. The first has to do with protocol, policy, and procedure and looks to past situations (retrospective model). The second looks at team responsiveness, clinical judgement, and how risk might be reduced in the future (prospective-responsive model) (Aggett et al., 2012). Both perspectives are considered important, but the latter is considered more progressive. With an AI approach, Aggett et al. (2012) look towards the organizational processes that are working well and envision processes that would work well in the future.

Aggett et al. (2012) hypothesized the concept of *benign invigilation*, an organizational value where staff can speak up about potentially sensitive issues of the practices of their

teammates without offending them. In other words, rather than being afraid to question a colleague's decisions around clinical risk, staff can openly and respectfully discuss their views and differences of clinical opinion. Aggett et al. (2012) suggest this is a method of merging the two risk discourses; it is a protocol that looks towards improving future practice.

Aggett et al. (2012) described a series of workshops they conducted with the CAMHS teams where participants were grouped into pairs to interview each other about particularly complex cases where difficult decisions around risk were made. The partner-interviews were to focus on what the participants felt was done right and highlight the strengths that came of the challenging situation (Agget et al., 2012). The feedback indicated that the workshops improved the quality of team discussions, but that the pragmatic measures of improvement were less impacted. Aggett et al. (2012) shared that they could have been more systematic and comprehensive around monitoring the impact of the workshops. Ultimately, this study demonstrates how strengths can be elicited through appreciative interviews and how risk can be viewed from a positive lens, a notion that has been mentioned in literature around recovery-oriented practice in acute care.

Appreciative Inquiry and Recovery

This section will explore the philosophical similarities between AI and recovery and describe studies that used AI to enhance a recovery-orientation in mental health settings. AI and recovery share several distinct philosophical assumptions: they both focus on empowerment, they are both strength-based, and they both emphasize a positive, hopeful vision for the future (Clossey et al., 2011). The literature demonstrates the significance of AI as a tool for research on facilitating recovery-oriented practice.

Clossey et al. (2011) described how client empowerment is an essential component of ROP and how staff empowerment is important in organizational change. Clossey et al. (2011) described the main tenets of the recovery model, highlighting its contrast to the medical model and how "such different worldviews implicitly engender disparate cultural perspectives" (p. 269). They suggested that staff who are accustomed to hierarchical cultures are not usually empowered to contribute to change of their organization. Further, implementing a client-driven model in organizations that are focused on illness and risk poses additional challenges, as previously discussed. Since the recovery model involves a shift in the way clients are perceived and provided with service, a shift in an organization's attitudes and values is imperative (Clossey et al., 2011). Organizational culture must be addressed if real change towards recovery is to happen, and AI can ease this shift by carefully and gradually shifting the dominant discourse.

Clossey et al. (2011) described how AI differs from other change methods by focusing on positivity rather than finding solutions to problems, which is akin to recovery's focus on client strengths. Other similarities include AI's emphasis on envisioning and creating a positive future and recovery's values of hope, healing, and empowerment. Clossey et al. (2011) also described the AI process as an effective antidote to professionals' unconscious and conscious difficulties adapting to recovery. The AI process elicits participants' values and when the appreciative perspective is experienced, participants become receptive to philosophical transformations of their organizations (Clossey et al., 2011). Through a dialogue of inquiry, questions are posed in a positive frame of what 'the best is' or 'has been'. AI is a guided dialogue that ultimately shifts how participants approach issues in the organization.

Clossey et al. (2011) discovered that using the AI process in two community mental health settings led to staff feeling hope for the future and being able to shift their focus away

from limitations and toward possibilities. Staff also discovered creative and pragmatic ways to implement recovery practices in their organization (Clossey et al., 2011). In summary, Clossey et al. (2011) stated that care provider attitudes and behaviours are noted to be key targets for change in recovery implementation. Irrespective of policy change, programming, and education, recovery cannot happen without the fundamental shift in values and attitudes about people with mental illness. Further, any new initiative in health care is often perceived as 'just lip service', however, Clossey et al. (2011) promote culture change as the antidote to such 'lip service'. AI is a tool that changes discourse and, as such, is well-suited in assisting organizations to create a recovery-oriented culture.

Another study by Chen et al. (2014) explored how AI can be used in the development of recovery education for inpatient mental health providers. In response to the unique challenges of implementing ROP in acute inpatient care settings, Chen et al. (2014) developed an educational program that utilized AI to improve the recovery knowledge of mental health professionals in these settings. The program allowed inpatient staff to share dialogue around difficult patient-related situations and reconceptualize the situations from a positive, recovery-oriented stance (Chen et al., 2014).

Chen et al. (2014) described existing recovery education programs to be too generic and focused on the community context; the programs failed to address the unique challenges to facilitating recovery in acute inpatient settings. The authors described three education theories that were used in the design of the education program: (1) adult learning theory, (2) interprofessional education, and (3) the Appreciative Inquiry (AI) approach. The education was designed in response to a needs assessment and the recovery competency framework for inpatient care provers (Chen et al., 2014). Part one of the program includes a user manual and an

interactive lesson on DVD that consists of three sections: (1) basic recovery concepts such as factors associated with recovery and strategies to promote recovery; (2) the tension-practice-consequence model which looks at different levels of tensions in the inpatient setting and their impact on relationships between inpatients and care providers; and (3) the recovery competency framework which describes eight core competencies for inpatient care staff to provide recovery-oriented services (Chen et al., 2014). Part two of the program involves group learning where two learning models, 'encouraging participation' and 'strength-based practice' are explored using real-life inpatient practice dilemmas. The groups of learners applied the 4D cycle of AI to the dilemmas and used their strengths to transform their current practice to one which is recovery-oriented (Chen et al., 2014). This article supports the use of a self-learning program to improve the recovery knowledge of mental health professionals working in acute care. It also supports the use of AI in addressing tensions and unique challenges of facilitating recovery in the acute care context.

Hennessy and Hughes (2014) explored what AI looks like in the research of mental health services. The appreciative interview process allows participants to look inward and discover their successes while identifying ways of improvement. Cooperrider et al. (2008) propose three stages of the appreciative interview process: (1) questions about peak experiences, (2) questions centred around the actualities, and (3) questions about what the future holds. The first part evokes a real experience and narrative around the participants best experiences (past or present) and the second and third parts allow the participants to envision the possibility for a better future.

As shared earlier, Kirkpatrick's (2008) article on storytelling also emphasized the importance of narrative as a powerful tool to shift towards a recovery paradigm, both on an

individual level and in the broader context. In the acute care environment, sharing stories can be powerful in the nurse-patient relationship, and reshaping a patient's story has the potential to shift the perspective of the health care team (Kirkpatrick, 2008). AI's emphasis on strengths and appreciative dialogue render the approach as well-suited to research around recovery.

Chapter 3: Methodology

The research question is as follows: How do psychiatric nurses best engage in ROP in acute inpatient psychiatric care settings? Since the research question aims to expand understanding of psychiatric nurses greatest experiences in providing ROP in acute inpatient settings, phenomenology is a suitable methodology. As a research method, phenomenology values the subjective human experience to give meaning and truth to phenomenon (Smith et al., 2009). In interpetive phenomenology, or 'hermeneutics', the subjective experience is influenced and connected by the unique social, political, and cultural contexts within which it lives (Flood, 2010; Smith et al., 2009). Further, Flood (2010) posits phenomenology is a respected research method for expanding the knowledge and development of nursing practice.

In this research, the experiences of psychiatric nurses within the context of acute inpatient psychiatric care settings and a philosophy of recovery is explored. Interpretive phenomenological analysis (IPA) is used to support the research process (Smith et al., 2009). Further, the principles of AI are incorporated throughout the research process in order to be in line philosophically with the recovery principles of using a strengths based approach, and in line with an IPA approach that values the lived experiene of participants. The purpose behind the research question, "How do psychiatric nurses best engage in ROP in acute inpatient psychiatric care settings" is to contribute to system change. AI and IPA are both used because both approaches are consistent with each other, consistent with recovery principles, and therefore, should allow a deeper opportunity to answer the research question. The following sections will provide an overview of the theoretical foundations, research methods, ethical considerations, and knowledge translation strategies for this study.

Theoretical Foundations

While phenomenology is the broad study of lived experience, IPA is concerned with the detailed examination of human lived experiene within the nuances or unique contexts; it allows this experience to be interpretted in its own terms (Smith et al., 2009). In AI, organizations and the people within them are valued and empowered to create change through positive inquiry, choice, and hope (Cooperrider et al., 2008). ROP values the uniqueness of individuals and their lived experience, instilling hope and supporting choice in a socially inclusive climate (MHCC, 2015). IPA, AI, and ROP all share similar principles and can build upon each other to support the purpose of this research. All three theoretical perspectives are being drawn upon because they share some principles in common and, thus, contribute to the analytical power of this research.

Interpretive Phenomenological Analysis

Smith et al. (2009) provide a rich process and theoretical framework for conducting IPA in research. IPA emphasizes capturing a particular phenomenon from a particular group of people; it is interested in experiences of particular significance (Smith et al., 2009). In this research, psychiatric nurses working in acute inpatient settings and practicing from a recovery philosophy were interviewed to discover how they best engage in ROP in the acute care setting.

IPA is founded in three theoretical bases: (1) phenomenology, the study of lived experience, (2) hermeneutics, the theory of interpretation, and (3) idiography, the emphasis on the particular (Smith et al., 2009). Heidegger's interpretation of phenomenology emphasizes that experiences and *intersubjective*, meaning experiences overlap and are influenced by their relationships in the world (Smith et al., 2009). In IPA research, the data includes the participants' interpretation of their experience, but their interpretation is a product of interactions

within social contexts. In this research, participants were asked to consider day-to-day experiences in their professional practice; they were asked about experiences that stand out as supporting the recovery of patients within the acute inpatient psychiatric setting. The nature of this setting involves complex relationships and diverse approaches to care, thus, IPA methods are well-suited to parsing meaning of lived experiences.

Appreciative Inqiury

AI is an approach to organizational change that focuses on the core strengths of an organization and the people within it (Cooperrider et al., 2008). In practice, AI follows the 4D approach of discover, dream, design, destiny. Organizations *discover* the strengths and best practices of the organization, *dream* of what could be and how to turn problems into innovative solutions, *design* a future by envisioning the ideal organization, and enact their *destiny* by engaging in positive change (Hennessy & Hughes, 2014). Trajkovski et al. (2014) shared that it is ideal to have the discovery phase and dream phase occur in the same interview, so that participants can use their positive stories to explore their hopes and dreams for the organization. For the purposes of this research, the emphasis is placed on the first two stages, discovery and dream.

AI is based on five principles: (1) constructionist, (2) simultaneity, (3) poetic, (4) anticipatory, and (5) the positive (Cooperrider et al., 2008). In other words, AI is based on the belief that reality is socially created, inquiry creates change, our focus describes the world as we know, images inspire action, and positive questions lead to positive change (Cooperrider et al., 2008). In this research, AI is used to focus on the unique strengths and vision of psychiatric nurses engaging in ROP, so that mental health organizations can learn where to focus efforts on implentation of ROP.

AI is also founded on the principles of hope, empowerment, and a shared understanding (Cooperrider et al., 2008). The incorporation of a shared understanding of best practice of ROP will be threaded throughout the data collection and analysis and will be detailed in subsequent sections. Framing the methodology for this research from an AI lens is intended to support the investigation of the research question: How do psychiatric nurses best engage in ROP in acute inpatient psychiatric care settings?

Recovery-Oriented Practice

ROP is what brings this research together. The philosophy and principles of ROP are evident in both IPA and AI. To name a few, ROP is founded on the principles of hope, lived experience, the uniqueness of individuals, empowerment, choice, and collaboration (MHCC, 2015). Much like the principles of intersubjectivity in IPA (Smith et al., 2009) and shared understanding in AI (Cooperrider et al., 2008), ROP is driven by the individuals of focus and the individuals are part of a social context. Shared decision making involves viewing individuals as being experts in their own lives, and placing individuals at the forefront of their health care decisions (Deegan & Drake, 2006). This same sentiment is seen in IPA, where the human subjective experience is of utmost value (Smith et al., 2009), and in AI, where the social hierarchy is dissolved and all opinions are valued equally (Trajkovski et al., 2013). In all arenas, relationships are ubiquitous and, no doubt, are also the foundation of psychiatric nursing practice.

Research Method

Data for this reseach was collected through personal, audio-taped interviews with key informants (psychiatric nurses). IPA was used to identify the themes in each interview and across interviews. To support validity, member checking interviews were included following the

initial stage of data collection. The member checking process was enhanced in order to incorporate a shared vision amongst participants.

The service user's perspective on recovery-oriented practice is necessary at every stage, from development, implementation, and evaluation (Kidd et al., 2015). Research with individuals who experience mental health care would ideally be participatory research, including service users as researchers—nothing about us without us (de Wolff, 2009). The purpose of this research was circumscribed and limited to learning from psychiatric nurses in order to be a feasible size for a thesis research project. It is anticipated that this research will lead to future projects that explore the AI approach with all stakeholders, including patients. For example, the study could be replicated with people who have been patients in acute inpatient pscyhiatric care settings.

Researcher Role

The researcher is a registered psychiatric nurse currently employed as a Clinical Coordinator for community Mental Health and Substance Use (MHSU) services in Nanaimo on Vancouver Island, British Columbia. Part of the researcher's role as a Clinical Coordinator is to support frontline nurses in providing Recovery-Oriented and Trauma-Informed care to marginalized populations. Previously, the researher was employed as a Clinical Nurse Eduacator in acute inpatient psychiatric settings and was resonsible for enhancing the quality of patient care through supporting best practice and the maintenance of professionalism of employees working in these areas. The researcher holds a Bachelors of Science in Psychiatric Nursing and is currently enrolled in the Master of Psychiatric Nursing program and Brandon University.

Trustworthiness

In order to enhance the trustworthiness of this qualitative research study, the researcher has maintained a solid and a consistent level of self awareness and engaged in strategies to improve trustworthiness. Reflexivity involves the self-awareness of the researcher's personal bias and the influence of self throughout the research process (Mays & Pope, 2000). For example, in this study, the researcher shared similarities with the participants: the reseacher is a psychiatric nurse, has been employed in an acute care setting, and is passionate about ROP. The researcher has engaged in this research based on a desire to enhance the current state of ROP in most acute inpatient psychiatric care settings. While sharing a similar professional role and philosophy of care as participants is helpful in keeping the researcher engaged, it is important to remain somewhat impartial to the participant experience (Smith et al., 2009). In order to engage in reflexivity, the researcher has kept field notes, noting initial thoughts and biases after interviews, and rationales for methodological decisions.

Trustworthiness was further enhanced by engaging in member checking with participants. Mays and Pope (2000) described member checking as the process where the researcher compares the themes generated by the researcher's anaylsis of data and the participants accounts of their data. This process allowed the researcher to take note of any errors developed in the data analysis and re-enter the thematic analysis with new data to interpret (Mays & Pope, 2000). Following the generation of themes, the researcher scheduled a 30-45 minute phone call with each participant to ensure the researcher's interpretation of the data was accurate according to the participant. The researcher described the themes found and asked if they make sense to the participant, if they represented what they were trying to say in the initial

interview. Lastly, the thesis advisor of the researcher was a second party reviewing the interviews for themes and congruency between advisor's and researcher's themes.

Participant Sample and Recruitment

According to Smith et al. (2009) six to eight participants is sufficient for obtaining qualitative data in an IPA study, therefore, the researcher strived for up to six participants. Unfortunately, recruitment was challenging and resulted in four participants. Challenges in recruitment may have been a result of lack of knowledge of ROP or lack of time of acute care psychiatric nurses to engage in further professional activities. Inclusion criteria for participants was as follows: (1) must be a Registered Psychiatric Nurse (RPN) or a Registered Nurse (RN); (2) must be currently working in an acute inpatient psychiatric care settings; and (3) must have knowledge and understanding of ROP. In order to support clarity around the latter criterion, key features of recovery-oriented inpatient psychiatric nursing practice were included in the participant recruitment process. The key features sought in participants included a nurse who (1) supports a culture of hope, (2) promotes autonomy and self-determination, (3) has a strong ability to build rapport and trust, (4) focuses on strengths, (5) provides holistic and personalized care, (6) and encourages community participation (McKenna et al., 2014). These key features were included in the letter of introduction and invitation to participate (see Appendix A) in order to establish some common ground in understanding recovery. Participants were also asked about their understanding of ROP over the phone when arranging interviews to ensure that they met this criterion. Exclusion criteria for participants includes having a professional or personal relationship with the researcher.

Participants were initially recruited using purposive snowball sampling. Purposive sampling involves the careful recruitment of participants with knowledge of the phenomenon in

order for the participants to give voice and share their knowledge of the phenomenon (Streubert & Carpenter, 2011). The researcher connected with a small group of acute MHSU leaders and requested referrals based on the research criteria. These leaders were given a letter of introduction and invitation to participate outlining the purpose of the study, the inclusion and exclusion criteria for particpants, and details regarding committment of participants. Each leader was asked to send the letter of invitation to at least three potential participants who met the inclusion criteria. When this recruitment method resulted in only one participant, the researcher had a letter (see Appendix B) sent by the regulatory college to all RNs and RPNs working in acute care in the province of British Columbia. The letter, which included a description of the study and the inclusion criteria for participants, resulted in three more particpants. Given the goals of this research, four participants was determined to be sufficient to answer the research question.

Informed Consent, Anonymity, Confidentiality

After participants made contact with the researcher by email, the researcher ensured participants had read the letter of invitation and arranged a phone call in order to ensure they were well-informed of the study and were able have any questions they had answered. The researcher also asked some questions about the potential participant's knowledge of ROP. It was important for goals of this research that participants had a strong understanding of ROP.

After the participant agreed to partake in the research, an interview was scheduled at a time and location of the participant's choosing. The researcher discussed the need for the interview site to be private, quiet, safe, and in an area that lacks interruptions (for instance, a room at a public library). Before the interview ensued, participants were provided with a consent—agreement to participate form (see Appendix C). The researcher discussed consent

with the participant to ensure they fully understood and had the opportunity to ask questions. The researcher ensured the participants knew they were free to consent to participate, refuse to participate, and could withdraw consent to participate at another time each without any negative consequences to the participant. Participants were provided with a copy of the consent—agreement to participate form. The researcher reiterated the purpose of the research and consent process throughout the data collection phase of research, in order to ensure ongoing consent. During the second member checking interview, this process of obtaining informed consent was repeated. Participants could withdraw from the research project at any time up to one month after their second interview. After this point, interview data were pooled into themes. Participants were able to contact the researcher by phone or email with any questions that may arise throughout the study. Further, the researcher offered to send a copy of the thesis to participants as requested.

Participant interviews were recorded on an audio recording device and were transcribed by the transcriptionist into a Word Document. The transcriptionist signed a letter of confidentiality (see Appendix D). The particiants were given a pseudonym, thereby, were anonymous throughout the analysis and dissemintation phase. While direct quotations were used in the final thesis product, the researcher made efforts to ensure that participants were not identifiable. For example, locations and places of work were not included.

Data Collection

Data was collected at a location of the participants choosing, such as a library. It was private and was recorded by an audio recording device. The data on the recording devices was uploaded to a password protected computer and a copy was uploaded onto a password protected USB device. The original copy on the audio recording device was deleted as soon as it was

uploaded onto the computer harddrive and USB. Data will be saved for one year following completion of the study, upon which it will be deleted from the hard drive and USB. When not in use, the USB was stored in a locked filing cabinet. Only the researcher and the researcher's thesis advisor have access to the data. A dedicated research Brandon University Moodle site was used for secure transfer of research files between the researcher and thesis adviser. Only files that were anonymized, coded for anonymity, and password protected were stored on the research Moodle site. The dedicated research Moodle site was password protected.

Interview

In this research, a semistructured interview was used. AI was incorporated in the interview schedule (see Appendix E) in that questions were focused on peak experiences of participants providing ROP. The interview schedule was flexible, meaning not all questions needed to be asked and questions did not need to be asked in sequential order. The researcher began with some broad questions and continued the interview based on the participants responses, allowing participants to explore the experiences that stood out for them. Interview questions were designed to elicit stories of proud experiences in providing ROP and were intended to allow nurses to dream what the future of ROP in acute inpatient psychiatric settings might hold.

As the researcher comes from a professional background of interviewing in the clinical context, it was important to understand the differences between clinical interviews and qualitative interviews. Hunt et al. (2011) cautioned that being confident in interviewing in the clinical setting can hinder the transition to being competent at interviewing in the research setting. One suggestion, is to take the ROP principle of shared-decision making to anther level where the participant becomes the expert who teaches the reseacher about the phenomenon of

interest (Hunt et al., 2011). Ultimately, Hunt et al. (2011) provided five suggestions to transitioning from clinical to research interviews: (1) to critically reflect on one's previous interview experience, (2) to carefully plan and prepare for the interviews, (3) to be clear, consistent, and mindful of power dynamics in the interviews, (4) to pay attention to the use of language and verbal cues, and (5) to reflect and evaluate on an ongoing basis. The researcher engaged in the strategies suggested by Hunt et al. (2011) and also sought guidance from the researcher's thesis adviser. To support the strategies highlighed above, field notes were used following every interview.

Following the data analysis, participants were contacted via email in order to set up a follow-up interview. Before beginning the interview, the researcher reviewed the purpose of the study and the follow-up interivew to ensure the participant was fully informed. Consent was verbally provided before the follow-up interview began. While these interviews were intended to engage in the member checking process, they were modified to incorporate further data collection. Follow-up interviews involved a discussion of the themes to both member check and to discuss a vision for practice. To support the development of a shared vision amongst participants, the researcher shared the summary of themes developed during the line-by-line analysis of the initial interviews through email prior to the follow-up interview. Participants were given an opportunity to review these themes and think about how they might contribute to a collective vision of ROP in acute inpatient psychiatric care settings. The follow-up interviews were 30-45 minutes and hand written notes were taken. The second interview analysis was based on notes made during the second follow-up interviews.

Data Analysis

Thematic analysis involves the method of developing themes from textual data (Maguire & Delahunt, 2017) and was used to analysize the data collected in the initial interviews and follow-up interviews in this research. Smith et al. (2009) describe the processes and principles involved in the analysis phase of IPA research. These include line-by-line analysis of data, identification of emerging patterns, the develoment of a framework for identifying relationships between themes, and the use of supervision and collaboration to test the credibility of the interprepation (Smith et al., 2009). As discussed earlier, the researcher also engaged in active self reflection of personal bias and influence throughout this process.

Maguire and Delahunt (2017) offered a step-by-step guide to novice scholars conducting in thematic analysis. The framework is drawn from Braun and Clarke's (as cited from Maguire & Delahunt, 2017) six-step guide for conducting thematic analysis. As this was the first attempt at qualitative research, the researcher's thesis advisor was closely involved in all stages of the research process. The first step involved getting familiar with the data. This involved reading and re-reading the transcripts. The second step involved the generation of initial codes where the researcher identified the interesting elements of the text that related to the research question. Open coding was used in order to allow the researcher flexibility with developing and modifying codes. The third step involved the search for themes of significance in the codes. Maguire and Delahunt (2017) described themes as patterns in the data that relate to the research question. Once established, the fourth step involved reviewing, modifying, and developing the preliminary themes. In this stage, the researcher asked if the themes made sense. The fifth step involved the last fine-tuning of themes where the researcher aimed to understand the essence of each theme. Lastly, the sixth step is the final written product of the thematic analysis. As this research is a

requirement for the Master of Psychiatric Nursing degree, the final product was developed into a thesis.

Ethics and Managing Risks

The researcher completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (see Appendix F). The researcher received ethics approval through the Brandon Univeristy Research Ethics Committee (BUREC) (Appendix G) . Participant recruitment and engagement with potential participants began once the the ethics application was approved by BUREC. As participants were being recruited as individuals via purposive snowball sambling, not as individuals attached to a single health authority, ethics approval was not required from other sources.

There were no anticipated risks associated with this study. To ensure the psychological safety of participants, the researcher provided informed consent throughout the process of participant recruitment and data collection. The researcher was clear that they could be contacted via phone or email throughout, as well. Had any participant required psychological support, the researcher would have provided resource recommendations, including counselling through the Employment and Family Assistance Program, which is available free of charge to all health care employees in BC. Since this research involved the discovery and exploration of positive experiences in nursing practice, the risks to psychological safety were percieved to be minimal.

Knowledge Transfer

The knowledge generated from this research will be shared with leaders of acute MHSU care settings across health authorities in BC. The key themes found in this research will be compiled into a PDF document of ideas and recommendations for using AI in workplaces

implementing ROP. The researcher will also aim to publish findings in peer-reviewed journals and will seek opportunities to present at conferences.

Knowledge translation will also occur within the study before results are disemminated. During data collection, each participant was asked about their dreams for ROP in acute inpatient psychiatric care settings. Upon completion of the interviews and initial stages of data analysis, the member checking process was fine-tuned. As a secondary function of member checking, the researcher worked with the participants to collectivise their dreams for ROP practice. The researcher anonymously shared the dreams of other participants and asked for feedback if the dreams suggested a way to move foreward. Akin to the principle of shared understanding in AI, the researcher strived to create the collective vision of participants in their dreams for enhancing ROP in acute inpatient psychiatric care settings.

Chapter 4: Data Analysis

The purpose of this research was to discover how psychiatric nurses best engage in ROP in acute inpatient psychiatric care settings through the lens of AI. AI is about transformational change; it is about *discovering* what is working best, *dreaming* of what 'could be', *designing* what 'might be', and fulfilling a collective *destiny*. AI is also about dialogue and collective visioning, the co-creation of something better. While the vast majority of literature on ROP in acute inpatient psychiatric care settings focuses on the barriers, this research intends to focus on what *is* working, acknowledge existing barriers, and explore recommendations for change. The initial interviews with participants focused on the *discovery* of what is working well to support ROP in the acute care setting. Participants also touched on *dreams* of positive changes that could support enhanced ROP in these settings.

Follow-up interviews were intended to confirm with participants that the themes developed were consistent with the participants' own perspectives, as well as collectivize their recommendations to further enhance ROP in acute inpatient psychiatric care settings. Follow-up interviews were completed after participants had experienced one year of the COVID-19 pandemic. While participants described added challenges to supporting ROP in an even more restricted care environment, the barriers and recommendations discussed in follow up interviews were aligned with their initial interviews, and were often explored to a deeper level. Follow-up interviews will be described further in the discussion chapter.

In this chapter, participants will be introduced and details around their level and context of experience will be summarized. Data from participants were analyzed and themes that connected their experiences providing ROP in acute inpatient psychiatric care settings were uncovered. Superordinate and subordinate themes were developed. Superordinate themes

included (1) recovery-oriented nursing practices and (2) barriers and recommendations. These themes often involve dialogue that applies to both the patient experience and nurse experience. Both patient and nurse were seen as needing to be within settings that support recovery, thus, this parallel structure was sometimes seen throughout the themes. Recovery-oriented nursing practices were further categorized into the following subordinate themes: (1) being flexible, (2) communicating with respect, (3) focusing on the patient perspective, (4) focusing on strengths, and (5) positively influencing the milieu. The theme of barriers and recommendations were categorized into subordinate themes of (1) time to care, (2) holistic approach, (3) continuity with community, and (4) leadership support. Barriers and recommendations were seen as one superordinate theme as the dialogue around barriers to ROP often coincided with recommendations that challenged those barriers. In the interest of maintaining an appreciative lens, barriers were a reality acknowledged by all participants, yet did not hinder their hopes for recommendations to be explored.

Each participant offered rich descriptions about their experiences in providing recovery-oriented care to patients in their workplace. Participants responded with rich descriptions of their beliefs and actions they took within the health care system to actualize ROP; these beliefs and actions were closely related to some of the recovery principles described in the literature (Leamy et al., 2011; SAMHSA, 2011). Themes illustrated the practical ways in which psychiatric nurses support the principles of recovery in the unique context of the acute care setting. Participants described their practices, shared their frustration about barriers, and envisioned how changes could come to be. While participants vented about the barriers to providing ROP in their workplace, they brightened when exploring how things could be better. They all demonstrated passion for the need for change and dedication to the patients they work

with. They showed equal passion and dedication for their role as psychiatric nurses and for the nursing profession. They came from diverse backgrounds and experiences, though voiced comparable experiences in both delivering care and what they wished for change.

Participants

Four psychiatric nurses with knowledge and experience in providing ROP contributed to the data for this research. At the time of the initial interview, all four participants were working primarily in an acute inpatient psychiatric setting(s) as a frontline nurse. Each participant was located in a different region and health authority across British Columbia, adding to the generalizability of this research. While each participant self-identified as having knowledge and experience in providing ROP, the researcher confirmed their knowledge during initial contact over the phone. Each participant was interviewed in a private location and discussed how they provided ROP in a semi-structured interview.

Participants were given pseudonyms and some context about their experience and workplace is provided. Table 1 highlights basic characteristics of each participant in terms of approximate age, years of experience, and education level. Jane, Melissa, Ashley, and Rebecca all differed in terms of years of nursing experience, however, they all identified that ROP was an integral part of their nursing care approach. The participants with more nursing experience tended to draw more on their experience when describing recovery-oriented nursing practices, whereas, the nurses with less nursing experience pulled more on nursing theory when describing ROP in the acute care context.

Table 1

Participant Demographic Information

Participants Name	Age	Education Level	Years of Nursing Practice
Jane	40-49	Bachelor's Degree	>15 years
Melissa	30-39	Bachelor's Degree	<1 year
Ashley	30-39	Bachelor's Degree	5-9 years
Rebecca	30-39	Diploma	1-4 years

Jane had the most experience and was the only participant to have worked solely in acute inpatient psychiatric care settings throughout the course of her nursing career. Melissa had the least experience and worked as a casual nurse on two acute inpatient care units in a hospital in an urban setting. Melissa was also pursuing a master's degree at the time of the interview. Melissa's perspective is unique in that she is not embedded on a specific team full time, and also has some experience in a community setting. Ashley held several casual positions at different inpatient units at different hospitals and was also pursuing a master's degree. Ashley also had experience in providing nursing education. Rebecca had a regular position that required her to float between acute care units and a medical centre in the community. Rebecca also had experience in an inpatient tertiary care setting. As the psychiatric nursing community is relatively small, more details around the participants' practice experience have not been included in order to protect their anonymity.

Interpretive Phenomenological Themes

All four participants provided rich descriptions of their experiences in providing ROP in acute inpatient psychiatric care settings. These descriptions were illustrated by stories of specific

patient experiences that stood out for participants, often described with a sense of pride. Data were analyzed for meaningful themes using IPA. The essence of each participant's unique experience in their unique social context was highlighted and a shared understanding for what ROP looks like and could look like was explored. Participants voiced what ROP in acute inpatient psychiatric care settings meant to them, and the researcher strived to make sense of the participants meaning making. In order to support the interpretation of participants' experience, direct quotes have been incorporated throughout the analysis chapter. Superordinate and subordinate themes were interpreted through a cyclical process of identifying what participants were saying, and by interpreting and making meaning of their sentiments.

Table 2 below has been offered to demonstrate the superordinate themes and subordinate themes that were discovered by the researcher during data analysis. Recovery-oriented nursing practices were described in terms of individual practices where participants engaged in ROP. Barriers and recommendations were discussed in terms of changes needed in order to enhance the existing ROP participants were engaged in. Barriers were rarely presented without recommendations for change. While recovery-oriented nursing practices were described as what was working well, barriers and recommendations were presented as challenges to be overcome through the recommendations that were provided in tandem with the barriers.

Table 2

Superordinate and Subordinate Themes

Superordinate Themes	Subordinate Themes
Recovery-Oriented Nursing Practices	Being Flexible Communicating with Respect Focusing on the Patient Perspective Focusing on Strengths Positively Influencing the Milieu
Barriers and Recommendations	Time to Care Holistic Approach Continuity with Community Leadership Support

Recovery-Oriented Nursing Practices

Each participant described a variety of practices or ways of being with their patients that they believed conveyed ROP. While several of these practices were felt to be subtle, there were also several concrete examples of how nurses provide ROP in the acute inpatient psychiatric care setting. These practices are broken down into the following subordinate themes: (1) being flexible, (2) communicating with respect, (3) focusing on the patient perspective, (4) focusing on strengths, and (5) positively influencing the milieu. While the majority of these practices pertained to the care provided to the patient, positively influencing the milieu pertained to the nurse and their nursing colleagues, as well. It was evident throughout the data that ROP in the acute care psychiatric setting was just as much about the well-being of the staff and work environment as it was about the way nurses provide care to patients.

Being Flexible. All participants described being flexible in their nursing practice, and that being flexible was about providing options and supporting personal autonomy. It was about seeing the patient as a unique individual and tailoring the care provided around their needs. Each

participant conveyed the need to be flexible and recognize each patient as unique in various aspects of their care provision.

Ashley described how *"every patient is different to the next one […] and, in turn, will require different services, attention, or support."* Ashley emphasized that her role is not about the required tasks she has to do, but working around the patient's individual needs. She shared, *"there's duties I need to do, but really, providing care to somebody, it should be around their care needs."* Ashley stated, "*it's about giving options and a lot of time"* and her role is to "*help them fulfill their priorities for the day."* Describing the environment, Ashley stated that *"things are very regimented and not built around flexibility, [but] recovery-oriented practice is about flexibility."*

Ashley also shared about the importance of being flexible, especially in terms of protecting a patient's dignity. Ashley shared a story about a woman who had recently been sexually assaulted who was brought into a seclusion room and told to change into pajamas by four security male guards. Ashley broke protocol and directed the security guards to leave the room, recognizing the risk of adding to this patient's trauma far outweighed the risk of abandoning protocol around pajamas. She stated, *"that was not protocol, but that was being human."* Further, Ashley suggested that *"you're trying to adjust your nursing to not be so regimented, being flexible around their care needs and trying to cater to them […] it can be a nursing call."* For Ashley, she had the confidence to break the rules in order to protect a patient from further trauma, highlighting the need for a flexible nursing practice.

Melissa also discussed ways in which she is flexible around supporting patient recovery. She described a patient who was struggling to take the next steps towards recovery, and who was capable of moving forward, but perhaps had some fear or lack of confidence to take the next

steps. Melissa described how she partnered with the patient to support those next steps. She described telling the patient, *"I know that you can do this. And I'm really going to push you to do this for yourself because I know that later on you'll need that strength. […] I'll walk with you."* Here, Melissa described adjusting her nursing practice to walk alongside the patient who she felt needed that extra level of support.

Rebecca described the importance of being flexible around the normal acute care nursing routine and that she strived to support meaningful activities. She shared, "*there is a lot of opportunity to help people engage in meaningful activities. They are still human beings. Do you want to wake up and have nothing to do and no passions and just live in ground hog days?"* Rebecca used this as an analogy of describing peoples' experience in acute care and why it is so essential to focus on meaning and purpose. She highlighted, "*I think every human being has something that they're really excited about […] that they're really passionate about. And a meaningful sort of vocation of any kind that they want to engage in. […] And we need to be like really finding out what those are and letting people explore it."* This can allow for meaning, purpose, and hope.

Jane did not explicitly describe being flexible, rather described herself as being comfortable with not knowing all of the answers when working with patients. She stated, *"I am ok with the messy stuff"* and described how she feels this allows for patients to feel comfortable with her. Jane shared that through offering an invitation to *"figure it out together",* she was able to become partners in care with her patients. Jane's comfort in not knowing provided her with the confidence to sit with people in uncomfortable spaces. Not knowing forces one to have flexibility in nursing practices.

Communicating with Respect. All four participants described ways in which they communicate with respect, both verbally and non-verbally. Communicating with respect was more than the spoken word; it was about subtle communications, first impressions, being genuinely interested in patients, and listening to the patients concerns. A patient's experience of being held against ones will and losing autonomy over important life decisions can be experienced as a great disrespect or assault; therefore, the relational ways in which respect is communicated by nurses was considered essential.

Jane shared that providing ROP in the acute care setting is often subtle. She shared that "*it's kind of in the little nuanced ways that we interact with people."* Jane struggled to define ROP as it applies in the acute care setting, though was easily able to describe it and recognize it in small interactions. For example, Jane shared that *"when somebody comes to the desk, and they are met with a 'go away and I'm busy right now' attitude, it interrupts their care. It's non therapeutic, it's hurtful, it's harmful."* Conversely, when a nurse makes the effort to let a patient know that they are heard, this supports recovery and *"recognizes the humanity*" in the care. Jane reflected, *"at the end of the day [being heard] is all everybody wants".* In a setting where patients are fraught with a loss of power and control and often in the midst of a deeply personal crisis, the subtle ways a nurse conveys respect can support recovery, or can make the experience a more healing one.

Another example of a subtle way to support recovery is how Jane begins a relationship with a new patient. In the acute care setting, where emphasis is made on tasks and clinical assessments, Jane shared that she begins relationships with new patients on a human being to human being level. Rather than focusing on assessing an individual she just met, she "*invites them into my day*". Simply put, Jane stated that she will introduce herself by portraying that

"*you're a human, how's it going? Breakfast is served. What can I do for you this morning?".* Jane demonstrated respect through her soft approach when meeting patients for the first time, recognizing that beginning any relationship by way of clinical tasks (i.e., assessments, medications) was unnatural.

Like Jane, Melissa also strived to make a good impression at the beginning of a relationship with her patients. Melissa shared that *"sometimes just taking that extra moment to really ask them, 'how was your day?'"* Melissa strived to convey to her patients that she was genuinely interested in their well-being and that she genuinely cared. Melissa felt that in order to do this, it was important that she get to know the patient. She described an experience where she asked a patient what brought him to hospital and he responded that she should already know by reading his chart. Melissa described communicating with her patient, *"I want to know from your perspective because I am reading someone else's interpretation of what you said."* She demonstrated genuine interest in hearing the patient's experience and discovered how this helped her earn his trust. She shared, *"that changed his perspective and he started talking about a bunch of stuff that had happened […] we had a better relationship."* Melissa's offering of genuine interest during her first interaction supported the development of a more meaningful relationship.

When asked how she provides recovery-oriented care in the acute care environment, Ashley described it as her way of being and her way of communicating. She shared that *"I think it has a lot to do with how I talk to my patients."* Ashley reflected on this further, stating *"I talk to my patients like I would talk to anyone else… and I think I do well in my position because of that… I'm pretty down to earth and straight forward."* Ashley is honest with patients about what is required during a hospital admission, and what she needs to do as part of her role; "*this is*

what we need to do today […] when are you free?" Her honesty conveys respect and allows for a trusting relationship to unfold.

Like Melissa, Rebecca communicates genuine interest in discovering what is important to her patients. Rebecca shared that discovering what is important to her patients happens regardless of significant cognitive deficits, *"I'm still trying to have conversations and be able to see what's important to that person."* It is evident that Rebecca feels strongly about the importance of meaning and purpose for patients and that this feeling drives her to focus on what is important to the patient from their perspective.

Focusing on the Patient Perspective. Focusing on the patient perspective was about taking the time to listen to the patient experience and allow patients to express their thoughts and feelings. Participants strived to understand the impact that being in hospital had on patients and to find ways to honour their individual goals. By focusing on the patient perspective, participants were able to acknowledge the patients unique experience and invite them to be more involved in their care.

Jane struggled to find a particular patient interaction that stuck out as being recovery-oriented. One interaction that was shared was about a patient who she spent significant time listening to. When asked what specifically stuck out about this interaction, Jane stated "*he did all the talking."* Jane viewed her role as allowing the patient the time and space to "*guide [his] own recovery and [his] own thoughts."* Jane shared that she understands how when *"you get a chance to talk things through, it gives you clarity […] and your perspective shifts and changes and solutions start to bubble to the surface."* Jane compared the process of supporting a patient to how they would work through their own struggles, that by having someone provide you with time and space to listen, it allows solutions and clarity. Jane recalled this patient leaving the

hospital feeling hopeful, *"there was a real element of the positive, [he] left the admission feeling very optimistic."*

Rebecca shared that she has been trying to focus on the perspective of the patient. She stated, "*lately, I feel like I've been trying to focus on the client's perspective of what their problem is. Because they come in and we're like, 'you need to be here', or, 'you have a mental health condition. They're like, 'no I don't, I don't need to be here. I've been moving away from that point. My job isn't to convince them that they need to be here because they have a mental health issue."* She explored how her patients might get help with what they see as helpful during the acute care admission. By focusing on their perspective and showing interest in what they feel they need help with, she was able to build rapport and the rest of the acute care tasks become easier.

Rebecca described how most of her patients are less concerned about their mental health, and more concerned about basic needs like housing and income. By opening up help in these areas, patients feel more at peace with parts of the admission that is outside of their control. Rebecca shared an experience where she used this approach with a young male who was involuntarily admitted and was angry. Rather than using her position of power about things like medications, Rebecca used motivational interviewing to talk about what was important for him and how it could be addressed. She stated, *"you know, you don't have to have all the resistance around people when you just try to focus on what they feel the problem is."* She discovered that he was stressed about housing and income and she offered support in those areas. She asked him, *"Why don't we get something good out of this? Is there anything good that can come out of being in hospital? You may as well take advantage of it."* She reported that he left hospital with housing and financial assistance and that he had more trust in the health care system than he did

when he was initially admitted. Rebecca reflected that *"it [wasn't] such an oppressive feeling for him."* By focusing on the young man's perspective of what his needs were, she was able to support him in getting his needs met and create a more positive experience for him.

Ashley shared how she was curious about the patient's perspective and experience, "*you never know the experience they have had in the mental health system […] I don't know their story, but all I can do is ask and try to be supportive."* Ashley recognized the negative experiences people have in mental health care, and how this impacts a patient's ability to form trust. Ashley stated, "*when it's in their best interest, they see it"* suggesting that when a nurse makes a choice to be flexible in support of a patient's needs, this is recognized and noticed. Ashley is also suggesting here that nurses have the autonomy to be flexible with the care they provide to their patient, in order to help foster trust between them and with the health care system in general. This could also be attributed to Ashley's longer nursing experience, and potentially her level of confidence as a nurse.

Focusing on Strengths. Focusing on strength was also about focusing on the positive, having hope, and instilling hope. The nurses highlighted supporting the patients to find the positive, similar to how AI is used to discover what was best about something. Jane and Ashley extended this further by focusing on the strengths of their nursing colleagues, recognizing that although their colleagues struggled at times, they all had the capacity to do well.

While the literature illustrates that it is challenging to provide hope in an acute care setting, Ashley shared that she holds a lot of hope for her patients. She stated, *"you get to see people move forward."* She communicated the hope she feels with her patients, "*I voice that a lot, […] really you're going to go up from here, we're here to help you move forward to the next place, for a better quality of life."* Ashley found it easy to have hope because she saw people

improve and she strived to instill this in her patients and add some perspective to their situation. When asked about a positive patient interaction where she felt she was able to provide recovery-oriented care, Ashley shined with pride and stated *"when you know what you did was remembered."* For Ashley, these interactions included those where she knew, as a nurse, she made a difference for someone. She shared a story about a patient who she was able to have a good rapport with and with whom she had time to spend. She heard later on, that this patient still mentioned her when he was in a different facility. She stated that *"there's times that I felt like I was a part of [his] journey, I was there at the right time to provide the right kind of support […] and I was hopeful in his recovery."*

Melissa described the importance of being positive, focusing on their strengths, and discovering what motivates them, what is driving their recovery. Recognizing that patients often *"feel like they're failing",* Melissa shared that *"I really try to be positive and convey that in terms of my tone and body language as much as I can."* Melissa does this by highlighting their strengths and *"celebrating the small wins."* She was curious about discovering *"that thing that is keeping them going and keeping them motivated"* in order to help instill hope in her patients through focusing on the positive. Melissa did this in simple ways through giving complements, and stated *"those small little compliments […] that make them feel good […] that totally changes their demeanor."* Melissa described making the extra effort compliment them, highlight something positive, and be kind.

Rebecca also discussed how she strives to help her patients focus on their internal locus of control, and find a sense of personal agency. She recognizes patients often feel helpless and powerless, *"so giving them sense of agency, like, you know, you do have some say in how things turn out for you."* While Rebecca didn't use the word empowerment, her approach embodied

that she was striving to empower patients. She asked her patients, *"how do you want your life to look? Do you know what's meaningful to you? You're your own person. And life becomes more exciting when you wake up and you feel like you're the maker of your destiny."*

Both Jane and Ashley focused on the strengths of their nursing colleagues. Jane described *"having an attitude of curiosity"* with her peer colleagues and recognized that everyone has bad days, but they all want to do good work. Seeing the best in her colleagues and recognizing that "*we're all on this raft together"*, embodied the importance of teamwork needed to create a healthy unit. Jane saw her role as *"reminding people [of this] in ways that are actually constructive."* She found the experience of highlighting the strengths of her colleagues to be rewarding and inspiring and the feeling of success prompted her to continue to work on this skillset in constructive feedback.

Positively Influencing the Milieu. ROP is holistic and pervasive not just about individual nursing practices. ROP occurs in an environment that supports recovery and the environment is directly influenced by its participants (i.e., staff). All four participants recognized the importance of having a positive care environment to support patient's recovery and made efforts to enhance this environment. Participants positively influenced the milieu by way of how they conducted themselves, how they supported their nursing peers, and how they found opportunity to create a sense of community on the unit.

Ashley, having experience on several acute care psychiatric units, "*feels the difference it makes from one psych unit to the next, is the staff…. Like, it's the staff that will make the difference for this patient*." Ashley suggested that it can help to "*be the nurse you want to be, and lead by example and shut down the negative stuff when you see it."* Discussed further, Ashley stated this was about *"the way that you treat patients, the way that you treat your day*

[…] and what you're doing and how you spend your time is noticed. Nurses notice other nurses' practice." Ashley is talking about how nurses bring themselves to the workplace and how this influences the culture of the unit. *"To create a better milieu and team is to be supportive […] and to show people what kind of nurse you want to be."*

Ashley shared that she tries to enhance the milieu on a unit, by "*try[ing] to be light, use humour, and offer support."* Even when she found herself in a toxic environment, Ashley "*tries to make the environment better for [herself] to work in*." Ashley recognized that being a nurse in acute care is hard and understood when other nurses are struggling, however, for her own sense of well-being makes an effort to improve the situation for herself. She shared "*there's things that happen to you, they're going to change you as a human being, so it's about learning how to handle the situation. Taking care of yourself, and in turn, being able to be a good nurse still."*

For Jane, being a supportive nurse involved how she supported patients and her colleagues alike. She identified as being "*comfortable with discomfort"* allowing her to "*sit with the messy stuff."* Jane recognized that there are often uncomfortable situations with colleagues where they feel depleted and frustrated. Jane extended her comfort with not knowing to be helpful for herself as a nurse and to her colleagues alike. She shared, *"I feel people respond to me, patients and colleagues alike. There is a comfort that they can reach when I am ok with their discomfort. I am ok with the messy stuff and that is conveyed somehow."* Jane was able to support her colleagues through challenging patient interactions.

Jane discussed the significance of the care team and the environment of the unit as being essential to supporting recovery. She felt that she was able to be a positive influence on others, including being able to provide feedback to her nursing colleagues. Jane shared a story about a colleague who was feeling disempowered and frustrated by a patient in distress. Jane recognized

that they could support this colleague by asking them questions to *"guide what [she] might ask the client [and] involve [her] in the care."* Jane emphasized that it was important that this nurse *"feel like [they] did know what they were doing"* and to feel empowered by being able to support their patient in a different way. Jane also identified the feeling of success in being able to see their colleague lighten with supporting a positive interaction.

When asked about a small change that would enhance the milieu, Jane stated that they think it's the day to day, how nurses *"walk into work each day".* Jane reflected, *"I know from experience you can walk on a unit and feel the energy. Cut it with a knife."* She offered, *"you can just shift it by your presence and how you then relate to everybody that's on the unit, and, by supporting people to continually do that […] It's an incredibly powerful tool […] everybody owns that tool. Everybody can use that if they recognize it and understand it."*

Melissa shared a story where the patients and staff were watching a football game together, totally outside the acute care norm. She described *"And just, it was really cool to see that for that brief moment, some of them, even some of them, I don't even think they really knew what basketball was or even cared. But that moment where they could have a break from whatever it is going on, that was super cool. It wasn't about anybody else. It was something that was really positive."* It was a normal human experience and created a sense of community on the unit. Enhancing the milieu by way of creating a sense of community can improve the care being provided in what is normally a tense and clinical environment.

Barriers and Recommendations for Recovery-Oriented Practice

In AI, it unrealistic to perceive only what is working well, it is necessary to acknowledge that barriers exist. While participants brought up several barriers to providing ROP in acute inpatient psychiatric care settings, they were often followed with recommendations that could

improve them. Thus, barriers and recommendations could not be distinguished as separate themes. By viewing the barriers in tandem with recommendations, the barriers were seen as opportunities for hope in the pursuit of a vision for ROP. Barriers and recommendations were described in the following subordinate themes: (1) time to care, (2) holistic approach, (3) continuity with community, and (4) leadership support. Follow-up interviews were completed after a year of the impact of the COVID-19 pandemic and further highlighted both barriers and recommendations for supporting ROP in the acute inpatient psychiatric care setting.

Time to Care. Participants described that there was not enough time to spend with patients and support their recovery in the acute care setting. A lack of resources, staff shortages, and challenging workload demands competed with the time needed to build relationship with patients. Further, not being able to provide the services that people needed hindered the participants ability to provide ROP. Suggestions for creating the time and space to provide ROP centred around more resources, education, and opportunities for nurses to engage with patients in different ways.

Ashley reflected on the time centered around charting and assessments and how this resulted in very little time to engage and spend time with patients. She shared, *"I can see what their goals are for the day, I can make my safety assessments […] but I'm not able to spend hours at a time with someone who might be lonely, might be sad, might be suicidal."* She vented about the lack of time, stating *"there's got to be more"* to spend with patients. In her follow-up interview, Ashley again expressed the need to create more time to spend with patients, sharing that it is unrealistic to expect nurses to document 18 times in an eight-hour shift. Ashley imagined that the recovery-oriented unit *"would have enough beds always, therapy, enough nurses to provide more one-on-one care."*

Jane highlighted the need for more nurses, smaller patient assignments, and enhanced education. Jane stated, "*I wonder if, like, ideally speaking again, if we had more nurses on the floor and a smaller patient assignment. And with that, more experience and education around, like, with counselling, providing CBT and DBT guided counselling, training on motivational interviewing. Those more… approaching the nursing practice from a counselling perspective, having a smaller patient assignment would allow us time to do that."* Jane felt strongly that if given the time, nurses could participate in more therapeutic supports for their patience and enhance their ability to provide recovery-oriented care.

Rebecca shared in her follow-up interview that she learned about a psychiatric unit where a group nurse role was introduced, and that this nurse was able to have a different experience with patients and not focus on clinical tasks. Rebecca shared the sentiment of nurses having time to be involved in activities outside of general nursing tasks. She imagined, *"we could actually do some recovery work […] we could be doing mindfulness groups, we could be doing CBT groups, maybe we could be doing other kinds of therapeutic modalities."* Rebecca felt that if she could be more involved in supporting these types of services, *"it would make me feel more like I'm doing, it would give me more of a sense of purpose I think, in my work."* Rebecca felt strongly about supporting her patients in finding meaning and purpose, and shared here that having meaning and purpose in her nursing practice is equally important.

Holistic Approach. All four participants shared that an acute care psychiatric admission should serve the patient as a whole and not merely focus on medication and symptom reduction. A holistic approach was described as one that provided patients with opportunities to find meaning and purpose, enhance their quality of life, and engage in normal life activities.

Jane voiced her frustration with how the acute care teams seem to assume what patients' recovery should look like. She voiced, *"it seems like from the medical side of things, the persons not fixed until the voices are or the delusional thinking is just gone… that doesn't seem like it's super realistic […] What that does is set people up to feel broken. […] It's demoralizing and it's hard, rather than building people up."* Jane offered, *"so if we could learn how to embrace people, their experiences, in a safe way… helping people live with their chronic illness in a way that is really satisfying, rather than trying to fix it all the time."* Jane iterated that it is better to tell people that *"we can help you, but you don't need fixing".* She shared, *"I think it's just a shift in how we think and the words we use and that kind of thing […] a shift in perspective."*

Rebecca strived to look at the whole person in her practice as a psychiatric nurse. Rebecca reflected on what ROP means in acute care and stated, *"so, really looking holistically at a person's life. Like, it's like it's not just like them coming in and getting on medications. Because that's like such a small part of the puzzle for a lot of people. Um, all parts, like vocation. Not just in the terms of a job, but how they engage in the community. How they feel incorporated as a specific member of society. Having long term meaning in your life."* In her follow-up interview, Rebecca shared that patients aren't coping well being isolated on the unit, that there is too much time to ruminate in their illness. Rebecca expressed that she would like to see more programming and activities offered to patients, highlighting activities like groups or sports would allow patients to have a sense of normalcy and connectedness, and experience something outside of their mind.

Melissa also recognized the need for more activities for patients, highlighting that patients are bored and that *"it's harder to get well"* when they have nothing to do. Melissa suggested that even in the midst of the pandemic restrictions, patients could be provided with

technology to connect with others or engage in virtual activities. Jane shared in her follow-up interview that these opportunities were being provided for patients in her workplace, that they were being connected to other services in the hospital, peer groups, online therapy, and normal activities like bingo and art. Participants felt that it was important for patients to feel connected and have things to do that allowed for some normalcy during their time in hospital.

Ashley stated, *"the patients need something where they can actually approach and feel they're receiving the services that they want."* Ashley described that patients need to have more decision making into the services offered and how they are provided. She envisioned what she believed this would look like for patients, *"there'd be a lot more activities and groups."* She also described the need for a fulsome team that offered different levels and styles of support, including social work, occupational therapy, and different support staff.

Continuity with Community. All four participants described the need for more connection with community services and that there was room for more community involvement during a patient's time in hospital. Participants recognized that patients' lives existed beyond the acute care environment and that narrowing the bridge between these settings could better support their recovery. Further, viewing patients as members of community allowed participants to develop a more fulsome perspective of their patients, further enhancing the care they provided.

Rebecca highlighted the importance of continuity of care between acute and community mental health services. She stated, *"continuity is really important"*, implying that supporting a successful discharge will help with recovery. Rebecca goes on to explain how services for people with more chronic mental illness like schizophrenia are better established. She is concerned for patients with anxiety and depression, stating *"those people get lost… because they aren't severe enough."*

Rebecca also spoke about having relationships with community agencies that can help support a more successful discharge. *"And like, I would love, would love to see like more connection between organizations that say, hire people with mental illness and stuff, in the hospital."* Rebecca is referring to agencies outside of regular mental health services, those that support other areas of wellness, like employment. *"'Cause I think there are a lot of young people would be like, yeah, that would be really great. But they, they need that um, they still need that intermediary kind of connection."* Rebecca shared that relationship building with community is essential, not just with health care but with vocational work, etc. *"Civic engagement. All that kind of stuff. It's going to help with recovery."*

For Jane, continuity with community is an area that requires improvement; both in terms of acute care nurses understanding the community resources well and in being more involved in discharge planning with their patients. *"As much as we try and gather that information as nurses, I don't think we ever have a really clear picture."* Jane talked about how having more knowledge about the resources would help her have conversations with patients and prepare them for discharge. She described how this is not typically a nursing role where she worked, however, *"at the same time I think it would deepen the value of our interactions, if we could have just a little bit more knowledge around that."* Jane also recognized the importance of knowing patients well when having conversations around discharge and community supports. She described the different role in her workplace that supports patients with this work and expressed that she's *"not sure that [they are] even equipped really, to have those deep end conversations […] they are juggling so much."* Jane is perhaps suggesting that in order to sit with someone and discuss their recovery hopes and goals, you really need to have spent time with them and gotten to know them.

In the initial interview, Ashley felt that the connection between acute care services and community services was lacking in the inpatient setting and that improvements could be made in terms of supporting patients transitions into the community. Ashley described how many patients often expect to get therapy while in the hospital, stating "*unfortunately, we're going to refer them to a mental health clinic once they leave."* She suggested that these services should be started while people are in hospital. In the follow up interview, Ashley described that there was added resource into community services. She described a team of nurses that supported the transition of patients from hospital to community and viewed this as important due to life stressors not going away while a person is in hospital.

Melissa shared about her experience working in a community setting, an overdose prevention site. She shared that "*Working in the community, especially, in a supervised consumption site is the first step… because you're on the other end… you're in people's turf right?... it shifts power imbalance."* Spending time working in a place that honours harm reduction and non-judgement, and is also a lifesaving service, can help put things into perspective and can provide an opportunity to have relationships that are less based on power. *"You just, you really get to build those relationships in a different way […] you kind of get to know people."* Melissa had shared earlier that getting to know her patients is the first step to providing good care. In the community setting, where the power difference is less so than in acute care, she felt that it was a bit easier to do this. When asked further about this, she shared *"you appreciate their struggles more when you hear it from their perspective."*

Melissa's experience in both acute and community care poses the question around whether providing acute care nurses time to spend in community settings could help shift their perspective in how they see their patients. Melissa shared a memory of seeing a patient of hers

working in a grocery store and how it reminded her that people do get better. In her follow-up interview, Rebecca shared the moral distress she was experiencing around the practice of seclusion. She explained that she had been imaging meeting these patients in the community and how being part of such an oppressive experience would negatively impact her relationship with them. She made a decision to take a break from working in acute care, stating *"I didn't feel like I could be proud of how I provided care."* Spending time with patients in a community setting, where the power imbalance is significantly less, could perhaps broaden nurses view of patients and, thereby, transition the care towards recovery-oriented care.

Leadership Support. All four participants voiced the need for leadership support in terms of staff wellness, being supported as a team, and knowing their role. Leadership support was discussed further in the follow-up interviews, as the challenges brought on by the pandemic highlighted the impact of leadership decisions. Leadership support related to reducing or enhancing nurses' ability to provide recovery-oriented care. Decisions or actions made by leaders that supported patient recovery, and also supported the staff and team well-being, were seen as conducive to enhancing ROP in the acute inpatient psychiatric care setting.

Rebecca understood the importance of staff wellness in supporting a healthy unit. She shared that *"if you're staff aren't well, they're not going to relay that the patients, right? I mean, it all just feels so fragmented, fly by the seat of your pants, patchwork care."* She spoke about the importance of teamwork and that how a unit is managed can impact the team and the care of the patients. She highlighted, *"it's hard to have a sense of a therapeutic milieu. It's hard to have a sense of teamwork."* Both the chaos of acute care and nurses not feeling part of a team make it challenging to have a therapeutic milieu. Nurses are more easily able to invest in their role when they have job stability and feel part of a team. Rebecca suggested, *"there's a lot we*

could do to improve it. From anything like staff sort of knowing their place and their role. Because that's how I feel. Like, sometimes, sometimes I don't feel like I have a role. I feel like I'm just plugging a hole." For Rebecca, understanding her role and having some power in decision making on how the unit is run would give her some sense of agency, some meaning and purpose. Here, Rebecca talks about acute psychiatric care in a larger medical system. *"I kind of feel like a lot of times like our own mental health team just gets consumed by the rest of the structure. And sometimes I don't even feel like we have a voice. So it kind of just, again, you just feel like, you just feel like you're there to plug holes."* The team is overpowered by system challenges, leading to a lack of voice and a lack of choice.

When asked about leadership support, Ashley shared that *"when we have problems on the unit, somehow I feel that management redirects it back to staff, who are already overloaded."* Ashley shared a story about multiple suicides on a unit and voiced that the unit was understaffed and had a poor layout for safe care. The staff came back to work with added trauma, yet were given *"more tasks to enhance safety, new assessment tools, and a new tool that they have to complete to prove that more staff are needed."* Ashley felt that *"it's very difficult to change and transform the system that we're in when we don't feel like we have the support or the tools necessary to do so."* When asked about specific tools needed, she stated *"support from management, adequate staffing levels and a safe environment, with extra resources available to provide to patients."*

Ashley also shared that "*it would be helpful for a team, to see their manager, like really concerned and wanting to support and doing everything they can."* Frontline staff often feel a lack of support from their leaders, and perhaps a level of disconnection. To feel heard and cared for was seen as important for nurses, as it was for their patients. She shared, *"it affects morale*

when you don't feel supported, and it really helps when leaders step in" to show their support. In her follow-up interview, Ashley described how a new leader in the workplace would step in and support nurses with the frontline work, as well as make good decisions for patient care. By being involved in the operations, nurses felt the support of their leader, and the leader was able to see the impact of their own decisions on the frontline.

In her follow-up interview, Melissa described challenges around having multiple leaders that were not aligned and that this created challenges in terms of transparent communication and consistent decision making. She described how leaders would engage in informal team huddles, sharing important information, but that this information wasn't communicated in more formal ways. While she recognized the efforts leaders made to check in with the team, she explained how these informal communications often resulted in gossip amongst frontline staff. Further, by having multiple leaders with different approaches led to confusion for both staff and patients. In terms of decision making, Melissa felt that decisions often seemed rushed and that there was a lack of consultation with the frontline team. She voiced that *"decisions need to show that staff are genuinely cared for"* and that nurses should have some voice in these changes. Melissa further suggested that leaders should *"give us the guidelines"* and allow nurses the autonomy to make decisions about their practice.

Jane, having stepped into a leadership role during the pandemic, described how she has seen positive changes in leadership and more efforts to supporting nurses' ability provide recovery-oriented care. Jane voiced that her leaders were aligned and focused on building the team up, understanding the challenges, and trying to help out on the unit. Jane voiced *"efforts are being made, but shifting culture is hard"* and that while leaders check in with staff regularly, staff are often too busy to participate. Jane reflected that staff notice the support of leadership

when they see tangible things that affect their ability to practice, such as extra staff on the unit. She reflected that *"changes aren't always communicated well, [but] transparent communication and being articulate about the goals"* are important. Lastly, Jane highlighted how having a head nurse that assists with care plans, and helps with workload is seen as supportive. Jane believed that having a strong head nurse that is available on the floor, and has the ability to provide immediate feedback is helpful, particularly for mentoring new staff.

Chapter 5: Discussion

This chapter includes how the data analyzed by the four participants relates and does not relate to recovery principles according to the literature. Nurses in acute inpatient psychiatric care settings described practices that they believed to be recovery-oriented, though literature suggests the practices described are more related to the ideals in relationship based psychiatric nursing practice. Some essential principles of ROP were not discussed at all, which may be reflective of the challenges in the acute inpatient psychiatric care setting.

Dreaming in acute care was possible, but challenging. The themes of barriers and recommendations discussed by participants are also reflected in the literature on ROP in the acute care setting. The data suggest that psychiatric nurses may best be able to support a person's recovery through being supported to engage in the ideals of relationship based psychiatric nursing practice, and that facilitating ROP in the acute inpatient psychiatric care setting requires a larger system change.

Connection to Recovery Principles

Through their personal narrative, participants described practices that they viewed as recovery-oriented: being flexible, communicating with respect, focusing on the patient perspective, focusing on strengths, and positively influencing the milieu. Despite ROP being an essential part of mental health services, there is still a lot of ambiguity and misconception around recovery (Cleary et al., 2013). The participants did not discuss directly the core recovery principles of peer support and collaboration, or person driven care planning. While participants did not talk about the practice of certain key recovery principles, they provided examples from their psychiatric nursing theory about hope, meaning, and empowerment.

According to Leamy et al. (2011), personal recovery includes the CHIME principles of connectedness, hope, identity, meaning, and empowerment. SAMHSA (2011) also developed ten recovery principles which include: involving hope; being person driven; involving multiple pathways; being holistic; being supported by peers; being culturally based; involving addressing trauma; involving individual, family, and community strengths; and being based on respect. The participants did not use much of the language of CHIME or SAMHSA; rather, the language used highlighted the ideals of relationship based psychiatric nursing practice.

Superordinate Theme – Recovery-Oriented Nursing Practices

While the superordinate theme if recovery-oriented nursing practices described fit well with relationship based psychiatric nursing practice, all practices described can be seen as in line with recovery principles. This suggests a possible way to link the relationship based psychiatric nursing practice with recovery-oriented practice. In the following section, the participants' understanding of their "recovery-oriented practice", illustrated through the subordinate themes emerging from the research data, are compared to recovery literature.

Being Flexible. Being flexible was a prominent theme described by participants and had to do with providing options and tailoring support to meet the unique needs of patients. Flexibility in care practices were discussed as a means of supporting the autonomy and self-determination of patients, both aspects described in recovery literature (Bonney & Stickley, 2008; MHCC, 2015). Flexible services are considered essential in providing individualized recovery-oriented services, albeit challenged in the restricted inpatient environment where choice is limited (Bonney & Stickley, 2008; McKenna et al., 2014). McKenna et al. (2014) described nurses using flexibility to advocate for patients. Ashley shared a story of being flexible where she broke protocol to advocate for protecting a patient's dignity and prevent re-traumatization.

This is in line with Borg and Kristiansen's (2004) study on what service users find helpful in professionals; service users appreciated small gestures that had a great impact and those behaviours that appeared to be on the edge of professional responsibility.

Communicating with Respect. For participants, communicating with respect was verbal and non-verbal, and often conveyed in subtle ways, such as how they went about first impressions. Gunasekara et al. (2013) explored service user, caregiver, and nursing perspectives of what makes a good nurse in acute inpatient care settings. Service users described respectful commination as having nurses introduce themselves, engage in general conversation, and explain their role and the care process (Gunasekara et al., 2013). Gunasekara et al. (2013) determined that clinical knowledge and skill were not at the forefront of service users' feedback, rather "what matters most is being treated kindly and feeling respected" (p. 7). Jane described how she communicates respect in the subtle ways of her practice, described as nuanced and difficult to articulate, but relaying treating patients as the people they are, irrespective of the clinical context. While respectful communication is not clearly identified as a core principle of recovery, it is a function of psychiatric nursing practice that supports recovery in acute inpatient care settings (Gunasekara et al., 2013; McKenna et al., 2014).

Focusing on the Patient Perspective. Through focusing on the patient perspective, participants strived to understand and hold space for patients' experiences and personally defined goals. Le Boutillier et al. (2011) described similar themes in their conceptual framework for understanding how to operationalize recovery in practice. Promoting citizenship and supporting personally defined recovery were identified as key characteristics of a recovery-oriented professional (Le Boutillier et al., 2011). Participants described exploring patients' goals, which were often different than the goals of the care team and showing genuine interest in what was

important to them. Themes around meaning and empowerment were also prevalent in the narrative of participants (Le Boutillier et al., 2011; Leamy et al., 2011).

Focusing on Strengths. Focusing on strengths for participants was about holding hope for patients and offering gentle reminders of their strengths. ROP involves the acknowledgement and encouragement of individuals strengths and natural supports (Le Boutillier et al., 2011). Rebecca shared how she strives to support patients in developing a sense of agency and purpose, and building up their internal locus of control. This practice is aligned with recovery principles of hope, meaning, and empowerment (Leamy et al., 2011).

Positively Influencing the Milieu. Participants in this study described positively influencing the milieu through how they conducted themselves, how they supported their colleagues, and how they formed a sense of community on the unit. An environment that has a sense of community has long been acknowledged as one that is centred in recovery (Anthony, 1993). While positively influencing the milieu is not identified as a core recovery principle, a positive milieu is viewed by services users as more meaningful than an environment with strong recovery programming and a poor culture (Clossey & Rheinheimer, 2013). Further, health professionals who experience a positive and empowering workplace are better able to relay that to their patients (Clossey et al., 2011; Jacobson & Greenley, 2001). Davidson et al. (2016) suggested that psychiatric nurses have historically been in a good position to influence the milieu. Participants described collegiality, advocacy, and creating a sense of community, supporting the notion that psychiatric nurses may be able to influence policy and practices toward a recovery-orientation (Davidson et al., 2016).

Recovery-Oriented Practice verses Relationship Based Practice

Person-centered care planning, collaboration, and peer support are fundamental components of ROP (Jacobson & Greenley, 2001; MHCC, 2015; SAMHSA, 2011), which were not discussed by participants. A lack of understanding of recovery principles (Cleary et al., 2013) and the challenges of implementing ROP in acute inpatient care settings (Waldemar et al., 2016) are well known, so it is no surprise that the participants in this study excluded some principles.

In the recovery paradigm, person-centred care planning and collaboration are interrelated. Jacobson and Greenley (2001) described collaboration as a model that "allows consumers and providers to work together to plan, negotiate, and make decisions about the services and activities the consumer will use to support his or her recovery" (p. 484). Person-centred care planning involves personally defined goals, not merely the goals of the clinical team, and consumers being involved in all levels of decision making (Le Boutillier et al., 2011), something that is often challenged or not possible in the acute environment (Waldemar et al., 2016). Collaboration in the recovery paradigm involves true partnerships between patient and health professional that focuses on strengths and self-determination (McKenna et al., 2014; MHCC, 2015), whereas, the focus on risk in the acute care environment dilutes the possibility of such collaboration (Bonney & Stickley, 2008; Waldemar et al., 2016). Participants lack of dialogue around person-centred care planning and collaboration with patients may not be a deficit in their nursing practice, rather, a reflection of the rigid system in which they practice.

Peer support is described as integral to recovery-oriented mental health services and help individuals find hope and connection through shared lived experience (Le Boutillier et al., 2011; SAMHSA, 2011). While the peer workforce is robust and well established (Gagne et al., 2018),

there is very little evidence describing peer support in acute inpatient psychiatric settings. One study explored naturally occurring peer support amongst inpatients and determined that peer support led to improved mental health and quality of life for both providers and recipients of peer support (Bouchard et al., 2010). Though formalized peer support may be present in inpatient settings, it was not discussed or explored with participants during interviews focused on ROP.

It is the interpersonal aspects of psychiatric nursing that distinguishes the profession from the biomedical models of care. Barker et al. (1997) proposed that "being with and caring with people-in-care is the process which distinguishes nurses from all other health and social care disciplines, and needs to be recognized as the process that underpins psychiatric nursing" (p. 661). Years later, the Tidal Model of Mental Health Recovery and Reclamation was developed as a mid-ranged nursing theory which has been well used across the globe to support the recovery of individuals in mental health services (Barker & Buchanan-Barker, 2011). Barker & Buchanan-Barker (2011) described the Tidal Model as having potential to empower psychiatric nurses to practice in an interpersonal way rather than the coercive way seen in acute psychiatry.

In this study, the participants appear to have indirectly made links between ROP and relationship based psychiatric nursing practice. Psychiatric nursing has long been founded on the ideals of relational practice (Peplau, 1992) and participants' descriptions of their practices may suggest a connection between recovery and the ideals in psychiatric nursing practice. Cusack et al. (2016) shared that psychiatric nurses could engage in ROP by fostering the caring aspects of their profession, while Delaney (2010) suggested that psychiatric nurses could embrace recovery through connecting to the roots of their profession. If psychiatric nursing is fundamentally about healing relationships and supporting individuals to rebuild their sense of self outside of the

illness (Barker & Buchanan-Barker, 2011; Delaney, 2010), can reinforcing the ideals of relationship based psychiatric nursing practice (through AI) support the recovery of patients?

Dreams for Practice

Participants were open to sharing their views around barriers to ROP in acute inpatient psychiatric care settings, but were also able to express their dreams through recommendations for change. They described their desires to improve nursing practices that were often inhibited by system barriers. ROP in acute inpatient psychiatric care involves a dilemma; nurses have dreams and aspirations, but they find it difficult to enact their dreams into practice.

Superordinate Theme – Barriers and Recommendations

The barriers and recommendations discussed by participants reflect similar barriers seen in the literature around ROP in acute inpatient psychiatric care settings. Participants clearly articulated the challenges in providing the care they wanted to deliver and described the organizational changes that could support their dreams for a change in practice. In the following section, the participants' understanding of their barriers in providing recovery-oriented care is described through the subordinate themes and compared to the existing recovery literature.

Lack of Time to Care. Lack of time to care was seen as a key barrier for participants, which when combined with a busy workload is seen as a key barrier to supporting the recovery process (Cleary et al., 2013; Waldemar et al., 2016). Psychiatric nursing practice in acute inpatient care settings is consumed with conflicting priorities (Cleary et al., 2013); participants voiced frustration about heavy workloads, time spent on documentation, and pressure for inpatient beds. Participants also discussed ways in which organizations could support more time to care, including the addition of more nursing staff, and by creating opportunities for nurses to

provide care in a different way. Literature leads towards the need to restructure how care is provided in inpatient settings to truly adopt a recovery orientation (McKenna et al., 2014).

Holistic Approach. A holistic approach involved the desire for participants to be able to support healing activities and approaches outside of the biomedical model of care. Le Boutillier et al. (2011) confirmed that recovery-oriented services should provide a holistic approach which offers a range of options to meet the needs of the whole individual in care. A holistic approach is seen as personalized care and can include alternative treatments as well as enhanced collaboration with families and carers (McKenna et al., 2014). Participants expressed a desire to have opportunities outside of regular inpatient tasks, such as facilitating groups or engaging in gardening with patients. While time to engage in such activities is an ongoing challenge in the acute inpatient care setting (McKenna at el., 2014), the openness and desire to engage in a holistic approach offers hope to realizing a recovery-oriented inpatient mental health setting.

Continuity with Community. Participants hinted that relationships with patients can be strengthened through engagement with individuals in community mental health settings. They also voiced frustration with their lack of connection and understanding of community services. Recovery occurs in the context of community, both in hospital and outside of hospital where a person lives their life. Rebecca recognized this when sharing her experience of helping a patient get connected to housing as that was his primary concern during his time on the unit. Literature describes the need for continuity between acute and community, and that the lack of continuity inhibits a cohesive recovery-oriented mental health system (Jørgensen et al., 2020).

Leadership Support. Lorien et al. (2020) reviewed the implementation of recovery-oriented models of care in hospital settings and determined that although the biomedical model continues to prevail, it is still feasible to implement recovery-oriented practice in these settings.

The studies they reviewed described success when approaches were multifaceted, long term, and supported at an organizational level (Lorien et al., 2020). All participants described the need for leadership support in their endeavours to provide recovery-oriented care, whilst leadership was described as focused on bed flow and risk management.

Participants described themes in line with relationship based psychiatric nursing practice. While touching on recovery principles, they did not mention core recovery-oriented practices (e.g., person driven care, collaboration, or peer support); either these components were not practiced in their work settings or the participants did not think to include these practices as part of their own ROP. Participants talked about how the system places barriers to psychiatric nursing practice as they dreamt it could be—supporting recovery through relationship based psychiatric nursing practice. Perhaps, psychiatric nurses can support an individual's recovery journey through actualizing the ideals in relationship based psychiatric nursing practice, and perhaps, ROP in acute inpatient psychiatric care settings is only possible through a system wide change.

Chapter 6: Conclusion

This study was completed to discover how psychiatric nurses best practice ROP in acute inpatient psychiatric care settings through the lens of AI. Four nurses who identified as recovery-oriented and who worked in acute inpatient psychiatric care settings were interviewed using a semi structured interview that was designed to elicit positive stories of providing ROP in these settings. This inquiry is important given the ongoing challenges of providing ROP in the acute care portion of the mental health care continuum and the integral part psychiatric nurses play in mental health services. IPA was used to understand the participants' experience of providing ROP through their perspective. Data analysis determined that certain practices related to recovery existed in tandem with ongoing barriers to ROP and dreams for practice change. The practices, as described by participants, reflected the recovery literature to an extent, though, appeared to be more in line with relationship based psychiatric nursing practice. Further, the participants' recommendations and dreams for ROP in acute inpatient psychiatric care settings pointed towards the need for system change in order for psychiatric nurses to engage in ideal practice. Themes that emerged did not strongly reflect the principles of recovery, although hinted at a recovery-oriented dream, perhaps through the ideals in relationship based psychiatric nursing practice. Support through education and organizational structures, may create opportunities for psychiatric nurses to engage in ROP.

Limitations

Lorien et al. (2020) described a lack of opportunity for involvement by the patients themselves as a significant barrier toward implementing recovery-oriented practice in acute care settings. Given that the inclusion of those with lived experience is such an essential component of ROP (Le Boutillier et al., 2011; MHCC, 2015; SAMHSA, 2011), this research is limited in

that it only includes the perspective of psychiatric nurses. One could argue that any exploration or inquiry into the recovery paradigm should always include the perspectives of those with lived experience.

In addition to lacking the perspective of people with lived experience, as described above, the small sample size in this study was an additional limitation. The recruitment process of this study was extended due to a poor response, despite multiple methods employed to recruit. It is suspected that a combination of ambiguity around ROP and busy workload, as supported by the literature, contributed to lack of participant interest.

Lastly, the researcher changed work environments from acute care to community care services, so there was no vehicle for the researcher to fully reflect on the findings and develop a collective response toward actualizing dreams for practice change. From an AI perspective, the researcher was disconnected from the context that this study took place, and therefore, unable to fully dream alongside participants.

Implications and Future Research

Participants described practices that related to ROP, even though it was not a full embodiment of recovery-oriented principles. Through their discussion around barriers and recommendations, participants expressed a desire to improve the patient experience, to see and treat patients as individuals, and to explore other supports outside of the medical model of care. The recommendations described could be a stepping stone towards ROP in acute inpatient psychiatric care settings. New (and old) literature around the patient perspective supports the notion that relationship based psychiatric nursing practices can and do support recovery (Cusack et al., 2016; Delaney, 2010). There is room for psychiatric nurses to think about how their philosophy and theories can fit with recovery principles that come from a different paradigm.

There is also room for psychiatric nurses to enhance their current practices in order to support the recovery of patients.

Participants discussed several practical practice changes that could allow them to support the recovery of their patients and enhance the milieu of the work environment. Participating in groups, and other activities outside of the typical acute care nurse role, could enhance their relationships with patients as well as their sense of purpose as psychiatric nurses. Making an effort to spend time with patients during common activities, such as watching TV or playing cards, could also allow for further connection with patients. Being mindful of one's attitudes and presence in the work environment and making a conscious effort to be kind, courteous, and professional can create a safer, more positive milieu for both staff and patients. Lastly, having courage to challenge colleagues and provide feedback on patient care that may be harmful, while being a role model for recovery-oriented nursing practice, can help encourage peer colleagues to elevate their own practice.

In order to fully understand how psychiatric nurses best engage in ROP or care practices that support recovery, the perspectives of persons receiving such services should be explored. Presently, efforts can be made to include and involve peers in the acute care setting. Peers can enhance the experience, safety, and connection for patients. Frontline nurses who are passionate about ROP and peers can champion these efforts with the support of leaders. AI could be used to allow for equitable dialogue between peers, nurses, and leaders on how to incorporate peers in the acute care environment in a safe and meaningful way.

While being removed from the context of this research by way of a position change to leadership in the community was seen as a limitation to the researcher's ability to reflect as a front line acute care nurse, the findings and discussion from participants did enhance the

researchers understanding of her role as a leader. Participants highlighted a need to understand their role in ROP, to be empowered, and be part of change. They described the importance of feeling supported by leadership in many ways, including transparent communication, the gift of additional time with patients, and genuine interest in their wellbeing. As a practice leader, the researcher has learned insights from participants through their discussion of their needs. Leaders are often overwhelmed by pressures for beds, balancing budgets, and implementing mandated changes. By making a conscious effort to shift their focus to the wellbeing of the frontline staff, leaders can help support a team's ability to provide ROP. By being aware of the health of the care team and being mindful of a team's readiness for change, leaders can make the choice to prioritize when and how change occurs, and even invite teams to create change together. Lastly, by connecting with staff on a human to human level, perhaps through helping out with frontline work, leaders can develop a stronger trusting relationship with team members and lessen the 'us and them' often seen between these two groups.

Health care organizations are fraught with hierarchical practices and these need to be challenged to allow ROP to take place. Leaders can play a vital role in advocating for changes in usual ways of business. For instance, organizational changes should involve consultation and involvement from all of those who will be impacted. Risk averse attitudes and problem-based approaches can be challenged in order to better support the rights and strengths of patients. Though the medical model has an important place in psychiatry, more balance could be created through the inclusion of other models of care and other disciplines. For instance, when reviewing treatment for patients, a holistic approach can be used to look at a patient's needs and goals beyond medication. Open dialogue between front line nurses about ROP can be facilitated

at team meetings and huddles to expand nurses reflections on how their practices support recovery, and discover ways to further enhance practice.

The research findings suggest that relationship based psychiatric nursing practice could be a significant means by which psychiatric nurses contribute to ROP. Through the process of AI, psychiatric nurses can explore their values and dreams, and thereby, become receptive to enhancing their practice (Clossey et al., 2011). If psychiatric nurses had time to reflect on their practice at work and spend more time with patients, they may be able problem solve together how to support relationship based and recovery-oriented practice. Educational activities that link relationship based practice with the principles of recovery could enlist enthusiasm for ROP in acute care psychiatric nursing. With opportunities to dream together, psychiatric nurses could be empowered to advocate for the organizational change required to realize a recovery-oriented mental health system.

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Appendix A

Facilitating Recovery-Oriented Practice in

Acute Inpatient Psychiatric Care Settings through Appreciative Inquiry

Letter of Invitation

(placed on Brandon University letterhead)

Dear RPN/RN,

I am a student in the Master of Psychiatric Nursing Program through the Faculty of Health Studies at Brandon University. I am conducting a research study as part of the requirements of my program and I would like to invite you to participate in my study. My thesis advisor is Karen Clements. The title of my research is "Facilitating Recovery-Oriented Practice in Acute Inpatient Psychiatric Care Settings through Appreciative Inquiry".

You have been contacted because you have been identified as having knowledge and understanding of Recovery-Oriented Practice. The key features being sought in participants include a nurse who (1) supports a culture of hope, (2) promotes autonomy and self-determination, (3) has a strong ability to build rapport and trust, (4) focuses on strengths, (5) provides holistic and personalized care, (6) and encourages community participation (McKenna et al., 2014).

The knowledge gained through this research will increase our understanding of what recovery-oriented practice looks like in acute inpatient psychiatric care settings. This is important as mental health services continue to pursue adopting a recovery approach to care and given the unique context of the acute inpatient care environment. Additional theory, practice, policies, and education related to ROP in mental health services may be derived from this study.

Results from this study may be presented at scholarly conferences, in publications, and to managers in health authorities.

If you volunteer to participate in this study, you will be asked to take part in an interview that will last approximately 60-90 minutes. The interview will be conducted in a quiet place at a time of your convenience. The interview will be audio-taped and transcribed by myself. You will also be asked some demographic questions, for example, your age, nursing education, and nursing experience. Approximately one to three months following the interview, you will be contacted again to schedule a 30-45 minute follow up phone interview. The two purposes of the follow up interview will be (1) to ensure the themes I have generated in our initial meeting are correct from your perspective and (2) to develop a shared vision of recovery-oriented practice in acute inpatient psychiatric care settings by sharing the visions of the other participants and confirming them with you.

Your name will not appear in any report or publication of the research. Your data (e.g., interview recording, transcripts of interviews) will be safely stored in a locked cabinet and in a password-protected computer and only the thesis advisor and primary researcher will have access to the data. Your identity will be protected by the use of pseudonyms or false names. When your interview is transcribed, your name will be removed and efforts will be made to remove any features of your interview that could make you identifiable. All data will be destroyed after the completion of the study. Paper copies will be shredded and electronic files will be deleted.

Participation is voluntary and you may refuse to answer any questions or withdraw from the study up until three months after the interview. Participating or declining to participate in this study will not affect your relationship with the researcher or Brandon University.

Thank you for taking the time to read this information. If you have any questions about the study, you may ask me or my thesis advisor at the contact information given below. The research has been approved by the Brandon University Research Ethics Committee (BUREC). If you wish, you may contact them for questions regarding ethics at (204)727-9712 and burec@brandonu.ca. If you would like to participate in this study, please contact me either at the phone number or email listed below.

Sincerest Regards,

Karly Fennell, RPN, BScPN

Master of Psychiatric Nursing Student

Faculty of Health Studies

Brandon University

Phone: (604) 910-2374

Email: fennelkf10@brandonu.ca

Karen Clements RPN, MA

Master of Psychiatric Nursing

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Appendix B

Facilitating Recovery-Oriented Practice in

Acute Inpatient Psychiatric Care Settings through Appreciative Inquiry

December 10th 2019

Greetings;

My name is Karly Fennell and I am currently working on my thesis in the Master of Psychiatric Nursing program at Brandon University. The title of my thesis is '*Facilitating Recovery-Oriented Practice in Acute Inpatient Psychiatric Care Settings through Appreciative Inquiry*.' The purpose of this research is to gain understanding of how Registered Nurses and Registered Psychiatric Nurses best engage in Recovery-Oriented Practice in acute inpatient psychiatric care settings. I will be doing this research by interviewing psychiatric nurses who work in acute inpatient psychiatric care settings and who have knowledge and understanding of Recovery-Oriented Practice. I will also be incorporating the principles of Appreciative Inquiry throughout the research process to introduce it as a possible tool for enhancing Recovery-Oriented Practice in the acute care setting.

Inclusion criteria for participants in this study are as follows:

1. Must be a Registered Nurse or a Registered Psychiatric Nurse
2. Must be currently working in an acute inpatient psychiatric care setting
3. Must have knowledge and understanding of Recovery-Oriented Practice
    a. The key features being sought in participants include a nurse who supports a culture of hope, promotes autonomy and self-determination, has a strong ability to build rapport and trust, focuses on strengths, provides holistic and personalized care, and encourages community participation (McKenna et al., 2014)

If you participate in this research, you will be asked to participate in a 60-90 minute in person interview, as well as a 30-45 minute follow up phone interview approximately one to three months after the initial interview. The thesis is expected to be complete by September 2020. If you are interested, please contact me by phone or email at the contact details below. Please also see attached *Letter of Introduction and Invitation to Participate* with more details around being involved in this research.

Letter of Introduction and Invitation to Parti

Sincerely,

Karly Fennell

(t) 604-910-2374

(e) Fennelkf10@brandonu.ca

Appendix C

Facilitating Recovery-Oriented Practice in

Acute Inpatient Psychiatric Care Settings through Appreciative Inquiry

Consent—Agreement to Participate

(placed on Brandon University letterhead)

Dear Participant;

Research Project Title

Facilitating Recovery-Oriented Practice in Acute Inpatient Psychiatric Care Settings through Appreciative Inquiry

Principle Investigator

Karly Fennell, Student, Master of Psychiatric Nursing Program, Faculty of Health Studies, Brandon University. Phone (604) 910-2374 or email: fennelkf10@brandonu.ca

Research Supervisor

Karen Clements, Master of Psychiatric Nursing Program, Faculty of Health Studies, Brandon University. Phone (204) 770-4375 or email: clementsk@brandonu.ca

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you a basic idea of the research and your participation. If you would like more detail about something in this letter, or information that is not included here, please feel free to ask. Please take the time to read this consent form carefully and to understand any accompanying information.

You are invited to participate in a study called “Facilitating Recovery-Oriented Practice in Acute Inpatient Psychiatric Care Settings through Appreciative Inquiry”, which is being conducted by me.

Purpose and Objectives

The purpose of this study is to explore the peak experiences of psychiatric nurses providing recovery-oriented care in acute inpatient psychiatric care settings. Principles of Appreciative Inquiry, such as a focus on strengths will be used in the interview, meaning, the focus of the questions will be to explore peak experiences of providing recovery-oriented practice.

Inclusion Criteria, Exclusion Criteria, and Participation

You are being asked to participate in this study because you are a Registered Psychiatric Nurse (RPN) or a Registered Nurse (RN) who is employed in an acute inpatient psychiatric care setting. You will not be able to participate in this study if you have a professional or personal relationship with the primary researcher (myself). Participation in this study is voluntary. You may stop at any time without any consequence or any explanation. You may decline to answer any question or you may withdraw from participating in this study by letting me know directly any time during the interview. You may also withdraw from participating following the interview by contacting me by phone at (604)910-2374 or by email at fennelkf10@brandonu.ca up until one month following the final interview. If you withdraw from this study, your data will not be used and it will be destroyed.

What is involved?

If you agree to participate in this study, you will be asked to take part in an interview that will take approximately 60-90 minutes. The interview will be conducted at a mutually agreed upon time and in a private place. You will be asked to complete some demographic questions, including age, education, and experience. You will also be asked to participate in a follow up interview, which will take place approximately one to three months following this interview.

The follow up interview will be over the phone and only 30-45 minutes, with the purpose being for myself to tell you about the themes I generated from our initial interview and confirm they are true to your interpretation.

Risks

Participation in this study may cause some inconvenience to you, including the time it takes to be interviewed. If at any point in the interview you feel uncomfortable and wish to stop, please let me know. As a participant you have the opportunity to withdraw from the study at any time. If you do not wish to discuss a particular question, please let me know and the question will be omitted. It is not anticipated that any information will be collected regarding the abuse of patients in care, however the researcher has a duty to report if this is disclosed.

Benefits

The knowledge gained through this research will increase our understanding of what recovery-oriented practice looks like in acute inpatient psychiatric care settings. This is important as mental health services continue to pursue adopting a recovery approach to care and given the unique context of the acute inpatient care environment. Present and future nurses may benefit from the results of this research, including the patients that fall under their care in the acute care setting.

Confidentiality

Your interview will be audio-recorded and transcribed by the researcher. Audio recording the conversation will allow me to transfer our dialogue into notes. I may also make a few handwritten notes during our interview. The computer files and transcripts of our conversation will be kept confidential and only accessed by myself, Karly Fennell and my thesis advisor, Karen Clements. The computer files will be saved on a USB flash drive and safely stored with

the notes in a locked filing cabinet. Transcribed electronic copies will be stored on a password protected computer. Your identity will be protected by use of pseudonyms or false names. When your interview is transcribed, your name will be removed and will not appear in any report, publication, or presentation of the research. I may quote you to illustrate a point, however, efforts will be made to remove any features of your interview that could make you identifiable.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways: published articles, posters or presentations at conferences, and as a thesis presentation. In addition, arrangements will be made to present the findings with leadership. Lastly, a pdf document with a summary of themes will be shared with the BCCNP and Health Authorities. Research findings will be shared with study participants following completion of the study via email with a link to the thesis.

Your signature on this form indicates that you have understood and are satisfied with the information provided regarding participation in this research project and have agreed to participate. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and / or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed in your initial consent, so you should feel free to ask for clarification or new information throughout your participation at any time. If you have questions, please do not hesitate to contact myself or my supervisor directly at the phone number or emails provided.

This research has been approved by the Brandon University Research Ethics Committee (BUREC). If you have any questions regarding ethics, they may be contacted at (204)727-9712 and burec@brandonu.ca. A copy of this consent form will be given to you to keep for your records and reference.

First Interview

Participant's Signature _____ Date _____

Researcher's Signature _____ Date _____

Follow up Interview

Participant's Signature _____ Date _____

Researcher's Signature _____ Date _____

Appendix D

Facilitating Recovery-Oriented Practice in

Acute Inpatient Psychiatric Care Settings through Appreciative Inquiry

Confidentiality Agreement

(placed on Brandon University letterhead)

Principal Investigator: Karly Fennell

I, _____ affirm that I will not disclose or make known any matter or thing related to the participants that comes to my knowledge during this research project.

Transcriptionist	**DATE**
Witness	**DATE**

Appendix E

Facilitating Recovery-Oriented Practice in

Acute Inpatient Psychiatric Care Settings through Appreciative Inquiry

Interview Guide

(placed on Brandon University letterhead)

You have been asked to participate in this study because your professional role entails practicing psychiatric nursing in acute inpatient psychiatric care settings. The purpose of this study is to explore how you best engage in Recovery-Oriented Practice within the acute care setting.

With your consent, this interview is being audio-recorded. I must report any information that is collected regarding the abuse of clients in care. If at any point in the interview you feel uncomfortable and wish to stop, please let me know. You may choose to not answer some questions. Take as much time to think about the answer of the questions as required. Your responses are confidential. My thesis advisor and I are the only individuals who will have access to your responses to these questions. When transcribed, any names present will be removed and efforts will be made to remove any identifiable features of your interview.

Interview Questions:

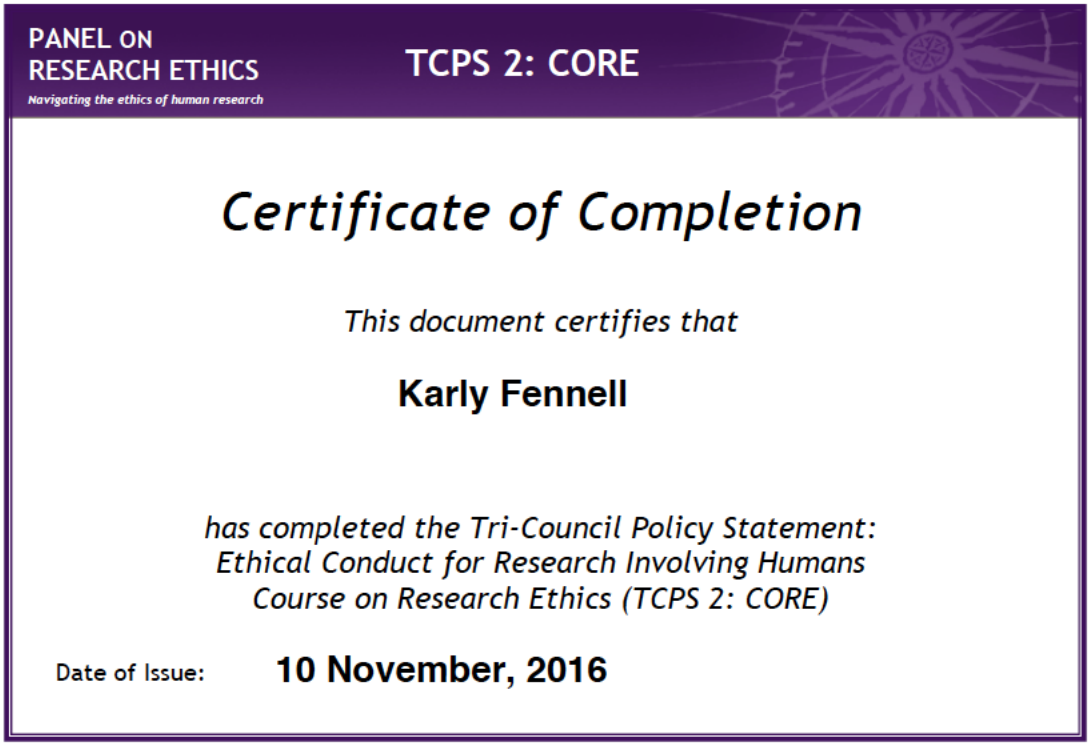
1. What does Recovery-Oriented Practice mean to you?
2. How does Recovery-Oriented Practice fit into the acute care context?
3. Please describe your experiences in providing Recovery-Oriented Care within your work in the acute care setting?
    a. How do you collaborate with patients in your daily practice and involve them in their care?

   b. How do you convey optimism and hope in your daily practice with patients?

4. Think about a time where you felt you were truly able to support a patient's recovery?
   a. Please describe that?
   b. What did your practice look like?
   c. Was there anything in particular that supported that experience?
   d. How did it feel from a professional standpoint?
   e. Why does this experience stand out for you?
5. What are the most important influences you have made to patient's wellness, recovery, and quality of life?
6. What would the ideal Recovery-Oriented Inpatient Psychiatric unit look like? Describe the layout and the staffing involved. What types of programs would be offered? How would recovery be supported?
7. What would transformed practice look like to you? What is your vision of a Recovery-Oriented Inpatient Psychiatric unit?
8. What supports are necessary to support Recovery-Oriented Practice in Inpatient Psychiatric Care Settings?

Appendix F

TCPS2 Certificate



PANEL ON RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Karly Fennell

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **10 November, 2016**

Appendix G

Brandon University Research Ethics Committee: Ethics Certificate

BRANDON UNIVERSITY

Brandon University Research Ethics Committee (BUREC)
Ethics Certificate for Research Involving Human Participants

The Brandon University Research Ethics Committee (BUREC) has reviewed and approved this ethics proposal in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2-2014)*, the *Brandon University Policy on Research Involving Humans,* and the *Brandon University Research Ethics Committee (BUREC) Policies and Procedures.*

This approval is subject to the following conditions:

1. Approval is granted only for the research and purposes as described in the ethics application.
2. Ethics Certification is valid for up to five (5) years from the date approved, pending receipt of Annual Progress Reports. As per *BUREC Policies and Procedures*, Section 6.0, "At a minimum, continuing ethics research review shall consist of an Annual Report for multi-year projects and a Final Report at the end of all projects... Failure to fulfill the continuing research ethics review requirements is considered an act of non-compliance and may result in the suspension of active ethics certification; refusal to review and approve any new research ethics submission, and/or others as outlined in Section 10.0".
3. Any changes made to the protocol must be reported to the BUREC prior to implementation. See *BUREC Policies and Procedures* for more detail.
4. Any deviations to the research or adverse events must be submitted to the BUREC as soon as possible.

As per *BUREC Policies and Procedures*, Section 10.0, "Brandon University requires that all faculty members, staff, and students adhere to the *BUREC Policies and Procedures*. The University considers non-compliance and the inappropriate treatment of human participants to be a serious offence, subject to penalties, including, but not limited to, formal written documentation including permanently in one's personnel file, suspension of ethics certification, withdrawal of privileges to conduct research involving humans, and/or disciplinary action."

Principal Investigator:	**Ms. Karly Fennell, Brandon University**
Title of Project:	**Facilitating Recovery-Oriented Practice in Acute Inpatient Psychiatric Care Settings through Appreciative Inquiry**
Co-Investigators:	n/a
Faculty Supervisor: *(if applicable)*	Prof. Karen Clements, Brandon University
Research Ethics File #:	22483
Date of Approval:	June 26, 2019
Ethics Expiry Date:	June 26, 2024

Authorizing Signature:

Christopher D. Hurst

Mr. Christopher Hurst
Chair, Brandon University Research Ethics Committee (BUREC)