Practices of Novice Acute Care Psychiatric Mental Health Nurses in Providing Recovery-Oriented Care

Elizabeth Rowlands, BSc, BN, MN, RN, CPMHN(C)

A Thesis Submitted to the Faculty of Graduate Studies
in partial fulfilment of the requirements for the degree of
Master of Psychiatric Nursing

Brandon University
Brandon, Manitoba

Thesis Committee:
Professor Andrea Thomson, Thesis Advisor, Brandon University
Professor Katherine Pachkowski, Brandon University
Professor Chantille Isler, Memorial University of Newfoundland

Abstract

Worldwide, recovery has become the dominant paradigm shaping psychiatric and mental health (PMH) policy. However, the biomedical model and clinical recovery have been prominent in acute care PMH settings, which has created challenges to the integration of recovery-oriented practice. Recovery education for PMH professionals has been the strongest factor in predicting improved knowledge and attitude regarding recovery. Across Canada, the educational preparation of Registered Nurses (RNs) has been through comprehensive (generalized) baccalaureate nursing programs. However, the PMH content in comprehensive baccalaureate nursing programs has varied. Using Sally Thorne's interpretive description method, the purpose of this inquiry was to explore and interpret the experiences of novice PMH RNs in the provision of recovery-oriented care in acute care settings. Six novice PMH RNs who worked in acute care were recruited through purposive and snowball sampling. Data were collected through from semi-structured interviews with participants and other collateral data sources. Overall, the participants voiced a general understanding of the topic of recovery, and they engaged in recovery-oriented practices in an adult acute care PMH setting. Nevertheless, they experienced challenges due to a dearth of workplace resources and educational preparedness. Novice PMH RNs reported that they want additional support to better service clients. The recovery education provided to undergraduate nursing students and novice PMH RNs should target their recovery knowledge gaps and bridge the theory-practice divide. Additionally, the support needs of novice PMH nurses must be addressed.

Acknowledgments

First and foremost, I would like to thank my thesis advisor, Professor Andrea Thomson. You provided a phenomenal amount of support. I will forever be grateful for your prompt feedback, clear communication, proof-reading skills, and encouragement.

I would also like to extend my gratitude to my thesis committee members, Professor Katherine Pachkowski and Professor Chantille Isler. Your valuable input and motivational messages were much appreciated.

I also thank Brandon University (BU) faculty who taught me. You taught me much about being a Psychiatric Mental Health nurse. I have been proud to be a BU graduate student.

I thank all the novice Psychiatric Mental Health Registered Nurses who took part in this study and enabled this research to be possible. I also thank my colleagues, past and present, for their support.

To my mom, thank you for the cooked meals and endless hours of childcare that you provided, sometimes on a moment's notice. To my significant other, Greg, thank you for your scheduling flexibility and for regularly reminding me that you were proud of me. To my four-year old son, Jake, thank you for always putting a smile on my face; spending time with you provided the mental health breaks that I frequently needed.

Finally, I need to thank my dad. You taught me the value of education and life-long learning. You encouraged me to work hard and to be the best that I can be. It was because of you that I applied to the Master of Psychiatric Nursing program in the first place and have been able to get through the past five years. Some day, I hope to be half as good of a writer -- and parent -- as you.

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Chapter 1: Introduction

Since the era of deinstitutionalization, which began in many countries during the 1960s and 1970s, people living with mental illnesses have been able to receive supports and services in a variety of settings, such as community and acute care (Anthony, 2000; Mental Health Commission of Canada, 2012a). Worldwide, recovery has become the dominant paradigm shaping psychiatric and mental health (PMH) policy (Braslow, 2013). Recovery-oriented practice is an approach to care based on the belief that people with mental health problems can live meaningful and fulfilling lives even with ongoing symptoms of illness (Anthony, 1993). Recovery-oriented practice focuses care on respecting individuality, instilling hope, and empowering personal choice (Mental Health Commission of Canada, 2015). In the provision of recovery-oriented care, effective and relevant services should be available, well-coordinated, and accessible to clients (Anthony, 2000). Mental health services are shifting towards recovery-oriented care. Due to this shift, in 2017, the Government of Newfoundland and Labrador (NL) released the provincial plan to transform mental health and addictions services in the province "towards recovery" (Government of NL, 2017).

Background

Recovery is not a new concept, however, it has been often poorly defined and misunderstood (Mental Health Commission of Canada, 2015), especially in acute care settings (Hristodoulidis et al., 2022; Waldemar et al., 2016). Consequently, although the provision of recovery-oriented practice is a guiding principle in PMH care, a gap has remained between policy and implementation (Le Boutillier et al., 2011). The biomedical model and clinical recovery have been prominent in acute care PMH settings, which has created challenges to the integration of recovery-oriented practice (Gyamfi et al., 2020; Lorien et al., 2020). Nursing care

provided in an acute care setting has focused on risk management and client containment (Hristodoulidis et al., 2022; Stevenson et al., 2015).

Recovery education for PMH professionals has been the strongest factor in predicting improved knowledge, attitude, understanding, perception, and expectation regarding recovery (Gyamfi et al., 2020). Since 2004, across Canada, the educational preparation of Registered Nurses (RNs) has been through comprehensive (generalized) baccalaureate nursing programs (Brookes et al., 2009). However, the PMH content in the comprehensive baccalaureate nursing programs varies. In 2015, 36 of 46 undergraduate nursing programs across Canada offered a designated mental health theory course (Vandyk, 2015, as cited in Kent-Wilkinson et al, 2016). Of the 36 designated courses, 19 were mandatory and seven were elective. Eight undergraduate nursing programs threaded mental health theory throughout their curriculum. Only 30 of the 46 nursing programs offered both mental health theory and mental health clinical courses (Vandyk, 2015, as cited in Kent-Wilkinson et al, 2016). New RNs working in PMH have reported a dichotomy between ideal practice and reality, creating confusion between what they were taught and the realities they encountered in practice (Hooper et al., 2016).

Problem Statement

There has been a paucity of literature exploring the experiences of new RNs in the provision of recovery-oriented care. Therefore, research was required to determine if novice RNs working in acute PMH settings possess the knowledge and/or confidence to provide recovery-oriented care.

Statement of Purpose and Research Question

The purpose of this inquiry was to explore and interpret the experiences of novice NL PMH RNs in the provision of recovery-oriented care in acute care settings. Sally Thorne’s

(2016) interpretive description method was used to explore the research questions: Are novice RNs enabled to provide recovery-oriented care; and what factors influence their ability to do so in adult acute care PMH settings? To answer this research question, six novice acute care PMH RNs were interviewed and described their educational and clinical practice experiences regarding recovery-oriented care. A deeper understanding was obtained of the factors that influence the provision of recovery-oriented care delivered by novice PMH RNs in an adult acute care setting. Implications for NL undergraduate comprehensive nursing programs as well as orientation classes for nursing graduates entering PMH practice will be discussed. Also, given that the recovery concept has been described as lacking clarity, research findings may assist PMH nurses in the development of an enhanced understanding of recovery-oriented practices in an acute care setting.

Conceptual Framework

Recovery, as outlined by Anthony (1993), was used as the conceptual framework for this research study. In the literature, Anthony's definition of recovery is the most widely cited definition (Vansteenkiste et al., 2021) which underpins recovery policy internationally (Slade et al., 2014). Anthony's (1993) description and principles of recovery was used to aid in the understanding of the research problem and generate the research question. Moreover, the recovery model provided a foundation for the study and was used to explain the research findings. Anthony (1993) described recovery as living a satisfying, hopeful, and contributing life, even with on-going limitations from mental health illnesses. PMH healthcare providers must understand recovery in order for a recovery-facilitating environment to occur (Anthony, 1993).

Using interpretive description, six novice PMH nurses were interviewed and discussed recovery-oriented care in acute care settings. Participants shared their understanding of recovery

and challenges to recovery-oriented care provision in the adult acute care setting. A lack of educational opportunities to better their recovery-oriented practices and PMH nursing care was reported. Despite a lack of educational opportunities, in this study, the participants' descriptions of recovery largely aligned with Anthony's definition. In addition, the participants described a lack of supports and resources available to assist with recovery-oriented care provision. Many of these findings are consistent with available literature which has noted challenges to recovery-oriented care provision (Cleary et al., 2013; Delaney, 2012; Le Boutillier, Slade, et al., 2015; Nardella et al., 2021; Terry & Coffey, 2019).

Chapter 2: Literature Review

In the past, mental health systems were established in the belief that people with persistent mental illnesses did not recover from their illness (Anthony, 2000). In the 1980s and 1990s, a key impetus for the recovery movement came from people with lived experience of mental health problems; they maintained that their personal identities were more than their diagnoses (Mental Health Commission of Canada, 2015). Recovery movements have grown and expanded in recent decades. In 2002, the United States proposed the transformation of the national mental health system with greater emphasis on recovery (Braslow, 2013). In 2009, Canada followed, announcing a national mental health strategy. The first goal of this strategy was that people living with mental illness be actively engaged, and supported, on their journey towards recovery and well-being (Mental Health Commission of Canada, 2009). Many other countries joined this movement by establishing their own mental health policies, focusing on recovery (World Health Organization [WHO], 2021). The recovery paradigm should shape and inform mental health policy (Davidson, 2016). In 2021, the WHO called for continued mental health care that respects human rights and is focused on recovery (WHO, 2021).

Recovery

The Mental Health Commission of Canada (2012b) definition of recovery described recovery as living a hopeful, satisfying, and contributing life, even while experiencing mental health problems or illnesses. Recovery occurs when people with mental illnesses or addictions feel empowered, are hopeful, and find meaning in their experience; this does not mean recovery from symptoms or a cure (All-Party Committee on Mental Health and Addictions [APCMHA], 2017). Both definitions described recovery as a positive process.

Recovery has been described as having contrasting conceptualizations: clinical recovery and personal recovery (Gyamfi et al., 2020). Clinical recovery frames mental illness from a deficit perspective, focusing on symptom stabilization through medications and risk-management (Le Boutillier, Chevalier, et al., 2015). Clinical recovery has been measured by symptom-remission, lack of relapse, acquired insight, and improvement in daily living skills (Le Boutillier, Chevalier, et al., 2015). The healthcare professional has been considered the expert within this perspective (Le Boutillier, Chevalier, et al., 2015). Alternatively, personal recovery has been described as a holistic approach in which the client's individuality is primary, and healthcare professionals and clients work as partners (Le Boutillier, Chevalier, et al., 2015). Personal recovery has been aligned with the definition of recovery offered by Anthony (1993):

> 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)

From the perspective of personal recovery, persons with lived experience are considered experts and the experience of recovery is not limited by illness and disability (Anthony, 1993). Recovery is a nonlinear process that can take place if symptoms reoccur and without professional intervention (Anthony, 1993). Moreover, recovery from the consequences of illness, such as stigma, maybe more difficult than recovering from the illness itself (Anthony, 1993). For the purpose of the proposed research, Anthony's definition of recovery was the selected definition of recovery, as it entails an acknowledgement that people living with mental illnesses can encounter

challenges. However, health care delivery in current PMH acute care systems have tended to align with the concept of clinical recovery (Hristodoulidis et al., 2022).

Recovery-Oriented Systems

A PMH system guided by a vision of recovery must have policies and procedures in place to increase the possibility of personal recovery occurring (Anthony, 2000). Anthony described the services of a recovery-oriented system by offering comprehensive organizational standards that incorporated systems-level research and recovery principles, which provided direction to system planners for matters such as leadership, management, and training. The standards provided a basis for client/family involvement which highlighted that, in the personal recovery approach, healthcare professionals and clients work as partners (Anthony, 2000). A recovery-oriented system should employ policies that ensure staff at all levels understand recovery and its implications in the context of services (Anthony, 2000). Also, policies should encourage training methods designed to improve staff knowledge, attitudes, and skills necessary to conduct services (Anthony, 2000).

However, in the literature, there have been criticisms of the application of recovery. It has been argued that, although ideally, recovery would benefit the provision of PMH care, the overwhelming agreement limits argument and evaluation (Tilley & Cowan, 2011). Furthermore, the lack of a single definition of recovery has resulted in a lack of clarity as to what steps should be taken for healthcare providers and organizational systems to provide recovery-oriented care (Pilgrim & McCranie, 2013). An organizational emphasis on processes has negatively altered recovery-oriented practice, shaping PMH staff understanding of recovery-oriented practice (Le Boutillier, Slade, et al., 2015). Recovery support has been modified to fit a health infrastructure organized around diagnosis, symptoms, and risk. Moreover, the meaning of recovery has been

shaped by the traditional focus on hierarchy, clinical tasks, professional language, medicalization, and psychiatric power (Le Boutillier, Slade, et al., 2015).

In 2017, content in NL's APCMHA report stressed the importance of system policies and procedures that put peoples' needs first (APCMHA, 2017). The importance of ongoing education and training to support/treat clients was declared essential. Also, in 2017, the Government of NL (2017) released its provincial plan, "Towards Recovery," to transform mental health and addiction services in the province. This recovery-focused vision included the provision of programs/services to instill hope and empower people to seek mental health and well-being. Four pillars set the policy direction: promotion, prevention, and early intervention; focus on the person; improvement of service access, collaboration, and continuity of care; and inclusion of people in every part of province. Staff in health and correctional systems were to receive the recovery education required (Government of NL, 2017). In July 2023, the Government of NL (2023a) released the final evaluation report, outlining changes that had occurred since the release of the provincial plan. Achievements in the transformation of the provincial mental health and addictions system into one that is more person-centred, trauma-informed, and recovery-focused were provided. However, it was recognized that challenges remain that need to be addressed which include limited local services/staffing resources, low awareness of existing supports/services; mental health literacy; and stigma.

In summary, it is the nature of mental illness to be multifaceted: people living with mental illnesses may have multiple residential, vocational, educational, and social needs/wants (Anthony, 1993). In the provision of recovery-oriented care, not only must effective and relevant services be available, but they should also be well-coordinated to be accessible and efficient

(Anthony, 2000). The largest professional group providing care to clients with mental health problems are PMH nurses (Foster et al., 2019).

PMH Nursing

Exploring what psychiatric nurses do has been important to the promotion and the defense of the profession and for the assistance of novice psychiatric nurses in the development of their knowledge and skills (Thomson et al., 2019). However, confusion regarding the PMH nurse-role exists. The role of the PMH nurse has been described as unclear by PMH nurses, their colleagues, and their clients (Terry, 2020). Communicating the role of the PMH nurse has proven difficult due to the complexity and frequent invisibility of their practice to others (Hercelinskyj et al., 2014; Landis et al., 2020; Terry, 2020; Waddell et al., 2020). Role blurring and an increased focus on administrative duties have contributed to PMH nurses experiencing role ambiguity (Terry, 2020).

Graham et al. (2020) indicated that psychiatric nursing is a distinct profession with care provision focused on developing therapeutic relationships with clients and providing holistic and recovery-oriented care. Also, psychiatric nurses were involved in stigma reduction and service improvement advocacy (Graham et al., 2020). However, that PMH nurses' professional identity was contextualized within the primacy of the therapeutic relationship was not always reflected in the literature. The term "mental health nursing" has been described as a myth, suggesting how nurses would like to be, rather than the reality of their practice (Barker & Buchanan-Barker, 2011). "Mental health nursing" has implied a more collaborative, health promoting role; yet, it has been argued that nurses' roles have not changed and involve keeping people safe, providing medical treatment, and managing the hospital environment (Barker & Buchanan-Barker, 2011). Nurses have reported being caught between principles of empowerment and long-standing

practices based on coercion (Cleary et al., 2018). Also, some nurses have thought that interpersonal engagement with people at risk of suicide as sometimes inappropriate or counter-therapeutic (Lees et al., 2014). Educators need to employ teaching strategies to ensure psychiatric nursing students are provided with the comprehensive knowledge required for practice (Graham et al., 2020).

Recovery Knowledge

Despite articles and documents defining recovery and providing guidance on recovery-oriented practice, there has been a lack of shared understanding of what recovery means in PMH nursing practice. As stated, PMH systems often align with the concept of clinical recovery, rather than personal recovery. Accordingly, PMH nurses and other PMH professionals have confused clinical and personal recovery (Gyamfi et al., 2020), equating recovery-oriented practice with the traditional medical approach revolving around medical stabilization, symptom relief, and a return to functioning pre-illness (Aston & Coffey, 2012; Hristodoulidis et al., 2022; Waldemar et al., 2016).

Without a thorough understanding of the concept of recovery, it has proven difficult to embrace a recovery-oriented service (Aston & Coffey, 2012). Since the era of deinstitutionalization, people living with mental illnesses have no longer been limited to receiving supports and services in hospital settings (Anthony, 2000). Recovery-oriented systems would provide a variety of supports in an array of settings, such as community and hospital (Anthony, 2000).

Recovery in Acute Care Settings

Psychiatric emergency services, general emergency departments, and acute care inpatient psychiatric units have been the usual settings where clients with mental health illnesses received

acute care (Schmidt & Uman, 2020). Key reasons for admission to acute care included risk of danger to self or others and the need for intensive observation, diagnosis, and medical treatment within a secure environment (Bowers, 2005). Clients have had elevated mood or experienced psychotic symptoms, which has often resulted in client agitation and aggression (Hristodoulidis et al., 2022). Accordingly, the acute care psychiatric setting has been described as involving high acuity, involuntary treatment, risk assessment/management, and rapid client turnover (McKenna et al., 2014). Around the world, it has been common for acute care psychiatric units to be locked, lest clients leave, harming themselves or community members (Muir-Cochrane et al., 2012).

Thus, care provided in acute care has focused on risk management and client containment (Hristodoulidis et al., 2022; Stevenson et al., 2015), which has had negative implications for the therapeutic relationship. In a British study, nurses working on acute psychiatric inpatient units said that having a locked unit made them feel more in control, however clients felt that the staff enjoyed the power and superiority it gave them (Muir-Cochrane et al., 2012). Mandated visual observations (time varying depending on estimated risk) can cause client frustration and social withdrawal (Hristodoulidis et al., 2022). Many acute care practices and procedures, such as surveillance rounds, rules, search procedures, locked doors, and the use of seclusion and restraint, may be experienced as traumatizing (Muskett, 2014).

Acute care units have been described as busy, fast-paced environments (Solomon et al., 2021). PMH nurses have said that time pressures impinge on their ability to provide care (Graneheim et al., 2014; McKenna et al., 2014). This was echoed in an Australian descriptive observational study: nurses, working in an acute care psychiatric inpatient setting, spent 32% of their time in direct care, 52% in indirect care, and 17% in service-related activities (Goulter et al., 2015).

In the acute care setting, the biomedical model has dominated (Lorien et al., 2020). Inherent in the biomedical model has been a systemic focus on hierarchy and the medicalization of treatment (Le Boutillier, Slade, et al., 2015). Inpatient hospitalization has involved waiting for medications to take effect, with psychotherapy mainly available as an out-patient service (Graneheim et al., 2014). In interactions with clients, nurses have felt that their priority was to gather information for physicians (Graneheim et al., 2014). Also, PMH nurses have been expected to stop what they were doing to attend physicians' reviews; implicit in that expectation was the suggestion that their work with clients was of lesser importance than the physicians' (Hristodoulidis et al., 2022). Nurses have described support from management as important to them; however, as they saw management as mainly invisible, they felt support was lacking (Graneheim et al., 2014).

Often, acute care hospitalization has been the first step for clients in their personal recovery journeys (Hristodoulidis et al., 2022). However, in light of the foregoing, the provision of recovery-oriented care in acute care inpatient settings has been challenging (Waldemar et al., 2019). The biomedical model has not aligned with personal recovery, in which healthcare professionals and clients are intended to work as partners (Le Boutillier, Slade, et al., 2015). In interactions between clients and health professionals, collaboration may have appeared "as if" they were equal, however decisions were primarily made by health professionals (Waldemar et al., 2016). Positive affirmation and listening to clients' concerns have been central to the recovery journey, yet PMH nurses have lacked time to prioritize this need (McKenna et al., 2014). Nurses opined that, for staff to "buy" into recovery principles, support should start with leadership (Repique et al., 2016), yet leadership in the acute care setting has been lacking (Graneheim et al., 2014). Lack of adequate clinical supervision has been an obstacle to client

engagement, supervision being important for the development and reinforcement of therapeutic skills (Lees et al., 2014). Misunderstanding of recovery principles, and difficulties translating them, requires exploration of recovery and acute care PMH nursing practice.

Recovery and Acute Care PMH Nursing Practice

Considering the foregoing, care provided by PMH nurses in the acute care setting has typically been aligned with the concept of clinical rather than personal recovery. PMH nurses have cited client aggression as impediments to recovery-oriented care (Hristodoulidis et al., 2021).

Nevertheless, PMH nurses, with the necessary knowledge and skills, have provided recovery-oriented care for clients at high risk for aggression in the acute care setting (Lim et al., 2021). A Canadian study reported that nurses had a responsibility to control clients' behaviours, however, some nurses associated clients' loss of power with risk of violence and strategized ways to give clients more choice (Stevenson et al., 2015). In an Australian observational study, nurses respected clients' rights; there was no evidence of coercion (Sreeram et al., 2023). Nurses who embraced the recovery model put their clients' needs first, above their own, with greater consistently than nurses who did not (Stevenson et al., 2015). Similarly, in Australia, to reduce aggression, by working in an egalitarian partnership with clients, nurses incorporated recovery-oriented care (Lim et al., 2021). Nurses related to clients in such a way that the clients felt safe sharing their thoughts and emotions; by exploring the impact of their lived experiences, clients assumed ownership of their recovery journey (Lim et al., 2021). The nurses acknowledged and explored clients' negative lived experiences, including hospitalization, and collaborated with clients to reduce triggers for aggression (Lim et al., 2021).

Person-centred care provision is an important aspect of client recovery in which care is tailored to client strengths, goals, and needs throughout their recovery journey (Thomson et al., 2019). In Finland, when communicating with clients in seclusion rooms, nurses strove to practice patient-centred communication by recognizing client needs as well as their attitudes and feelings (Berg et al., 2023). In a Canadian study, expert acute care psychiatric nurses worked with clients to develop and deliver person-centred care plans, including the determination of goals and the enhancement of coping strategies (Thomson et al., 2019). Additionally, the psychiatric nurses provided person-centred teaching, with the aim of helping clients cope with their illnesses and assist with their recoveries (Thomson et al., 2019), which is consistent with the perspective of personal recovery. The psychiatric nurses listened to the clients, fostering hope (Thomson et al., 2019). Similarly, in New Zealand, recovery-oriented nursing care involved working collaboratively with clients, focusing on their strengths, finding meaning, and instilling hope (Solomon et al., 2021).

Thus, in the PMH acute care setting, in order to provide recovery-oriented care, nursing care priorities were deemed to require a shift from a task focus to spending time with clients (Solomon et al., 2021). Despite organizational and contextual challenges, some acute care PMH nurses have pragmatically found ways, unique to their environments, to engage with clients (McKenna et al., 2014). For example, PMH nurses have made the most of opportune moments (McKenna et al., 2014). Interactions with clients have often been unplanned, taking place in corridors (Graneheim et al., 2014). Also, PMH nurses have used humour to make protocols more acceptable and person-centred for clients (Cleary et al., 2011). Years of experience has improved nurses' communication skills (Graneheim et al., 2014) and understanding of how recovery-oriented care can be provided in acute care setting (Lim et al., 2021). Person-centred care

requires empathy, patience, respect, and understanding of these skills should be incorporated into nursing education (Thomson et al., 2019).

Recovery and PMH Education

Happell, Byrne, et al. (2015) argued that the education of PMH professionals is crucial to the successful implementation of recovery-oriented practices. In the literature, conflicting findings were noted while exploring the recovery knowledge of PMH nurses versus other PMH professionals. In a narrative review, it was found that PMH nurses' recovery knowledge and attitudes were similar to non-nursing PMH professionals (Sreeram et al., 2021). In an Australian observational study, it was thought that the evidence of positive recovery-oriented practices on an acute care unit might have been associated with the presence of younger nurses whose education had emphasized recovery-oriented practices (Sreeram et al. 2023). However, the younger nurses demonstrated a discernable level of anxiety before communicating with clients (Sreeram et al., 2023). Yet, in Japan, social workers had significantly higher Recovery Knowledge Inventory (RKI) scores than nurses (Chiba et al., 2020). Given the differences in scores between nurses and social workers, community-based education was considered more effective than the medical-based education used in nursing education (Chiba et al., 2020).

Canadian PMH Nurse Education

In Canada, the educational preparation of nurses caring for the PMH population varies (Smith & Khanlou, 2013). Licensed Practical Nurses (LPNs), RNs, and Registered Psychiatric Nurses (RPNs) all provide PMH care, but have differing standards of practice (Smith & Khanlou, 2013). Regulation is managed provincially and territorially.

Since 2004, across Canada, the educational preparation of RNs has been through comprehensive (generalized) baccalaureate nursing programs (Brookes et al., 2009). Many

comprehensive nursing programs no longer have dedicated PMH nursing courses; instead, content called psychosocial nursing has been integrated throughout the curriculum (Brookes et al., 2009). Conceivably, students have graduated from comprehensive baccalaureate programs without having ever interacted with a person living with mental illness (Brookes et al., 2009).

RNs can specialize in a particular field, which involves developing knowledge and skills in that field, going beyond basic nursing education (Miller, 2002, as cited in Canadian Nurses Association, 2015). After practicing the required number of years in a field, certification in a specialized area of nursing may be achieved by writing an examination (Canadian Nurses Association, 2022). However, this certification is often optional, rather than required, for nurses to work in a specialized area such as mental health.

Upon graduation from a comprehensive program, RNs are expected to perform entry-to-practice competencies (Canadian Council of Registered Nurse Regulators, 2018). Based on the current competencies, RNs are to provide recovery-oriented care in partnership with clients, use principles of trauma-informed care, incorporate mental health promotion, and incorporate suicide prevention approaches (Canadian Council of Registered Nurse Regulators, 2018). The preceding RN entry-to-practice document, published in 2012, did not mention recovery (Jurisdictional Collaborative Process, 2012), which may contribute to a lack of a consistent understanding of recovery-oriented PMH nurse care provision.

Novice PMH Nurse Experiences

Clinical judgement has developed through engagement in the social context of practice (Benner et al., 1997). A Canadian study found that novice nurses working in PMH transitioned from taking a passive role to an active one (Schwartz et al., 2011). Through observation, nurses learnt the social processes inherent in healthcare teams (Schwartz et al., 2011). Similarly, Iranian

novice nurses reported being unsure what PMH nursing competencies were. Gradually, as they were accepted by staff and established relationships with clients, they developed professional identity (Khankeh et al., 2014).

Novice nurses working in PMH have reported a dichotomy between ideal practice and reality, creating confusion between what was taught and the realities encountered in practice (Hooper et al., 2016). Novice nurses entering PMH practice have lacked the time to engage with clients in ways that they had assumed they could (Wright et al., 2011). Also, novice nurses working in PMH have reported low levels of confidence (Hooper et al., 2016). They lacked confidence in disseminating client information and voicing their opinions to the interdisciplinary healthcare team, not feeling as competent as other members and being uncertain what is necessary information to report (Schwartz et al., 2011). To the author's knowledge, there are no articles available that discuss novice PMH nurses experiences providing recovery-oriented care.

Research Recommendations and Gaps in Research

The focus of nursing centers on the relationship formed between an individual who is ill or in need of health services, and a professionally-educated nurse who recognizes and responds to their needs (Peplau, 1991). However, this personal-interactional work of PMH nursing has been lessened in the acute setting (Goulter et al., 2015). It is unclear if RNs receive adequate recovery education in their comprehensive programs. Also, due to the invisible nature of PMH nursing work and the contextual/organizational issues inherent in the PMH knowledge, values, beliefs, and practices (Lakeman & Hurley, 2021), additional research is needed to determine if novice RNs have the knowledge or the confidence to provide recovery-oriented care. In the literature, the impact of PMH nursing culture had been alluded to, but not well documented;

without further investigation into the cultural nuances of PMH nursing and novice graduates' experiences, improvements cannot be made (Hooper et al., 2016).

Future research has been recommended to clarify the concept of recovery and how it applies to PMH inpatient settings (Waldemar et al., 2016). Also, future research has been recommended to seek pragmatic examples of recovery-oriented care in acute inpatient PMH services and devise strategies to assist recovery-oriented care in acute inpatient units (McKenna et al., 2014). To improve the quality of care and increase the well-being of both clients and staff, nursing interventions, such as dialogues, must be prioritized (Graneheim et al., 2014).

A review of articles, books, and grey literature was completed to provide context for a research project exploring the experiences of novice PMH RNs in the provision of recovery-oriented practice in an acute care setting. To locate relevant literature, the databases CINAHL, PsychINFO, and Google Scholar were searched. Search terms used included: "psychiatric nurse" OR "mental health nurse" OR "registered nurse" in combination with "lived experiences" OR "recovery." Additional references were obtained from citations in the reviewed articles. Based on the review of the literature, a gap has been noted regarding the experiences of novice RNs working in PMH, particularly in Canada. Only two articles explored the experiences of novice RNs working in PMH in Canada, both published in 2011, prior to the publication of the current RN entry-level competencies (Schwartz et al., 2011; Wright et al., 2011). If positive change is to occur in recovery-oriented services, the views of personnel entering the PMH workforce must be understood and addressed (Happell, Byrne et al., 2015). Accordingly, the purpose of this research was to investigate whether novice RNs working in adult acute care PMH were enabled to provide recovery-oriented care and to discern which factors influenced their ability to do so.

Chapter 3: Research Method

Interpretive description (Thorne, 2016) was utilized as a research methodology to explore and interpret the experiences of novice NL PMH RNs in the provision of recovery-oriented care in acute care settings. Philosophically underpinning interpretive description is the assumption that there are multiple constructed realities that can be studied only holistically; reality is complex, contextual, constructed, and subjective (Thorne et al., 2004). Interpretive description aims to answer clinically-relevant questions relating to a discipline, in which the comprehension of the nature of that discipline's focus of action is significant (Thorne et al., 2004). The use of interpretive description offers qualitative health researchers the opportunity to work outside of the disciplinary confines of traditional methodological approaches, thus creating a methodological design that is consistent with the investigative aims of clinical health and illness phenomena (Thorne et al., 2004). Accordingly, interpretive description allows for a discipline-specific lens to be applied (Thorne, 2016). By employing logic derived from a disciplinary orientation, the use of available research techniques and procedures beyond conventional rules and contexts is thereby justified (Thorne, 2016).

Conceptual Framework

The recovery model, as described by Anthony (1993, 2000) was selected as the conceptual framework. Anthony defined recovery (1993) and developed recovery system standard dimensions as a guide for system development (2000). This model was used to understand the research problem and generate the research question. Moreover, the recovery model provided a foundation for the study and has been used to explain the research findings. A mental health system guided by a recovery vision must have policies and procedures in place to promote recovery (Anthony, 2000).

Research Questions

Interpretive description was utilized to explore the research questions: Are novice RNs enabled to provide recovery-oriented care; and what factors influence their ability to do so in adult acute care PMH settings?

Study Objectives

Findings from this study will contribute to PMH nursing literature on recovery. A deeper understanding of the factors that influence the provision of recovery-oriented care delivered by novice PMH RNs in an adult acute care setting was obtained. Findings may inform NL undergraduate education, as well as the orientation of nursing graduates upon their entry into PMH practice. Research findings may also assist PMH nurses in further recognizing and understanding the recovery-oriented practices they use and in developing their skills in providing recovery-oriented care to adult clients in acute care settings.

Research Design

Using interpretive description, this inquiry was designed to explore and interpret the experiences of novice NL PMH RNs in the provision of recovery-oriented care in acute care settings. Interpretive description was selected as the research method since recovery-oriented care is a complex phenomenon with distinct relevance to the PMH nursing discipline,

Primary Investigator's Role

The primary investigator is an RN, working solely in PMH since graduating with a Bachelor of Nursing degree in 2007. She achieved CNA PMH certification in 2013 and was recertified in 2018. Additionally, the primary investigator holds a Bachelor of Science degree in Biochemistry, a Master of Nursing degree, and is currently enrolled in Brandon University's

Master of Psychiatric Nursing (MPN) degree program. This research was pursued for the thesis requirement of the MPN program.

The primary investigator is employed in the NL Health Services organization. She previously worked as a front-line nurse in Mental Health Emergency Services and Acute Care. A year ago, she was awarded the position of Case Manager for the Psychosis Intervention Early Recovery (PIER) Program of NL Health Services. Other prior clinical experience involved working on a forensics unit and as a float psychiatric nurse, both in a PMH hospital. Her teaching experience has been as a preceptor for fourth-year comprehensive nursing students enrolled in an extended nursing practicum, who had an interest in working in PMH upon graduation.

In interpretive description, the researcher, not a formulaic recipe for research, is the driver of interpretation; the researcher determines what constitutes data, which data are relevant, and how data conceptualizations will be structured (Thorne et al., 2004). The researcher has the knowledge base to identify and describe the phenomenon in question, while using an inductive approach to explore and interpret meanings that are useful for clinical application (Thorne et al., 2004). Accordingly, Thorne (2016) said that the researcher will have to acknowledge and document ideas they have about the phenomenon in question prior to the conduct of research and throughout data collection and analysis. The primary investigator self-reflected following each interview and maintained a personal reflective journal (Thorne, 2016).

Participants and Setting

Benner (1982) said that nurses pass through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. Recent graduates have been said to practice at the novice or advanced beginner level (Masters, 2018). Novices have exhibited an inability to

exercise discretionary judgement, using context-free rules to guide their practice (Benner, 1982). Advanced beginners have demonstrated marginally-acceptable performance, but must be supported by competent-level nurses (Benner, 1982). Advanced beginners have been unable to yet determine what is important (Benner, 1982). For the purpose of this study, the term novice was used to depict both novice and advanced beginner nurses, as outlined by Benner (1982).

In NL, healthcare services were previously provided by regional organizations: Eastern Health, Central Health, Western Health, and Labrador-Grenfell Health. However, in April 2023, the province amalgamated the four regional health organizations into one province-wide health board: NL Health Services. This amalgamation occurred during participant recruitment.

Recruitment

Following ethics and organizational approval, purposive and snowball sampling were used to recruit novice RNs working in PMH acute care. The method of purposive sampling involves the selection of individuals for participation in a study based on their knowledge of a phenomenon (Streubert & Carpenter, 2011). Snowball sampling involves one study participant sharing recruitment information with another potential participant (Streubert & Carpenter, 2011).

Initially, participants were recruited solely from the Eastern Health regional organization. A letter was sent to Eastern Health's Regional Director Mental Health and Addictions, Acute and Tertiary Services (see Appendix A, Correspondence with Mental Health and Addictions Regional Director). It was requested that the director ask managers of PMH acute care inpatient units and the nursing casual/float pool to email the letter of invitation to their nursing staff (see Appendix B, Letter of Invitation). In addition, in the letter to the Regional Director, it was requested that managers place invitational posters on acute care units, inviting RNs to participate in the study (See Appendix C, Recruitment Poster). Also, an invitational post was placed on the

Facebook page belonging to the local PMH branch of the Registered Nurses' union (See Appendix D, Facebook Recruitment Post). Initially, RNs with around three years or less of nursing experience were being recruited.

However, due to a low response rate, the recruitment pool was expanded to include PMH RNs who had around five years of nursing experience. An email was sent to Eastern Health's Regional Director Mental Health and Addictions, Acute and Tertiary Services (see Appendix A, Correspondence with Mental Health and Addictions Regional Director) informing him of the change and to request that the primary investigator be given permission to place the updated invitational posters on acute care units.

Again, due to a low rate of response, the recruitment pool was expanded to include novice nurses who were currently working on adult PMH acute care units throughout the province of NL. The College of Registered Nurses of Newfoundland and Labrador (CRNNL) was asked to send an invitational email to RNs who had provided consent to the college to be contacted for research and who met the study inclusion criteria (See Appendix H: CRNNL Invitation Letter). Also, the CRNNL included a link to the invitational letter to all members in their electronic newsletter.

To achieve snowball sampling, participants were asked to share the letter of invitation with potential participants who might be interested in joining the study; however, participants were informed that forwarding the letter of invitation was optional and would not impact their participation in the study. Alternatively, participants were able to choose to share the email address of a potential participant with the primary investigator, who would then email the letter of invitation to that person directly. Other collateral resources were also collected; in the invitational letter, RNs were informed that, during the interview, participants would be asked if

they had used any resources to assist them in the provision of recovery-oriented care, and, if so, would they be willing to share them with the interviewer.

Inclusion and Exclusion Criteria

The final criteria for inclusion encompassed persons who (a) had graduated from a comprehensive (generalized) baccalaureate nursing program; (b) had current experience working on adult PMH acute care units; and (c) had around five years of nursing experience. If participants were Licensed Practical Nurses prior to becoming Registered Nurses, they were asked to answer questions based on their nursing baccalaureate education and Registered Nurse orientation/employment. The exclusion criteria were (a) persons not in good standing with the CRNNL; and (b) those solely employed on child/adolescent and geriatric PMH units, because their working solely with other populations could influence results.

Participant Description

Six novice PMH RNs, who work in adult acute care PMH settings in NL, were interviewed. Attrition did not occur. Although, throughout recruitment, an inclusion criterion changed from around three years to around five years of nursing experience, all participants had approximately three years or less nursing experience. All participants were female. Also, all participants had completed an undergraduate degree in nursing and were RNs in good standing with the CRNNL. See Table 1for additional participant information. In semi-structured individual interviews, each participant discussed their experiences in the provision of recovery-oriented care.

Table 1

Participant Demographic Information

Name	Nursing Education	Years of Nursing Experience	Current Nursing Position
1	Bachelor's Degree	< 1	Temporary
2	Bachelor's Degree	1.5	Temporary
3	Bachelor's Degree	1	Casual
4	Bachelor's Degree	< 1	Permanent
5	Bachelor's Degree	1	Permanent
6	Bachelor's Degree	3	Temporary

Data Collection

Within interpretive description, sampling and data collection methods derive from research questions and are informed by what is already known about the phenomenon (Thorne et al., 2004). Interpretive description allows for choice of a wide range of design decisions (Thorne, 2016). The thoughtful application of varying data sources has been recommended, in order to add strength to the usual data sources of interviews and observations (Thorne et al., 1997). Data were collected from interviews with novice nurses and other collateral data sources (Thorne, 2016).

Semi-structured, individual interviews (see Appendix F, Interview Questions) were conducted over Microsoft Teams. The interviews were digitally recorded and transcribed via Teams automatic transcription, with the consent of the interview subject. Interviews ranged in length from approximately 30 to 40 minutes. Participants were given the option to have their video on or off. During interviews, participants were asked if they have utilized resources to assist them in the provision of recovery-oriented care, and if so, if they could be shared with the

primary investigator. Anticipated resources included materials that participants received during their undergraduate nursing education; received during their orientation when hired as an RN; received during an in-service offered by their place of employment; or read as required reading for a nursing journal club. Anticipated resources could also have included materials that participants sought out on their own, to improve their PMH nursing practice. The use of text holds the possibility of unveiling underlying beliefs, opinions, and attitudes toward a phenomenon (Thorne, 2016). However, the purpose of a document will have to be noted in order to understand its potential limits; for example, as Thorne explained, healthcare policies would be unlikely to be written in such a manner that would be an embarrassment to healthcare organizations or governments (Thorne, 2016). The use of other collateral data sources was used to contextualize participants' perspectives and assist with data analysis. Although participants reported utilizing a variety of resources, only one participant shared resources with the primary investigator.

Interpretive description research can be conducted on samples of almost any size; it is incumbent upon the researcher to defend the proposed number of participants in order for study results to be worthwhile (Thorne, 2016). In qualitative research, generally, data collection ends when saturation occurs (Streubert & Carpenter, 2011). However, Thorne (2016) identified data saturation as a hollow concept due to the potential for infinite and uniquely personal experiences. Because of the limited study scope, the study size was projected to have between eight and ten participants. Data collection ended after six participants were interviewed and meaningful themes were uncovered.

Data Analysis

Interpretive description is an inductive approach (Thorne, 2016). Inductive reasoning builds from specific observations of a phenomenon toward broader generalizations about that phenomenon with reference to pattern or theoretical construction (Thorne, 2016). Data collection and analysis inform one another iteratively (Thorne et al., 2004). Thus, the direction of the inquiry evolves as new possibilities arise and are considered (Thorne et al., 2004). However, with interpretive description, the researcher must remain skeptical of what is perceived as being immediately apparent and should construct avenues of data-collection that will question, rather than entrench, preliminary conceptualizations. Therefore, the researcher should seek alternative linkages, atypical cases, and contrary instances, to broaden, rather than reduce, the scope for possible conceptual linkages (Thorne et al., 2004).

Thorne (2016) said that using alternative data sources as a collateral approach does not require a separate methodological argument for how each form of data will be analyzed separately. However, thoughtfulness in advance will be required to think about how perspectives from one will be used to inform the other in order to create a more transparent audit trail (Thorne, 2016). As stated, other collateral data sources were used to contextualize participants' perspectives and assist with data analysis. Use of multiple data sources help to provide rich data sets and assists with generating findings (Thorne, 2016). It was anticipated that the multiple data sources would include participant interviews and recovery resources from a variety of sources (university, healthcare organizations, private organizations, or academic research).

During analysis, Thorne (2016) recommended the avoidance of early or excessively-detailed coding. To facilitate this, prior to coding, the researcher simultaneously listened to the interview recording and read the transcription text in order to develop a "feel" for who the

participants were and what their stories represented (Thorne, 2016). Notes were made about the participants' verbal emphases and physical expressions when the video was turned on. Moreover, the researcher read the transcripts several times, thereby immersing herself in the data prior to coding. Data were initially analyzed using broad codes and grouped by similar characteristics. As more data became available, the coding groups evolved. In interpretive description, the identification of which data are important, grouping them into patterns, and considering the relationships between the individual pieces and the patterns, are aspects of the process of inductive reasoning through which the researcher proceeds, in progressing towards findings (Thorne, 2016). Thorne (2016) recommended that, during analysis, as the mind moves from data to pattern, and from pattern to relationship, the researcher needs to continually question how the linkages are being established. Questions asked by the researcher to assist her in the interpretation of the data included "Why is this here? Why not something else? And what does it mean?" (Thorne et al., 2004, p. 7). When challenging the relationships among data, it is recommended that the researcher see the emerging analysis within the context of the larger purpose (Thorne, 2016). The researcher remembered her purpose, remembering why she, a professional in the field of psychiatric nursing, decided to explore the phenomenon in the first place (Thorne, 2016).

Interpretive description calls for attention to rigor in the data analysis process and the reporting of the process (Thorne et al., 1997). As stated, the researcher used a reflective journal to document her reactions to the process of data interpretation. Also, an audit trail was used to assure the trustworthiness and authenticity of the data collected. The audit trail included a log of all activities, a reflexive journal, and notes made during interviews. Further, member checking was utilized. In interpretive description, member checking can enrich analysis (Thompson

Burdine et al., 2021). In order to do this, the transcript and a summarized interpretation of the interview was sent to each participant, via email, to ensure the validity of transcribed data and to assist with analysis. Participants were informed that they could add/omit/clarify information for a two-week period following the interview and that a response to the email was optional. Two participants responded saying that they agreed with the information provided. No additional feedback or edits were suggested other than a request for the removal of filler words, if quoted.

Ethical Considerations

Prior to data collection in the Eastern Health region, the research proposal was submitted for approval to Brandon University Research Ethics Committee (BUREC), NL's Health Research Ethics Board (HREB), and Eastern Health's Research Proposals Approval Committee (RPAC). Also, permission to approach RNs was obtained from Eastern Health's Mental Health and Addictions Regional Director for Acute and Tertiary Services.

Ethics amendments were also submitted to BUREC and HREB and approved. The first amendments were submitted in order to increase participants' years of nursing experience from around three years or less to around five years or less. Permission to do this was sought from Eastern Health's Mental Health and Addictions Regional Director for Acute and Tertiary Services (See Appendix A: Correspondence with Mental Health and Addictions Regional Director). Second amendments were submitted to recruit novice nurses across the entire province of NL. Following BUREC and HREB approval, the research proposal and proof of ethics approval was submitted to the CRNNL for internal review.

The protection of human subjects requires participants to provide informed consent (Streubert & Carpenter, 2011). Information provided through the consent process was based on the Tri-Council Policy Statement {TCPS 2} (Canadian Institutes of Health Research, Natural

Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2022). An information letter identified the researcher, indicated the duration of participation, outline procedures, and explained participants' responsibilities. Possible participant risks were related, and participants were informed that, should they have ethical concerns, they could contact the organization and ethical boards that provided study approval. The researcher strove to eliminate or mitigate coercion, persuasion, or leading questions. Participation in the study was voluntary. As, in interpretive description, data collection and analysis inform one another, participants were able to withdraw at any time prior to the interview and two weeks following the interview. Confidentiality was maintained. A pseudonym was used to assist with anonymity. Prior to the interview, participants were asked to sign the consent form. Digital signatures were accepted.

Data collected was kept confidential. All data were stored in three private Microsoft Team channels, accessible only to the primary investigator (Elizabeth Rowlands) and thesis advisor (Professor Andrea Thomson). Any paper documentation obtained was scanned and uploaded to the Microsoft Team channels and the files were password-protected. The first private Microsoft Teams channel includes consent forms, video files, transcripts with identifiers, collateral data sources provided by participants, the primary investigator's reflection notebook, and anything else with participant information. The second private Microsoft Teams channel includes transcripts with false names and analysis files. The third private Microsoft Teams channel contains the list that links false with actual names. Information collected for this study is being kept for seven years, after which the Microsoft Team channels will be deleted by the thesis advisor. Data will be used solely for the purposes for which it was collected and will be destroyed seven years after thesis defense.

Previous colleagues had the potential to be interviewed; however, the researcher did not approach them requesting an interview and was not in a position of power over them, as the researcher was in neither a management nor administrative position. Potentially, an ethical issue could have arisen if participants viewed the researcher as a colleague or friend rather than a researcher *per se*, and thus revealed information that they might not have otherwise. It was considered unlikely that this additional information would be harmful to participants; nevertheless, to protect against this possibility, the consent form indicated that, although the researcher and participant may have worked together, her role during the interview was that of a researcher and not a colleague (See Appendix E: Registered Nurses' Initial Consent). Moreover, the researcher followed the interview guide. Participants were made aware that the information they provided would be used for presentation/publication of a thesis, published articles, and conferences. When conducting qualitative research in the context of pre-existing peer/collegial relationships, the potential problem of familiarity may not become apparent until data transcripts are being reviewed, after which time the participant could have the opportunity to clarify (McDermid et al., 2014). As stated, member checking was offered as a means of validation. Participants were informed that they could add/omit/clarify information for a two-week period following the interview and that their response to the email was optional. In addition, participants were given the opportunity to withdraw from the study up to two weeks following the interview.

Chapter 4: Findings

The findings in this study were identified through data collection and analysis using Sally Thorne's (2016) interpretive description. Overall, the participants voiced general understanding of the topic of recovery. They engaged in recovery-oriented practices in an adult acute care PMH setting. Nevertheless, they experienced challenges due to a dearth of workplace resources as well as a lack of educational preparedness. Novice PMH RNs want additional support to provide better service to clients. See Table 2 for a summary of the main themes and respective subthemes.

Table 2

Themes and Subthemes

Novice PMH RNs' Understandings of Recovery	● Clinical Recovery ● Personal Recovery
Novice PMH RNs' Recovery-Oriented Practices	● Novice PMH RNs' Interpersonal Skills ● Involving Clients in their own Care ● Facilitate Support
Novice PMH RNs Encounter Challenges in the Provision of Recovery-Oriented Care	● Patient-Related Challenges ● Unit- and System-Related Challenges ● Stigma/Bias
Novice PMH RNs' Educational Experiences have been Lacking	● Undergraduate Program ● Work Orientation
Novice PMH RNs Want and Need Support	● A Lack of Support ● Novice PMH RNs' Mental Health

In this chapter, various terms will be utilized to describe adult clients being cared for on an acute care unit. The participants often referred to this population as "patients," whereas the researcher preferred to use the term "clients." Both terms will be used to describe adult clients in an PMH acute care setting. Each theme and subtheme listed in Table 2 will be discussed and will include direct quotes from participants. Identifying information and filler words have been removed from participants' quotes.

Novice PMH RNs' Understandings of Recovery

Participants were asked to reflect on their understandings of recovery. Two subthemes emerged: participants discussed recovery in terms of both clinical and personal recovery. When asked to describe recovery, the participants included aspects of both clinical and personal recovery in their explanations.

Clinical Recovery

In exploring participants' understandings of recovery, a subtheme that emerged was that aspects of their understandings aligned with clinical recovery. In the sense of clinical recovery, recovery included symptom stabilization and improvement in clients' daily-living skills. Three participants regarded recovery as involving symptom stabilization. Symptom stabilization was described as the primary focus of acute care hospitalization and involved pharmacological treatment. Participant 1 said:

> …They're experiencing really intense, often psychiatric symptoms. So, a lot of the time is more so focused on stabilizing the symptoms at the time than it is working through a specific issue in their life.

With symptom stabilization, recovery was described by two participants as a return to a client's previous level of wellness, referred to as their "baseline." Participant 6 explained the primary focus of recovery in an acute care setting is clients' return to baseline, with improvements in clients' wellbeing occurring in the community:

> Recovery is usually a long-term thing. What we do in hospital is short-term. People say that the hospital doesn't help people, but when you think of any hospital, mental or physical, you're getting someone back to their baseline. You're getting them out of an acute phase of illness. But to me, recovery is more long-standing than that. Sure, it does encompass that phase of getting from acute illness back to baseline, but also improving someone's baseline towards wellness and I think that part of things is more so done in the community.

Two participants described recovery in terms of improvement in their daily-living skills. Participant 2 said:

> I think it's just getting someone to their optimal level of wellness, whatever that might be for that individual person, so they can function the best they can. For some people that could be working a job… other people, it might be just getting up and going to the mail every day or just getting out of the house. It's different for everybody.

Personal Recovery

In contrast to clinical recovery, the exploration of PMH RNs' understandings of recovery identified another subtheme: personal recovery. An integral factor of recovery, included by all participants, was that recovery is individualized, based on clients' illnesses and life situations. Participant 1 asserted that a client's individuality is primary, "[recovery is] working towards achieving whatever the client's definition of health and wellness is". In addition to being individualized, Participant 4 characterized recovery as a non-linear journey:

> [Recovery is] not only an individualized approach, but an approach that's not a linear approach. I talk to my patients about it -- there's ups and downs in recovery. It's not a linear thing. I like to meet the patients where they are in their recovery process that day.

Despite living with a mental illness and having different life circumstances, Participant 3 averred that recovery is not limited by illness and disability, "my understanding of the concept of recovery is that, despite living with symptoms of mental illness, you can still live a fulfilling life where you can."

Recovery was also described as involving support by three participants. Participant 3 explained that, in her understanding of recovery, recovery involves support for the client:

> When I say support, I mean access to services, healthcare services, and healthcare providers who are educated in recovery-oriented and harm reduction approaches. Also, support from family and community resources. Support also means being free of stigma. I know that's not realistic, but it's important as a health care provider, when thinking of recovery-oriented approaches, to reduce stigma and think about bias and whatnot.

Three participants highlighted the importance of families as supports in client recovery; to provide holistic care, they integrated families into their recovery-oriented practice.

Novice PMH RNs' Recovery-Oriented Practices

Building on participants' understandings of recovery, a second theme that emerged was the recovery-oriented practices of novice PMH RNs. Participants discussed how they would use interpersonal skills in interactions with clients and involve clients in their own care. Also, participants described facilitating support for clients, both in hospital and a community setting.

Novice PMH RNs' Interpersonal Skills

All participants described using interpersonal skills in the provision of recovery-oriented care. Participants shared that the PMH nurse's role involves providing validation, support, and reassurance. Three participants reported using therapeutic communication skills to develop a relationship with the client. Participant 3 described the importance of not only being aware of her own nonverbal communication but also the client's during one-on-one interactions:

> I remember in nursing school, I had a professor say you should always be at the same eye level as somebody. So, if they're sitting, you should sit too. I feel that's a really good …strategy through therapeutic communication. Just really being present and listening actively and noticing their body language and observing how they are feeling.

Four participants described listening to clients as an important role of the PMH nurse. Listening was regarded as necessary to learn about the client's symptoms, their experiences, and future goals. Also, listening was identified as an important factor in building a rapport with the client, which included giving them an opportunity to ask questions themselves. Knowledge gained through nurses' one-to-one interviews with clients enabled them to individualize their approach to meeting clients' needs.

Three participants described providing clients a safe and non-judgmental space for them to feel and process emotions. Participant 5 shared how she has provided clients with a quiet space in order for them to talk freely about their situation:

> A client would be agitated, and I would try to talk to them [in] a calm manner and take them into a quiet space. Try to figure out what's on their mind…what's going on in their situation. Try to validate their feelings and provide them with skills to try to overcome what they're experiencing.

In order to provide clients with this safe space, Participant 4 has learned not to take client agitation personally. This was a challenge initially as a novice PMH RN:

> I've definitely been getting a lot more comfortable with talking to patients when it's hard to do so - when they're really upset and when they're agitated with staff. [I'm] learning not to take that personally as an attack on me per se. I've been getting more comfortable with allowing the patients that freedom to express their feelings. That's one thing that I've been trying hard to learn as a new grad.

Recognizing recovery as a non-linear process, two participants described the importance of meeting the client where they were, psychiatrically, on that particular day. Participants said that clients' PMH needs could vary day-to-day.

In an adult acute care setting, three participants reported that giving medications was part of their nursing care. In addition to giving regular medications, nurses provide medications to clients as needed, such as when they are feeling anxious or agitated. However, participants reported that the provision of pharmacological treatment did not negate the importance of using interpersonal skills in their interactions with clients. Participant 6 related:

> With…a psychotic disorder, a lot of the treatment involves pharmacological therapy. But in that, there's different ways of communication and de-escalation [techniques] that you need, to meet the patient where they are at that time.

Involving Clients in their own Care

In their provision of recovery-oriented care, five of six participants shared that they would involve clients in their own care. In providing advice to PMH novice nurses, Participant 2

recommended “don't force your idea of what wellness is onto [the client] -- you would take the lead from them.”

Three of six participants described the importance of clients being active participants in their own recovery. Participants would encourage clients by giving them autonomy and responsibility. Participant 2 provided an example of how she has encouraged a client to be involved in their own care, by providing them with choice:

> …Sometimes you have people and they're there for days and they're not showering. You give them the option: why don't you shower in the morning…in the evening? Encourage them to get involved and make the decision…. rather than forcing people to do things.

Encouraging client involvement, participants would provide education about nurses’ roles and available outpatient services. Participant 1 said why these conversations were important:

> As a nurse, you need to often have a lot of discussions with the patient about being active in their care. When they’re discharged from the hospital, actively being involved and actually showing up to appointments… because if they’re not going to be compliant or do the work…to stay in the hospital is not necessarily going to be that effective either.

Four participants related how they would involve clients by encouraging them to develop goals that were achievable at that time. Participant 6 explained that, particularly for clients diagnosed with mood and anxiety disorders, self-care in the hospital setting is important: “We encourage independence with those patients. You might encourage them to pick one goal a day and meet that.”

Four of six participants reported teaching positive coping strategies as well as helping clients identify strategies that work for them. Participants said that the use of coping strategies enables clients to manage the mental health concerns they are experiencing, both in hospital and in the community.

Facilitate Support

Five of six participants described how they would facilitate support for clients. Support had been identified as important for clients in their recovery. Participants related that they would facilitate support for the client collaborating with interdisciplinary team members, involving families, and teaching clients about, and connecting clients with, community resources.

Two participants described how they would facilitate support by collaborating with interdisciplinary team members (who included psychiatrists, general practitioners, and social workers). Participant 3 reported partnering with them is necessary to provide individualized care:

> …When you collaborate with all these different people, you can develop a care plan that's really well-suited to the specific patient and helps them meet their needs through recovery-oriented approach.

Participant 4 described her role as a PMH nurse is to be the client's advocate and to share the client's needs with the other team members:

> You are the advocate for the patient… When you're interviewing your patients going through the recovery process, [assess] their different needs, what may or may not be a trigger for their anxiety on the unit…so that the team can know…because it is a team approach. It's not just me here.

Three participants reported facilitating support for clients by including families in client care. Involving families was described as important in the provision of holistic care. Participant 4 reported that she would provide families with updates (with the permission of the client). She said: "I'm kind of in the middle…liaison between the patient and the family." Participant 4 also described the importance of reducing the stigma associated with mental health problems when interacting with families.

Participants described the importance of clients having support outside of the hospital setting to facilitate their recovery. One participant encouraged clients to engage with other clients, friends, and family members. Also, four participants told how they initiated client

support by teaching clients about, and connecting them with, community resources. When faced with client resistance, the role of education was described by Participant 6:

> Counseling is something that they have to be active and participate in…When there's resistance, it definitely changes the conversation that you have with the patient…Sometimes it takes a little bit extra encouragement. I find the way that you present it to the client, rather than "Oh, you should try this," sometimes you need to present it as, "This is proven to be the best form of treatment and I think it would be really good for you. I think you could see a lot of benefit from this."

Novice PMH RNs Encounter Challenges in the Provision of Recovery-Oriented Care

Participants described the challenges that they have experienced in the provision of recovery-oriented care in the adult acute care PMH setting, which included challenges which were patient-related as well as unit- and system-related. Also, participants reported that stigma/bias held by nurses and other health care professionals negatively impacts the provision of recovery-oriented care.

Patient-Related Challenges

Participants described patient-related challenges that have influenced their ability to provide recovery-oriented care. Two participants shared that learning how to engage with clients in the PMH acute care setting has been challenging when beginning work following nursing graduation. Participant 4 reflected on how it was initially taxing, learning how to talk to clients with varying mental health presentations:

> As a new grad, it's definitely been a challenge. It has been a learning curve getting used to talking to patients when they're going through such a crucial time in their recovery. You meet patients that have no intention to stop using the drug that brought him into mental health care in the first place…Sometimes they don't want to talk, that's fine. Sometimes they want to talk for a while and they want to rant…I'm trying to learn as a new grad, recovery-oriented care is meeting the patient where they are and really trying to, as hard as it is sometimes, to put myself in their position.

Three participants reported that lack of client engagement was an impediment to their provision of recovery-oriented care. Participant 1 shared that it has been a learning experience,

enabling and motivating clients to set and achieve goals. Two participants described how clients' psychiatric acuity hampered their ability to provide recovery-oriented care. Tensions on the unit, resulting from client relationships with one another, can negatively impact nurses' ability to provide recovery-oriented care. Also, in an acute care setting, clients are sometimes aggressive and nurses' therapeutic communication skills prove unsuccessful, as reported by Participant 5:

> There's other times where you try to talk to clients who are more aggressive and you use all the communication skills you've been taught, and the ones you learn in practice, and sometimes it's impossible to talk people down.

Short admissions were identified by two participants as an obstacle to their provision of recovery-oriented care. The short amount of time that nurses were able to spend with clients resulted in a lack of rapport between nurses and clients. This, in turn, contributed to a lack of nurse awareness about the clients' history or future goals. Participant 2 provided an example of how a short admission can impede the development of a positive nurse-client relationship:

> [Clients] aren't there long enough to really take advantage of what you are offering... Sometimes we get a lot of personality disorders, like borderline personality, and they're doing things, self-harm and stuff. You're offering coping mechanisms, you're discussing different things with them, and they just don't take you up on it. They're there for a few days. They're not interested in engaging in what you're doing, and then they just leave. They don't take you up on your offer and they leave in the same state they came in with.

Unit- and System-Related Challenges

Novice PMH RNs reported that they have experienced unit- and system-related challenges in their provision of recovery-oriented care to clients in an adult acute care setting. Participants described how providing care to clients, and involving their families, has been difficult due to the busyness, unpredictability, and acuity of clients, in an acute care unit. For nurses, working on acute care can involve going to interdisciplinary rounds, giving medications, receiving admissions, discharging, documenting, and handling code white situations. Participant 1 described how the busyness of day shifts limits her ability to spend time with clients:

> Patients need to be seen in rounds. Rounds often take multiple hours to finish. You're going in and out with your patients. You're often working on discharge documents. With all of this going on, you don't get to actually spend as much time sitting with your patient in a calm environment. I find a night shift, you're not giving out as many medications, there's not so many people walking the halls, so many distractions. I do feel that on weekdays… the time that I can spend doing direct care with my patient is more limited.

Although involving families had been identified by some participants as important to the provision of recovery-oriented care, Participant 4 described how this can be challenging to a novice PMH RN working on a busy acute care unit:

> I'm trying to learn as…a new grad, recovery-oriented care is… acknowledging the families as well. It's definitely been a challenge at times with families. They're calling the unit quite often, especially in the middle of a busy day… But it's important to not neglect the family members as well. I've been learning, as a new grad, [to involve] the family as much as possible in the care and give them a thorough update if the patient allows information to be given, of course.

Considering the busyness, unpredictability, and acuity of clients in PMH acute care, three participants described how the nursing shortage has been an impediment to the provision of recovery-oriented care; nurses are working short-staffed and are being mandated to work shift-extensions. Participant 4 explained how mandated shift-extensions and nurse exhaustion negatively impacts care provision:

> I've been mandated already twice in the six months that I've been a new grad. I would be mandated after a 12 hour [day] shift to stay and then expected to come back to work 8:00 the next morning. You're running on barely any sleep. You're exhausted. You're short staffed. That has been a big factor impacting recovery-oriented care especially, because you don't have an hour to give per patient.

Participant 3 said that, due to staff shortages, nurses may be assigned more clients than usual, giving them even less time to spend with clients. Ultimately, this increased workload leads to low morale, which in turn negatively impacts their provision of recovery-oriented care. Participant 5 said that the nursing shortage is further challenging on day shifts, when RNs have

to be available to answer questions asked by other healthcare professionals, while also providing care to multiple psychiatrically-unwell clients.

With nurses being unable to spend more time with their clients, Participant 1 shared that a lack of resources for clients on the acute care units negatively impacts their recovery:

> There could be more resources throughout the day for patients in acute care… counseling that could happen on a unit or even more frequent therapeutic recreation... The nurse is not available 100% of the time to be able to sit and talk with the patient because you have often the workload of multiple patients….I've noticed an increase in their psychiatric symptoms when they're just spending time doing nothing. Whereas, if they were spending their time doing something positive, it might help to relieve these symptoms.

Stigma/Bias

Three of six participants reported that stigma/biases held by nurses and other health care professionals towards clients negatively impacts the provision of recovery-oriented care on an PMH acute care unit. Participant 3 described how healthcare providers can stigmatize clients based on their diagnosis:

> I found some healthcare providers would be stigmatizing towards certain populations of patients, especially those with borderline personality disorder for example. Getting an admission, some [healthcare providers will say] “Oh my God. Not another borderline.” You see it across all levels of providers, in my experience.

Participant 1 reported that healthcare providers can make their own judgments about clients, which may be based on clients’ past medical or psychiatric history. She recommended that novice PMH nurses listen to clients to enable them to understand what clients are experiencing:

> Listen to your patient because I find that a lot…of nurses and doctors don't really listen to what their patients are saying. They're making their own judgments about the symptoms that they're presenting with, or their past psychiatric or medical history. I find that if you spend more time with your patients, you actually take the time to let them explain themselves, how they’re feeling, you're going to get a better understanding of what their experience is and how you can actually help them.

Participant 6 urged PMH nurses to be aware of their own biases:

> Every nurse has personal experiences. We bring our biases and our experiences to work and subconsciously they affect us. Every nurse, in every area, needs to drop [their] baggage at the door and…care for this patient in an objective way.

Novice PMH RNs' Educational Experiences Have Been Lacking

In this theme, most participants described the way that their PMH nursing education experiences have been lacking. Participants described the perceived deficiencies in both their undergraduate nursing programs as well as their work orientation when hired as a PMH RN.

Undergraduate Program

Most participants related examples of what they regarded as deficiencies in their undergraduate nursing programs in PMH nursing practice. They reported that the courses were lacking both in theory and the clinical setting. Three participants reported that their core undergraduate courses provided insufficient recovery-oriented education. Only one participant reported that recovery-oriented care was a large part of the curriculum. Participant 2 said:

> I think they mentioned recovery models at the very end of the course. It was maybe half of a class. It was just mentioned briefly, we didn't go in depth into what that means or how it's applied to patients or how you would even approach it in an actual working setting. It wasn't the focus of the course at all.

Although the focus of the research was recovery-oriented care, most participants reported that, in general, the undergraduate program did not prepare them for PMH nursing practice. It was felt that the mental health theory course should be longer and more in-depth, as RNs will encounter clients with mental health issues in all areas of healthcare. Three participants reported that PMH courses in their undergraduate program did not provide them with a realistic picture of PMH nursing. Participant 5 described how the undergraduate PMH courses did not provide subject-matter applicable to the real-world PMH acute care setting:

> …They just gave you communication techniques on how to speak with the client. They didn't really tell you how to deal with clients when they become aggressive or when they have thoughts of suicide and stuff like that. That was more of a self-learning situation after I started my career. I didn't understand, when I was in school, the type of situations you would really come across. The techniques that they provide really aren't accurate when it comes to reality.

Likewise, Participant 6 described how she felt the undergraduate program lacked education on how to validate and foster hope, while simultaneously interviewing and assessing a client. Participant 1 said that, even with the theory education, clinical education is necessary in order to prepare PMH nurses for practice:

> I didn't get enough clinical time in a mental health care setting. You can be educated and read about [psychiatry], but unless you're actually providing the care, it is difficult coming out [of school] and wanting to become a nurse that works in psychiatry, having very little clinical experience in that area.

Outside of the core undergraduate courses, increased PMH nursing experiences during their undergraduate nursing program increased participants' ability to provide PMH nursing care and recovery-oriented care upon graduation. Having made the nursing school aware of her interest in PMH nursing, Participant 4 was given the opportunity to do her community health clinical with a PMH community team in rural NL. The participant described how this helped her provide recovery-oriented care, enabling her to develop an awareness of the struggles that clients can encounter in the community:

> That helped me with my recovery-oriented care because I got a bit of a head start. Seeing [clients] in their home environment, seeing them in a rural community, and seeing the limited resources that are available for supports for someone going through addiction and mental health concerns…It's easier in (urban city); there's a lot more resources than in rural Newfoundland. It opened up my eyes and it helped me to see how much of a struggle it can be for patients and it helps me put myself in their shoes. When I'm [working] in the hospital, I can see, due to a lack of resources, why sometimes it's hard for some patients to recover when they get in the community.

Also, Participant 4 said that she was first introduced to recovery-oriented care during her community health rotation; she attended an opioid treatment conference and listened to a person with lived-experience:

> …Hearing the personal story like that, how her team helped her, was definitely inspiring and opened up my eyes to recovery-oriented care. That was my first introduction to recovery-oriented care.

Three participants described how they were given opportunities to do their extended clinicals in a PMH acute care setting, which enhanced their PMH nursing practice upon graduation. Participant 2 related that the extended clinical benefited her practice, because she was able to work one-on-one with a PMH nurse for ten weeks. Participant 4 described how the extended-clinical rotation benefited her practice, as during her PMH clinical, patient interactions were limited due to Covid restrictions.

Work Orientation

Participants reflected on their orientation when hired as a PMH RN. All participants reported that their orientation involved both classroom and clinical (on-unit) learning; participants used the term orientation when describing both. Two participants related that the classroom aspect of their orientation provided education mainly on policies, documentation, and legalities. Participants suggested that classroom orientation should include more education on how to interact with clients. To improve classroom orientation, Participant 2 specifically recommended that nurses be taught Dialectical Behaviour Therapy (DBT), so that they can teach clients how to develop skills to regulate their emotions.

However, Participant 5 said that she found her orientation helpful, as content was included that was applicable to practice. Although not specific to recovery-oriented practice,

Participant 5 described how a beneficial part of orientation was the inclusion of suicide intervention training:

> I did find [suicide intervention training] very beneficial because they did provide examples, certain situations that you could come across…even in the community or certain things patients could say to you and they would make us act out scenarios. The person you were partnered with came up with a scenario and you would have to talk them down, which I found very beneficial because I do come across a lot of patients that are anxious or have thoughts of suicide or thoughts of self-harm.

Nevertheless, Participant 5 reported that she worked for months before she received the suicide intervention training. She said that orientation could be improved by "making sure all these different education sessions take place prior to starting your position."

Two of the six participants reported that the classroom orientation did not prepare them to provide recovery-oriented care: Participant 3 said:

> I can't remember seeing anything specific to recovery-oriented care. When I reflect on it, nothing on that topic. There were other topics discussed, but I don't believe that was a topic.

However, Participant 1 reported that their classroom orientation did include teaching about recovery-oriented care:

> When I was doing my orientation, there were a lot of online aspects to that as well. We did watch multiple videos about providing psychiatric nursing care. There were parts of that that were focused on providing recovery-oriented care. I wouldn't be able to tell specifics from these videos because that was quite a few months ago.

Clinical orientation experiences varied in length. Longer clinical orientations increased participants' PMH nursing competence. Participant 1 reported receiving six weeks of clinical orientation, which benefited her recovery-oriented practice:

> The orientation that I did when I entered the mental health program was really long. I got to spend a number of shifts on all of the psychiatric units that a casual nurse might go to, most of these being acute care units. I feel I got a good general experience of caring for different types of psychiatric patients and the different types of care that's involved. I feel I got a good broad knowledge base of the different types of patients and how I would help each type of patient achieve different types of goals.

Two of the six participants reported that their clinical orientation was short and that they would have preferred it to be longer, due to the specialized nature of PMH nursing. Participant 2 felt that observing how nurses interacted with clients was the most beneficial aspect of orientation and that she would have benefited had it been longer:

> I had three days of shadowing nurses on the unit. My orientation actually got cut short, so it was only 2 1/2 days. I did find that was beneficial, just shadow other nurses and see how they approached patients, what kind of support they provided, how they talk to patients, and how they prepared patients for discharge. That was probably the most beneficial part of it -- should have been longer.

In addition to participants wanting educational improvements in the undergraduate program and work orientation, participants voiced their desire to receive more education in PMH nursing and recovery-oriented care. Participant 6 said that, for novice nurses to be able to provide recovery-oriented care, more opportunities for education are needed, particularly on the provision of recovery-oriented care:

> When I started the job, [I] used my mental health textbook from nursing. But that's more diagnostics and medications and not necessarily strategies or treatments for recovery. When I worked in other areas, there were lots of different resources that I could use. I had no trouble finding reputable sources for a new nurse in whatever area. I think [it] is more difficult for us [in mental health] to do that on our own. It would be good if [education] could be offered by the employer, by the union, something like that.

Considering the lack of education, three participants reported that they had sought out learning materials themselves. Participants reported a wide variety of resources that they used to guide their nursing practice, including books, research journals, a podcast, websites, and a 16-hour DBT course. With the exception of one participant, the majority sought out additional learning on their own violation due to interest in PMH nursing and commitment to recovery-oriented care.

Novice PMH RNs Want and Need Support

The final theme was that novice PMH RNs want and need support to aid them in both their nursing practice and personal wellbeing. Participants described how they experienced a lack of organizational support, and so they relied on other nurses for support. Also, they said that they needed support for their own mental health.

A Lack of Support

Three participants reported a lack of organizational support for novice PMH RNs. Two participants identified a lack of support regarding staffing matters, such as working short-staffed. Participant 3 said that there is a lack of support for novice PMH RNs, as they adjust from being in school to embarking upon a nursing career:

> In my experience, talking to nurses who are just graduating and joining the mental health program, they are finding it a little challenging, kind of that transition from, being in school to having a career and having consistent shifts.

In the light of a lack of organizational support, all participants described the importance of novice PMH nurses receiving support from other nurses. They were identified as a resource for the answering of general questions and the relating of their personal nursing experience. Four participants described seeking advice from other nurses about communication and interaction with clients. Participant 6 described the importance of novice PMH RNs being supported by other nurses due to the specialized nature of PMH nursing:

> I think probably the biggest form of support would be mentorship from other nurses… Coming to mental health from another area was a big shift for me in in the type of care that you're providing. I explained to other nursing friends that, it's not really doing for your patients so much as doing with them and guiding them, which is difficult coming from another area of care where you want to do everything for your patient. That is not necessarily the most beneficial thing to do in this type of nursing. Learning that, learning different communication styles, and boundaries within the unit -- that's something that I relied heavily on other more senior nurses for.

Three participants described how they would observe the way that other nurses would interact with clients, particularly when faced with a challenging situation, such as approaching an irritable or agitated client. Participant 6 described how she benefited from observing another nurse attempt to de-escalate a situation:

> …Just to see the way that this nurse interacted with the patient, I learned a lot. She was very patient with the patient. She lowered her tone of voice. She got down physically on her level. It was just a very interesting interaction, and while [it] still didn't necessarily have the best outcome, I thought that the nurse was kind yet firm, which is a hard thing to learn as a new nurse. You feel like you're supposed to do every single thing that your patient asks. Seeing that and then seeing when the nurse knew when draw the line and set that boundary…that was a really good experience for me to see.

Although the focus of the research was recovery-oriented care, participants reported that they sought the advice of other nurses in the provision of all aspects of PMH nursing care. Other nurses have provided guidance with documentation and the navigation of supports/systems. Despite participants identifying the need for novice PMH RNs to be supported by other nurses, one reported that support was not always available. Participant 4 described how this impacts novice PMH RNs:

> I've struggled a little bit when I first started with bullying in the workplace. That was a struggle for me personally. I do see it happen a little bit with novice nurses, which obviously, they get intimidated to ask the senior nurses any questions out a fear of being bullied, or made fun of, or made to feel stupid.

Novice PMH RNs' Mental Health

The need for novice PMH RNs to receive support for their own mental health as a pre-requisite for providing recovery-oriented care was mentioned by three participants. Participant 4 reported going to therapy through her healthcare organization's Employee and Family Assistance Program (EFAP): "Therapy for myself is a more proactive approach rather than reactive." She encouraged other novice nurses to also utilize EFAP. However, Participant 3 had a different experience, calling for better mental health resources for PMH nurses:

> I feel there should be better resources for counseling, or referrals to be met with a physician and stuff. Just resources so you can take care of yourself and your health. Because I know as a casual you don't get any benefits and you do see a lot of novice nurses doing casual first and then taking a position.

Likewise, Participant 5 reported being unaware of what counselling services were available, saying that she mainly uses the support of her coworkers.

Three participants discussed how, to benefit their mental health, they intentionally avoid thinking about work outside of work. Participant 4 said: “I just make a little mental note when I leave. I said to myself, ‘OK, it's done for another day.” After encountering client aggression at work, Participant 5 said that she initially found it difficult to leave work at work, and was given advice by senior nurses:

> At first I found it really difficult to separate those situations from my home life. I found [senior nurses] giving me advice on how to take it and leave it at the door when you leave at the end of the day. I guess they kind of gave me mechanisms to try and relax at home. Like, get a bath at the end of the day.

She emphasized the importance of RNs maintaining a work-life balance:

> It's important to take care of yourself at the end of the day as well. Because if you don't take care of yourself, it's impossible for you to provide the best care you can to your clients as well. Because taking things home can be hard to let go, so it's important to try to overcome that.

Summary of Research Findings

In summary, the participants provided their understandings of recovery. They engaged in recovery-oriented practices in an adult acute care PMH setting. Nevertheless, they reported that they experienced challenges to their provision of recovery-oriented care. Participants also reported a lack of PMH nursing educational preparedness, both in their comprehensive baccalaureate education programs and their orientation when hired as a PMH RN. Participants related how they want and need additional supports to better serve their clients. They want support in the workplace and also for their own mental health.

Chapter 5: Discussion

Utilizing interpretive description, the exploration of novice PMH RNs' experiences in the provision of recovery-oriented care revealed that their knowledge and nursing practice largely aligned with Anthony's definition of recovery (1993) despite a lack of formal education related to recovery-oriented care. In addition, novice PMH RNs are challenged as they provide this important service due to a lack of resources and support in adult acute care settings, as discussed below.

Novice PMH RNs' Understandings of Recovery

Fundamental to the provision of recovery-oriented care is an understanding of recovery. Participants' understandings of recovery largely aligned with Anthony's (1993) definition. Anthony described recovery as a "highly personal process" (Anthony, 2000, p. 160). PMH nurses have described the recovery-oriented approach as individual-centred, focused on an individual's strengths, needs, beliefs, and personal experiences (Cusack et al., 2017). Similar to what is described in the literature, participants in the current study described of recovery as being individualized, based on clients' illnesses and life situations, and involved client goal setting. However, PMH nurses have understood personal recovery to be difficult in an acute PMH setting and more aligned with community-based care (Hristodoulidis et al., 2021). Recovery-oriented systems should support clients' goals in a wide variety of environments (Anthony, 2000), despite the initial challenges faced when clients are acutely psychiatrically unwell.

Recovery was also described by participants as involving support. Support was described as the client's ability to avail of a variety of resources, including healthcare staff, community resources, and family support. This is consistent with Anthony (2000), who said that policies in a recovery-oriented system ensure that programs are provided in a variety of settings, and, within a

given setting, present varying levels of support. However, it is noteworthy that participants did not stress the importance of connecting clients with other people who also have mental health lived experiences, known as peer support. Anthony (1993) said that people who are aware of their own recovery journey can help others as they progress through the course of their journeys.

Two participants described recovery as a non-linear journey. Recovery can progress even though symptoms reoccur (Anthony, 1993). However, in the literature, mental health professionals and students have had low RKI scores regarding the non-linearity of the recovery process, suggesting that they were less familiar with that aspect of recovery (Gyamfi et al., 2020). In one study, nurses had significantly lower RKI scores regarding the non-linearity of the recovery process when compared to non-nurses (Gaffey et al., 2016). Given that only two of six participants in the present study mentioned the non-linear component of recovery is consistent with the literature findings. As, throughout the recovery process, PMH professionals should foster clients' hopeful and realistic expectations, it is important that teachings about the non-linear aspect of recovery be incorporated in undergraduate education and professional development (Gyamfi et al., 2020).

Participants also included aspects of clinical recovery (symptom stabilization and improvement in clients' daily living skills) in their understanding of recovery, which is inconsistent with Anthony's definition of recovery, and likely related to the dominance of the biomedical model in institutional settings. The inclusion of clinical recovery in PMH nurses' understanding of recovery has been echoed in the literature. PMH nurses and other PMH professionals have confused clinical and personal recovery (Gyamfi et al., 2020), equating recovery-oriented practice with the traditional medical approach which focuses on medical

stabilization, symptom relief, and a return to functioning pre-illness (Aston & Coffey, 2012; Hristodoulidis et al., 2022; Waldemar et al., 2016).

Notably, only one participant shared the view that recovery is not limited by illness and disability. Recovery involves the development of new meaning and purpose in life as the client emerges from the debilitating effects of psychiatric illness (Anthony, 1993). A recovery-oriented organization advocates for an understanding of recovery potential (Anthony, 2000). That only one participant expressed this view, has, potentially, negative consequences for the provision of recovery-oriented care. Pessimistic attitudes towards mental illness by healthcare professionals negatively impacts the recovery of people diagnosed with mental illness (Sreeram et al., 2023). Nevertheless, none of the participants shared a negative opinion of recovery. This potentially indicates that participants had positive attitudes towards recovery, even though they omitted specific mention of their awareness that recovery involves the development of new meaning and purpose in life. In the provision of recovery-oriented care, in addition to having recovery knowledge and skills, PMH nurses also must have positive attitudes towards recovery (Sreeram et al., 2023).

Novice PMH RNs' Recovery-Oriented Practices

Anthony (1993) said that an important aspect of recovery is the presence of people who believe in, and stand by, the client. All participants used interpersonal skills to provide validation, support, and reassurance. Participants described the importance of meeting the client where they were psychiatrically on a particular day, aligning with Anthony's (1993) description of recovery as a non-linear journey. Further, participants described providing clients with a safe and non-judgmental space in which they could feel and process emotions. These findings support descriptions in the literature in which PMH nurses have related to clients in such a way that the

clients felt safe sharing their thoughts and emotions; by exploring the impact of their lived experiences, clients assumed ownership of their recovery journey (Lim et al., 2021). Anthony (1993) noted that all recovering persons, whether psychiatrically ill or not, experience strong emotions and a wide range of emotions; the mental health system must allow clients to express these emotions in a non-stigmatizing and understanding environment (Anthony, 1993). In the current study, one participant reported that, as a novice PMH RN, it was initially a challenge not to take client agitation personally. PMH nurses not taking a client's behaviour personally has been identified as a skill requiring practice (Whitehurt, 2021). PMH nurses have exercised self-awareness as a method of their avoiding the taking of clients' behaviour personally (Whitehurt, 2021).

Participants encouraged clients to be active participants in their care; clients were given autonomy and responsibility, or as Anthony (1993) stated, clients hold the key to their own recovery. Critical to recovery is the belief that there are options from which one can choose (Anthony, 1993). Participants described providing clients with choices and encouraging them to establish goals. In an acute care setting, as part of the provision of patient-centred care, psychiatric nurses have listened to clients' goals and helped them develop strategies to attain their goals (Thomson, 2019). As a novice PMH RN, one participant shared that enabling and motivating clients to set and achieve goals was a learning experience. Anthony (1993) said that a key element of recovery is that there is hope for the future. In the current study, to inspire client-motivation, none of the participants discussed the role of hope.

A significant aspect of participants' recovery-oriented practices was the facilitation of support in the hospital and the community. Nurses would collaborate with interdisciplinary team members to provide individualized care. In interacting with interdisciplinary team members, one

participant shared that her role as a PMH nurse was to be a client's advocate. This contrasts with a Canadian study in which PMH RNs, with eighteen months or less of clinical experience, said they lacked confidence voicing their opinions and disseminating client information to other team members (Schwartz et al., 2011). However, two participants here were comfortable collaborating with other healthcare team members. In the literature, recovery had been made to fit a healthcare infrastructure where its meaning was shaped by a traditional focus on clinical tasks, hierarchy, and psychiatric power (Le Boutillier, Slade, et al., 2015). A characteristic of a recovery-oriented system is that staff advocate for a holistic understanding of clients' situations (Anthony, 2000).

As part of supporting clients, participants also facilitated family involvement. Anthony noted the importance of the inclusion of a support system, saying that recovery may be facilitated by clients' natural support systems, such as families, friends, and self-help groups (1993). However, in the literature, there has been a lack of engagement between PMH nurses and family members (Skärsäter et al., 2018). As described in the present study, participants also facilitated support for clients by teaching clients about, and connecting clients with, community resources. Yet, Anthony (1993) noted that it is important for PMH professionals to recognize that what promotes recovery is not simply the array of mental health services. Recovery can occur without professional intervention (Anthony, 1993). This was not an aspect of recovery discussed by participants in this study, perhaps because of their role as helping professionals.

Novice PMH RNs Encounter Challenges in the Provision of Recovery-Oriented Care

Participants reported that, at times, their clients' psychiatric acuity hampered their ability to provide recovery-oriented care. Nardella et al. (2021) also found that PMH nurses have opined that it was difficult for clients to focus on recovery during an acute care admission, as they were too unwell to participate fully in their own care. Findings in the current study indicated it was a

learning experience for novice PMH RNs as they sought to enable and motivate clients to set and achieve goals; a lack of client engagement was considered an impediment to the provision of recovery-oriented care. In the process of providing information to a recovering person, PMH professionals should not automatically characterize client denial as non-functional (Anthony, 1993). Sometimes, denial can be a necessary part of the recovery process, preventing the recovering person from being overwhelmed (Anthony, 1993). PMH professionals must allow for variation in the care they provide, based on the client's day-to-day status (Anthony, 1993).

A lack of time was identified as barrier to recovery-orientated care. The lack of time was described in two ways: short client admissions and time constraints during care provision. The limited amount of time that nurses were able to spend with clients resulted in a lack of rapport between nurses and clients. This, in turn, contributed to a lack of nurse knowledge about the clients' history or future goals. Psychiatric nursing practice in acute inpatient care settings has been complicated by conflicting priorities (Cleary et al., 2013). Participants in the present study wanted to spend time with clients and their families but were often occupied going to interdisciplinary rounds, giving medications, receiving admissions, discharging, documenting, and handling code white situations. This, when combined with working short-staffed and experiencing fatigue were seen as key barriers to the support of clients' recovery process. It appears that nursing time in an adult acute care PMH setting is not being effectively utilized in the interest of clients (Goulter et al., 2015; Graneheim et al., 2014; McKenna et al., 2014; Terry & Coffey, 2019). With nurses being unable to spend time with their clients, one participant in the current study noted how a lack of resources for clients while hospitalized negatively impacts recovery. A lack of resources for clients on acute care units does not align with the recovery-oriented system described by Anthony (1993); recovery-oriented mental health systems should

be structured in such a way that recovery is encouraged. Anthony (1993) identified a lack of meaningful opportunity of activity and engagement as a barrier to recovery-oriented care. Based on the studies findings, this barrier appears to remain in NL today.

Participants also reported that stigma/biases held by nurses and other health care professionals towards clients negatively impacts the provision of recovery-oriented care on an PMH acute care unit. Participants said that healthcare providers can make negative judgments about clients, based on their past medical or psychiatric history, which conflicts with Anthony's (1993) description of recovery as a non-linear journey. Stigma experienced by clients is an example of how recovery from the consequences of the illness is sometimes more challenging than recovery from the psychiatric illness (Anthony, 1993). Stigma cuts into the core of recovery, as it oppresses the spirit that is essential to the recovery process (Delaney, 2012). For example, recovery involves living a satisfying, hopeful, and contributing life even when constrained by the limitations imposed by illness (Anthony, 1993). Experiencing stigmatizing attitudes from healthcare professionals, clients have reported a dearth of attention given to their treatment preferences and the prevention of the formation of efficacious partnerships (Martínez-Martínez et al., 2021). Such professional practices align with clinical recovery, in which the healthcare professional has been considered the expert (Le Boutillier, Chevalier, et al., 2015). That the novice PMH RNs noted the stigmatization of clients in the current study is itself positive; they did not blindly integrate such attitudes from other healthcare professionals into their own practices. Canadian RPNs regard advocating to decrease of the stigma associated with mental illness and addictions as being part of their role (Graham et al., 2020).

Novice PMH RNs' Educational Experiences have been Lacking

Participants described the perceived deficiencies in both their undergraduate nursing programs as well as their work orientations when hired as PMH RNs. Anthony stated that an understanding of recovery is required by those who provide care to clients (1993). In this research, only one participant reported that recovery-oriented care was a significant part of her undergraduate nursing curriculum. Three participants reported that their core undergraduate courses provided insufficient recovery-oriented education. Another recalled that her orientation included specific teaching about recovery-oriented care. This, despite the literature identifying that recovery-related education is important for the enhancement of PMH professionals' recovery knowledge and attitudes (Sreeram et al., 2021). Furthermore, current RN competencies state that RNs are expected to provide recovery-oriented care in collaboration with clients (Canadian Council of Registered Nurse Regulators, 2018).

It has been recommended that the education provided to undergraduate nursing students and new PMH nurses be relevant and applicable to their practice (Cleary et al., 2011; Goh et al., 2021), thereby bridging the theory-practice gap (Happell et al., 2020). Thus, in learning about recovery, nursing students and novice PMH RNs must be taught how recovery can be applied in practice. In the present study, during her undergraduate education, one participant reported being given the opportunity to do her community health clinical with a PMH community team in rural NL. The participant described how this experience helped her in the provision of recovery-oriented care, as it enabled her to develop an awareness of the struggles that clients encounter in the community. The difficulties faced by clients in a rural community is another example of how recovery from the consequences of illness is sometimes more difficult than recovery from the illness itself (Anthony, 2000). It would be of benefit to nursing students in their undergraduate

programs to be given more PMH community placement opportunities to better understand the challenges that clients experience. In Japan, social workers had significantly higher RKI scores than nurses (Chiba et al., 2020). Given the differences in scores between nurses and social workers, community-based education was more effective than the medical-based education used in nursing education in fostering recovery knowledge (Chiba et al., 2020).

As stated, only one participant reported that her orientation included specific teaching about recovery-oriented care through watching videos. However, the participant was unable to provide specifics of the videos' content. The use of a video was insufficient to illustrate the complexities of the recovery concept. Policies in a recovery-oriented system encourage training methods designed to improve the necessary knowledge, attitudes, and skills (Anthony, 2000). To achieve this standard, healthcare organizations could avail of teachings by people who have mental health lived experience. One characteristic of a recovery-oriented organization is the inclusion of people who have mental health lived experience in the design and evaluation of organizational systems (Anthony, 2000). People who have recovered, or are recovering, from mental illness can be knowledge sources about how others can be helpful to people who are recovering, as well as the recovery process in general (Anthony, 1993). For example, in the education of nurses, lived-experience involvement has played a role in the addressing of fear and the demystification of mental illness (Happell, Bennetts et al., 2015). In Ireland, nurses who attended a workshop, co-produced and co-delivered by people with lived experiences of mental health challenges, showed a significant increase in confidence using a recovery model of care following the workshop (Walsh et al., 2017). In the present study, only one participant reported being given an opportunity to listen to a person with lived experience during her undergraduate nursing program.

Transition shock describes the initial reaction experienced by new nurses upon moving from the sheltered setting of academia to the unfamiliar and unpredictable environment of real-world practice (Duchscher, 2009). PMH Nurses in their first year of clinical practice have reported low levels of confidence (Hooper et al., 2016). They were confronted with a dichotomy between ideal practice and reality, which created confusion between what they had been taught and the realities of practice (Hooper et al., 2016). Nursing schools and healthcare employers should design clinical education and orientation programs that prepare nurses for the dynamic and conflict-prone context of real-world practice (Duchscher, 2009). As described in the current study, increased PMH nursing experiences in undergraduate nursing programs and longer clinical orientations increased participants' ability to provide PMH nursing care and recovery-oriented care. In the exploration of transition programs for recent graduate nurses working in PMH, programs varied both in length and learning activities (Tingleff et al., 2014). Participants in the present study reported that their observation of how nurses interacted with clients was a beneficial component of mentorship. This is consistent with the literature; in an Australian study exploring the process of how mental health nursing identity is influenced, participants reported that observing the way that experienced staff conducted themselves was a major influence in the formation of their own professional behavior, values, attitudes, and sense-of-self as helping agents (Hurley & Lakeman, 2011). However, in a study exploring recovery-oriented practices of RNs working in acute care PMH settings, participants minimized their role in creating space for recovery-oriented practice, often saying, 'it's just what we do." (Solomon et al., 2021, p. 971). The authors attributed this to the tendency for skilled nurses to be unaware of how they use their skills or engage in practices that they take-for-granted (Benner, 1994). Nonetheless, it is

noteworthy that, novice PMH nurses have also learned from experienced nurses' practices that are problematic, perhaps influenced by tradition embedded in unit culture (Danda, 2022).

As described by participants in the present study, novice nurses are independently taking the initiative to self-educate. Participants reported a wide variety of resources that they used to guide their recovery-oriented care and PMH nursing practice. While their drive to better themselves as PMH nurses should be applauded, they should not have to seek this education independently; in a recovery-oriented system, policies should encourage the use of training methods designed to improve knowledge, attitudes, and skills necessary to provide care (Anthony, 2000).

Novice PMH RNs Want and Need Support

In the provision of recovery-oriented care and PMH nursing care in general, participants reported a lack of organizational support. Yet, Anthony (2000) said that leadership must demonstrate, in both word and deed, that they are engaged in moving towards recovery-oriented practices. In the literature, PMH RNs have said that, to move towards the creation of a recovery-oriented organization, support must start with the leadership (Repique et al., 2016). Other studies have identified the need for management to be visible and to encourage the discussion about, and the facilitation of, PMH nurses' priorities in nurse-client relations (Graneheim et al., 2014; Salberg et al., 2019). In a Canadian study exploring the factors that influence the practice of newly-graduated nurses (not working in PMH), some managers expected the nurses to be practicing beyond the advanced beginner level immediately after the orientation period (Charette et al., 2019). It could be argued that novice PMH RNs require additional leadership support as they not only adjust to nursing practice in general, but to the specialization of PMH as well.

In the light of the perceived lack of organizational support, all participants described the importance of novice PMH nurses receiving support from more experienced nurses. This is consistent with Benner (1982), who said that the advanced beginner needs support in a clinical setting. Anthony (1993) said that universal to the recovery process for clients is someone who they can trust in times of need. If that is so, to manage a recovery-oriented organization, novice PMH nurses should also be provided with colleagues they can approach for support. However, one participant said that she experienced bullying as a novice nurse. In other Canadian studies, novice nurses have also experienced bullying by colleagues (Chachula et al., 2023; Charette et al., 2019). Bullying is not conducive to the creation of a recovery-oriented organization which is supposed to instill hope for clients and needs to be addressed.

Participants described their own mental health needs. Although not specifically addressed by Anthony, the need for nurses to attend to their own mental health aligns with his statement that "recovery is a deeply human experience, facilitated by the deeply human responses of others" (1993, p.18). If follows that, without novice PMH nurses receiving mental health support themselves, they will be unable to provide "deeply human responses" to their clients. In the Government of NL's (2023a) Towards Recovery final report, it was said that steps had been taken to address staff compassion-fatigue, stress, and burnout. However, it was acknowledged that, in general, future work is needed to address the low awareness of existing supports and services (Government of NL, 2023a). In this present study, two participants reported low awareness of existing supports for their own mental health needs.

Implications for Practice and Education

Based on the current Canadian RN competencies, RNs are to provide recovery-oriented care in partnership with clients who are experiencing a mental health condition and/or addiction

(Canadian Council of Registered Nurse Regulators, 2018). Although participants' understandings of recovery largely aligned with Anthony (1993, 2000), there were gaps in their recovery knowledge. Only a few participants described recovery as a non-linear journey and that recovery involves developing new meaning and purpose in life as one emerges from the debilitating effects of psychiatric illness. Also, participants did not share an awareness of the importance of connecting clients with other people who also have mental health lived experiences. Further, at times, participants included aspects of clinical recovery in their understanding of recovery. In light of the dominance of the biomedical model in acute care PMH settings, acute care PMH professionals need to understand personal recovery to support clients effectively in their recovery process (Lorien et al., 2020).

Accordingly, there is a need to improve the recovery knowledge of novice PMH RNs by targeting these knowledge gaps, thereby aiding them in their provision of recovery-oriented care. PMH nursing education should foster development of values, beliefs, and attitudes (Graham et al., 2020). One way this could be accomplished would be by including clients' lived experience, thereby benefiting undergraduate nursing programs as well as work orientation programs for PMH RNs. Lived experience involvement enhances PMH professionals' empathy, knowledge, and skills, thereby strengthening recovery-oriented care (Sreeram et al., 2021). Also, the involvement of lived experience in education could, potentially, highlight the importance of clients connecting with other people who have mental health lived experiences.

Also, the recovery education provided to undergraduate nursing students and novice PMH RNs should bridge the theory-practice divide. Staff working within PMH hospitals who received specific/practical education demonstrated a greater increase in recovery attitudes than professionals who received general/inspirational education (Tsai et al., 2010). After receiving

education sessions intended to improve American PMH RNs' knowledge of, and attitudes toward, recovery-oriented care, participants reported that they would have preferred that the education program be more applicable to their practice in an inpatient setting (Repique et al., 2016). Likewise, to improve learning modalities, Canadian PMH nurses have recommended the integration of case studies (DeSchiffart Marcogliese & Vandyk, 2019). Providing nursing students or novice PMH RNs with education on communication strategies with clients, in, for example, motivational interviewing, would enable them to develop confidence in the provision of recovery-oriented care, assisting clients to develop new meaning and purpose in life. In the current study, one participant recommended that novice nurses be taught DBT.

Additionally, there is a need for novice PMH RNs to be provided with more educational opportunities and/or be made more aware of available continuing education opportunities, as findings in the current study indicated that participants mainly sought out resources themselves. Canadian PMH RNs have reported a desire for self-directed learning and practice (DeSchiffart Marcogliese & Vandyk, 2019). However, in 2017, NL's provincial PMH Nurses' special interest group concluded (CRNNL, 2017). The creation of such a group could, potentially, provide educational resources for novice PMH nurses to promote their self-directed learning. Consideration could be given to the provision of educational opportunities to novice PMH RNs by the employer during work hours. This is consistent with the findings of DeSchiffart Marcogliese and Vandyk (2019) in which Canadian PMH RNs expressed a desire to receive continuing education during work hours.

A theme in this study was the description of recovery-oriented practices. However, participants experienced barriers in care due to a lack of resources and support. For novice PMH RNs to be able to provide recovery-oriented care in an acute care setting, these barriers must be

addressed. Recovery educational interventions have not been effective in maintaining a long-term effect on recovery knowledge and attitudes (Sreeram et al., 2021). The lack of adequate resources (such as workforce, budget, organizational support, workplace culture, and clear guidance) may have impeded recovery-oriented practices (Sreeram et al., 2021). To improve the quality of care and increase the well-being of clients, nursing interactions with clients need to be prioritized. It was acknowledged by the Government of NL (2023a) that limited PMH staffing resources is an ongoing challenge that needs to be addressed. PMH clients would benefit from additional resources on acute care units that encourage recovery.

Moreover, to change acute care unit cultures to one that fosters recovery-oriented practices, additional education is required as an initial strategy to reduce and mitigate PMH healthcare professionals' stigmatization of clients. Sreeram et al. (2022) found that in the literature, anti-stigma interventions involved heterogeneous groups of healthcare professionals; they recommended that training to be designed and delivered for specific professionals (such as PMH nurses) for interventions to be more relevant to clinical practice. For example, providing education to PMH nurses on recovery as a non-linear journey would be of benefit, as findings suggested in the current study that participants' colleagues sometimes stigmatize clients based on their PMH history.

The support needs of novice PMH nurses also requires attention. In the summer of 2023, the RNUNL signed a new collective agreement with the Government of NL. Two additions to the new collective agreement were: the enhancement of the existing preceptorship program and the addition of a mentorship program to support nurses as they adapt to practice (Government of NL, 2023b). Nurses who serve as mentors/preceptors should have skills which include the ability to nurture and support novice nurses (Chachula et al., 2023). However, the complexity of PMH

nursing practice is not always fully understood; there is a need for nurses to articulate their roles and skills, both to one another and to others (Cleary et al., 2011; Terry, 2020).

Mentors/preceptors should be provided with the necessary preparation for this task, making them aware of the need to articulate their practice skills. Also, support and encouragement from the organization and its leaders are necessary for PMH nurses to reflect critically on the influence of cultural contexts that may be involved in stigmatization (Sreeram et al., 2022). Management and clinical educators should provide regular check-ins with novice nurses to assess their professional and personal well-being, providing then with support if required (Chachula et al., 2023). Both community and inpatient PMH nursing staff have relayed the necessity of clinical supervision to debriefing and to the development of skills, however they found this support was lacking (Lees et al., 2014; Mooney & Kanyeredzi, 2021). The problem of the bullying of nurses by nurses should also be addressed to foster an atmosphere conducive to recovery. Orientation should provide information about policies fostering a respectful workplace environment, as well as about to whom novice nurses can go for support should they experience bullying (Chachula et al., 2023).

Supporting the mental health needs of RNs could be initiated in undergraduate nursing programs. Self-care activities were introduced in an American undergraduate PMH nursing course (Snyder, 2020). By learning about, and practicing, self-care strategies and coping skills, students reported a reduction in stress with an increase in self-awareness and self-reflection (Snyder, 2020). Further, there is a need to support novice PMH RNs' mental health as they transition from nursing school to work life. The employer may provide information about mental health resources that are available to staff, but it should be done in a way that is engaging and therefore memorable. Only one participant in the current study shared her awareness of EFAP

availability; two participants said that they did not know where to go for mental health support. When PMH RNs are hired, the availability of supports for staff mental health needs should be specifically included in their orientation. Also, regular personal check-ins by their managers, part of which should involve relaying mental health supports, would be of benefit to novice PMH RNs.

Research Recommendations

In a review of the literature, only two articles explored the experiences of novice RNs working in PMH in Canada, both published in 2011, prior to the publication of the current RN entry-level competencies (Schwartz et al., 2011; Wright et al., 2011). Replication of this study is recommended in other Canadian provinces. In addition, research that compares the perspectives and experiences of RNs and RPNs in Western Canada is recommended to determine if educational preparation impacts recovery-oriented care provision.

Findings suggested that participants' understanding of recovery largely aligned with Anthony (1993); however, there were gaps in their knowledge. Given that the Government of NL (2023a) recently stated that future efforts will increase mental health literacy and awareness of programs and services in the province, quantitative research utilizing the RKI (Happell, Byrne, et al., 2015) is recommended to identify gaps in novice PMH RNs' recovery knowledge and developing education strategies targeting these gaps. Also, participants reported challenges to their recovery-oriented practices; future research is recommended to address specific structures/procedures that impede the provision of recovery-oriented care.

Previous research findings have found that being young may positively contribute to better recovery knowledge and attitudes (Chiba et al., 2020; Cleary & Dowling, 2009). In this current study, participants described observing, and requiring the support of, other nurses;

accordingly, future research is recommended to investigate if expert PMH RNs in NL are enabled to provide recovery-oriented care, and what factors influence their ability to do so, in adult acute care PMH settings. Future research is also recommended to explore the effectiveness of the addition of a mentorship program in NL to support nurses as they adapt to new practice (Government of NL, 2023b) in PMH. Participants also said that they facilitated support for clients by involving families. However, in the literature, there has been a lack of engagement between family members and PMH nurses (Skärsäter et al., 2018). In addition, qualitative research is recommended to explore the experiences of families in their interaction with PMH nurses in NL.

Strengths and Limitations

A strength of this study is that it focused on a specific professional group. This study explored the recovery knowledge of novice PMH RNs and gave examples of how they provide recovery-oriented care in an adult acute care PMH setting. Further, findings in this study were used to identify the challenges that novice PMH RNs face in the provision of recovery-oriented care, as well as their perceived educational deficits.

The use of varying data sources has been recommended to add strength to the usual data sources of interviews and observations (Thorne et al., 1997). Data were collected from semi-structured interviews with novice PMH RNs and other collateral data sources (Thorne, 2016). While, during interviews, participants reported the use of a variety of resources utilized to guide their recovery-oriented practices, only one participant provided her specific resources to the primary investigator. Nevertheless, that participants reported the use of a variety of resources was beneficial to data analysis.

As the primary investigator is a PMH RN working in the province of NL, to reduce bias, following each interview, the researcher self-reflected and maintained a personal reflective journal. Also, member checking was offered as a means of validation. Although participants may have worked previously with the primary investigator, they were asked to answer the interview questions as honestly as possible, remembering that the primary investigator was acting as a researcher and not a colleague. Participants were informed that their decision to participate in this project, or not, would not impact their relationship with the primary investigator. However, the primary investigator's insider perspective aided with analysis. Given the primary investigator's education and practice history, she had a good understanding of participants' experiences and was able to connect with them. An outsider may not have fully appreciated the context of their professional practice.

This study consisted of a relatively small sample of six participants. However, the sample size often varies with interpretive description (Thorne, 2016). It is possible that the study topic appealed to novice PMH RNs who are passionate about the profession, thus rendering a false impression of the recovery-oriented practices of novice PMH RNs in an acute care setting. Also, it is possible that participants provided information that they thought would please the primary investigator.

Both a strength and limitation of this study is participant homogeneity. All participants had around three years or less of PMH nursing experience; participants were indeed novice PMH RNs. However, all participants were female; it is possible that gender differences might have yielded different perspectives. Also, the ethnic background of participants was not explored. Participants were recruited throughout the province of NL.

Chapter 6: Conclusion

It has been argued that, if positive change is to occur in recovery-oriented services, the views of personnel entering the PMH workforce must be understood and addressed (Happell, Byrne et al., 2015). There has been a paucity of literature exploring the experiences of novice RNs in the provision of recovery-oriented care. It has been unclear from the literature whether novice Canadian RNs working in an acute care PMH setting had the knowledge or the confidence to provide recovery-oriented care (Schwartz et al., 2011; Wright et al., 2011). Using interpretive description, the purpose of this inquiry was to explore and interpret the experiences of novice NL PMH RNs in the provision of recovery-oriented care in adult acute care settings. Six novice PMH RNs were interviewed, who shared their educational and clinical practice experiences regarding recovery-oriented care. Participants reported the knowledge, desire, and ability to provide recovery-oriented care to adult clients in acute care PMH settings. Yet, they experienced barriers in care provision due to a lack of resources and formal support.

Challenges described by participants were patient-related as well as unit- and system-related. Beginning work following nursing graduation, learning how to talk and build a rapport with clients with varying PMH presentations was difficult. Also, finding time to provide care to clients and their families was complicated by the busyness, unpredictability, and acuity of clients in an acute care setting. Additionally, the nursing shortage was identified as an impediment; nurses are working short-staffed and are being mandated to work shift-extensions resulting in fatigue. Further, the stigma/biases held by nurses and other health professionals towards clients negatively impacts the provision of recovery-oriented care in an acute care setting.

A lack of education in both participants' undergraduate nursing programs as well as their work orientation when hired as a PMH RN was highlighted; this contributed to gaps in their

recovery knowledge. Consequently, a need for ongoing learning was indicated. Participants in this study used a variety of resources to guide their recovery-oriented and PMH nursing practices. With the challenges faced by novice PMH RNs, participants shared a need for support in both for their nursing practice and their own mental health. If RNs are expected to specialize in an area of nursing practice and develop knowledge and skills that go beyond basic nursing education, they must be given the educational opportunities and support to do so.

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Practices of Novice Acute Care Psychiatric Mental Health Nurses
in Providing Recovery-Oriented Care
Appendix A: Correspondence with Mental Health and Addictions Regional Director

(Placed on Brandon University Letterhead)

Dear Mr. Whalen,

My name is Elizabeth ("Beth") Rowlands, and I am a Registered Nurse currently working in Eastern Health's Mental Health and Addictions program. I was recently awarded the position of PIER Case Manager, with the start date of 18 Sept 2022. Prior to this, I worked in the department of Mental Health Emergency Services at the Waterford Hospital. I am also currently a student in the Master of Psychiatric Nursing degree program offered by the Faculty of Health Studies of Brandon University.

I am writing to request permission to conduct a research study, in which novice Registered Nurses will be interviewed. The purpose of the proposed study is to explore if novice RNs are enabled to provide recovery-oriented care and what factors influence their ability to do so in adult psychiatric mental health acute care settings.

Recovery-oriented practice is an approach to care that is based on the belief that people will mental health problems can live meaningful and fulfilling lives even with ongoing symptoms of illness. Recovery-oriented practice focuses care on respecting individuality, instilling hope, and empowering personal choice.

In 2017, the Government of Newfoundland and Labrador released the provincial plan to transform mental health and addictions services in the province "towards recovery." However, according to the Mental Health Commission of Canada, although recovery is not a new concept, it has been often poorly defined and misunderstood.

Consequently, in the literature, although the provision of recovery-oriented practice is a guiding principle in psychiatric mental health care, yet a gap has remained between policy and implementation. The biomedical model and clinical recovery have been prominent in acute care psychiatric mental health settings, which has created challenges to the integration of recovery-oriented practices. Nursing care, provided in an acute care setting, has focused on risk management and client containment.

In the literature, novice nurses working in psychiatric mental health have reported a dichotomy between ideal practice and reality, which has created confusion between what they were taught and the realities encountered in practice. It is unclear whether RNs receive adequate recovery education in their comprehensive programs, or have the confidence to provide recovery-oriented care. Also, future research has been recommended to seek pragmatic examples of recovery-oriented care in acute inpatient psychiatric mental health services and devise strategies to assist recovery-oriented care in acute inpatient units.

With your permission, I hope to invite Registered Nurses, with generally around three years or less of nursing experience, who work on adult psychiatric mental health acute care units, to participate in an interview. Prior to the interview, participants will be asked if they have used any resources to assist them in the provision of recovery-oriented care, and if they would be willing to share them with the interviewer. Their names will not appear in any report or article published because of this study. Participation will be voluntary, and they may withdraw from the study prior to two weeks following the interview.

The proposed study has received ethics approval from the Brandon University Research Ethics Committee (BUREC) and the Newfoundland and Labrador Health Research Ethics Board (HREB). If you consent to the study, approval will be sought from and Eastern Health's Research Proposals Approval Committee (RPAC).

If you consent to the study, following RPAC approval, in order to recruit participants, I request that you ask unit managers to email the attached letter of invitation to their nursing staff. I also ask permission to place the attached recruitment posters on the acute care units. I have attached the ethics certificates for your review.

I am happy to answer any questions or concerns you may have. You can contact me at (709) 743-7925 or at rowlanec84@brandonu.ca. You may also speak to my thesis advisor, Professor Andrea Thomson at (204) 761-5843 or thomsona@brandonu.ca. For questions regarding ethics, you can contact the Brandon University Research Ethics Committee (BUREC) at (204) 727-9712 or burect@brandonu.ca; the Health Research Ethics Board (HREB) at (709) 777-6974 or info@hrea.ca; or the Research Proposals Approval Committee (RPAC) at (709) 752-4636 or rpac@easternhealth.ca.

Sincerely,

Elizabeth Rowlands, BSc, BN, MN, RN, CPHMN(C)

Hello Patrick,

You previously granted me permission to conduct a study within Eastern Health's Mental Health and Addictions program, in which I will investigate if Novice Registered Nurses are enabled to provide recovery-oriented care and what factors influence their ability to do so in adult psychiatric mental health acute care settings.

I thank you for your support thus far, and for sending the information about the study to your managers, who forwarded the information to potential participants.

Due to a low response rate, I have since changed an inclusion criterion for my study. I now hope to invite Registered Nurses, with around five years or less of nursing experience, who work on adult psychiatric mental health acute care units, to participate in an interview.

Previously, I sought to interview Registered Nurses with around three years of experience. If you consent, in order to recruit participants, I request that you ask the unit managers and the managers of the casual/float pool to email the attached letter of invitation to their nursing staff. I also ask permission for me to place the attached recruitment posters on the acute care units. The changes have received ethics approval from the Brandon University Research Ethics Committee (BUREC) and the Newfoundland and Labrador Health Research Ethics Board (HREB) (certificates attached).

I am happy to answer any questions or concerns you may have. You can contact me at (709) 743-7925 or at rowlanec84@brandonu.ca. You may also speak to my thesis advisor, Professor Andrea Thomson at (204) 761-5843 or thomsona@brandonu.ca. For questions regarding ethics, you can contact the Brandon University Research Ethics Committee (BUREC) at (204) 727-9712 or burec@brandonu.ca; the Health Research Ethics Board (HREB) at (709) 777-6974 or info@hrea.ca; or the Research Proposals Approval Committee (RPAC) at (709) 752-4636 or rpac@easternhealth.ca.

I thank you again for forwarding the study information previously, and this will be my final request.

Sincerely,

Elizabeth Rowlands, BSc, BN, MN, RN, CPHMN(C)
MPN Student, Brandon University

Practices of Novice Acute Care Psychiatric Mental Health Nurses
in Providing Recovery-Oriented Care
Appendix B: Letter of Invitation

(Placed on Brandon University Letterhead)

Dear Registered Nurses,

I am writing to invite you to participate in a research study exploring if novice Registered Nurses (RNs) are enabled to provide recovery-oriented care and what factors influence their ability to do so in adult psychiatric mental health acute care settings. Participants will engage in an interview utilizing Microsoft Teams. It is anticipated that the interview will last approximately 60 minutes. You will also be asked to share resources used, if any, to guide recovery-oriented nursing practice.

Recovery-oriented practice is an approach to care that is based on the belief that people with mental health problems can live meaningful and fulfilling lives even with ongoing symptoms of illness. Recovery-oriented practice focuses care on respecting individuality, instilling hope, and empowering personal choice.

However, according to the Mental Health Commission of Canada, although recovery is not a new concept, it has been often poorly defined and misunderstood. Consequently, in the literature, although the provision of recovery-oriented practice is a guiding principle in psychiatric mental health care, a gap has remained between policy and implementation.

It is unclear whether RNs receive adequate recovery education in their comprehensive programs or have the confidence to provide recovery-oriented care. Also, future research has been recommended to seek pragmatic examples of recovery-oriented care in acute inpatient PMH services and devise strategies to assist recovery-oriented care in acute inpatient units.

I am currently a student in the Master of Psychiatric Nursing degree program offered by the Faculty of Health Studies of Brandon University in Brandon, Manitoba. My thesis advisor is Professor Andrea Thomson. The information gathered in this study will be included in my thesis. It may also be utilized to write scholarly articles and be presented at conferences.

Your information will be kept secure. It will not be shared without your permission. Your name will not appear in any report or article published because of this study. Participation will be voluntary.

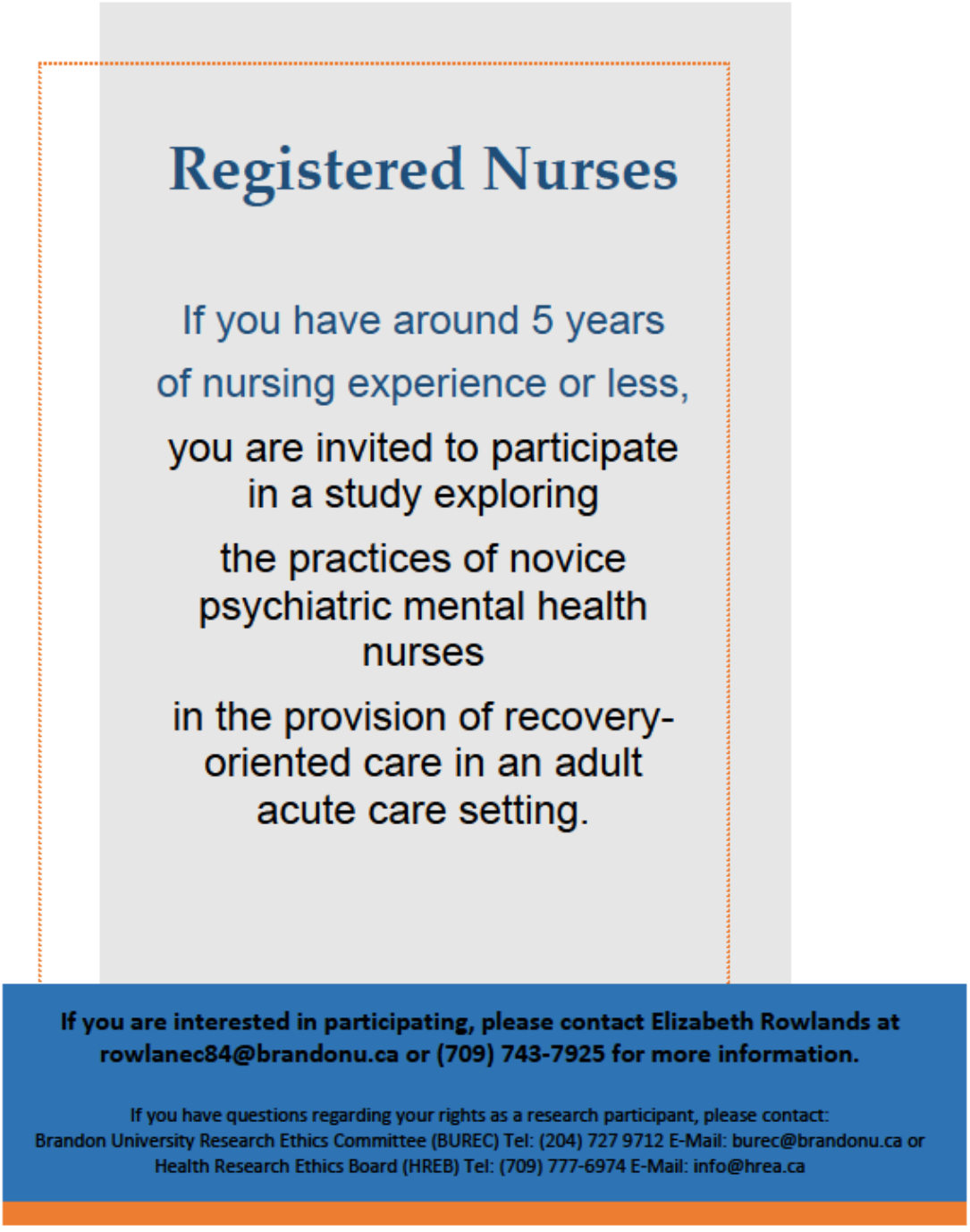
If you are a RN with around five years of nursing experience or less and are interested in participating in the study, please contact me at rowlanec84@brandonu.ca. Should you have any questions, please contact me to further discuss the project. You may also speak with my thesis advisor, Professor Andrea Thomson, at (204) 761-5843 or thomsona@brandonu.ca. For questions regarding ethics, you can contact the Brandon University Research Ethics Committee (BUREC) at (204) 727-9712 or burec@brandonu.ca; the Health Research Ethics Board (HREB)

at (709) 777-6974 or info@hrea.ca; or the Research Proposals Approval Committee (RPAC) at (709) 752-4636 or rpac@easternhealth.ca.

Sincerely,

Elizabeth (“Beth”) Rowlands, BSc, BN, MN, RN, CPMHN(C)
Master of Psychiatric Nursing Student
Faculty of Health Studies
Brandon University

Practices of Novice Acute Care Psychiatric Mental Health Nurses
in Providing Recovery-Oriented Care
Appendix C: Recruitment Poster



Practices of Novice Acute Care Psychiatric Mental Health Nurses
in Providing Recovery-Oriented Care
Appendix D: Facebook Recruitment Post

Hello Registered Nurses,

My name is Elizabeth ("Beth") Rowlands and I am currently a student in the Master of Psychiatric Nursing degree program, offered by the Faculty of Health Studies of Brandon University in Brandon, Manitoba.

I am conducing a research study exploring if novice RNs are enabled to provide recovery-oriented care and what factors influence their ability to do so in acute care settings.
If you are a novice RN and are interested in being interviewed, you can contact me at rowlanec84@brandonu.ca or 743-7925.

If you have questions regarding your rights as a research participant, please contact:

Brandon University Research Ethics Committee (BUREC)
Tel: (204) 727 9712
E-Mail: burec@brandonu.ca

Health Research Ethics Board (HREB)
Tel: (709) 777-6974
E-Mail: info@hrea.ca

Practices of Novice Acute Care Psychiatric Mental Health Nurses
in Providing Recovery-Oriented Care
Appendix E: Registered Nurses' Initial Consent

(Placed on Brandon University Letterhead)

Registered Nurses' Consent

TITLE: Practices of Novice Acute Care Psychiatric Mental Health Nurses in Providing Recovery-Oriented Care

PRINCIPAL INVESTIGATOR: Elizabeth Rowlands, BSc, BN, MN, RN, CPMHN(C)

THESIS ADVISOR: Andrea Thomson, BScPN, RPN, MPN

You have been invited to participate in a research study. Participation is voluntary. It is up to you to decide whether to partake in the study or not.

Please read this carefully. Ask questions about anything that is unclear.

1. Introduction/Background

Recovery-oriented practice is an approach to care that is based on the belief that people will mental health problems can live meaningful and fulfilling lives even with ongoing symptoms of illness. Recovery-oriented practice focuses care on respecting individuality, instilling hope, and empowering personal choice.

2. Purpose of Study

The purpose of the study is to explore if novice Registered Nurses are enabled to provide recovery-oriented care and what factors influence their ability to do so in acute care settings.

3. Description of the Study Procedure

Novice Registered Nurses who work in adult psychiatric mental health acute care settings, will be interviewed. For the purpose of this study, a novice is defined as Registered Nurses who have generally around five years of practice experience or less. The interview will take place over Microsoft Teams and will be recorded. Participants may choose to turn their video off. Transcription will be automated and verified by the primary investigator. The Primary Investigator may take notes during the interview.

It is anticipated that the interview will be approximately 60 minutes in length.

During the interview, Registered Nurses will be asked if they have used any resources to assist them in the provision of recovery-oriented care, and if they would be willing to share them with the interviewer.

Participants will be emailed a transcript of their interview as well as a summarized interpretation of the interview so they can verify that what they articulated was consistent with their experience. The primary investigator will state a few key points of information derived from analysis of that participant's interview data. Participants will be able to add/omit/clarify information for up to two weeks following the interview. Responding to the email will be optional. No response will be considered consent to use the transcript as distributed.

In addition, participants will be asked to give the letter of invitation to potential participants who might be interested in joining the study. Sharing the letter of invitation is completely optional. Alternatively, participants may choose to share an email address of a potential participant with the primary investigator, who will then email the letter of invitation to that person directly. Sharing contact information is completely optional as well.

5. Possible Risks and Discomforts

Risks associated with this study are minimal. However, it is possible that, during the interview, you could experience some discomfort. If this occurs, you will be reminded that you can choose to skip questions or end the interview at any time without penalty.

6. Benefits

Participants may benefit from reflecting on what is helping them to develop expertise in their practice. Also, your participation will provide valuable information on what factors influence novice Registered Nurses in their practices in relation to recovery-oriented care in a psychiatric mental health acute care setting.

7. Liability Statement

Signing this form gives your consent to participate in this study. It indicates that you understand your role in the research study. When you sign, you will not give up your legal rights; agencies and researchers involved in this research study will still have their legal and professional responsibilities.

8. Privacy and Confidentiality

The Primary Investigator will collect and use only information needed for this research study. Your name will be kept secure and will not appear in any report or article published as a result of this study. Your name will be replaced with a false name. Your identity will only be known to myself. Any potentially identifying information will be removed from your transcripts to protect your identity.

Participants can withdraw from the study at any time prior to data analysis, which will take place two weeks after participants have been emailed their interview transcript and summarized interpretation of the interview. It will not be possible to destroy individualized data following analysis, as data will be aggregated. Refusal to participate, or withdrawal from the study, will not affect your employment status or your relationship with the primary investigator.

All data will be stored in three private Microsoft Team channels, accessible only to the Primary Investigator (Elizabeth Rowlands) and Thesis Advisor (Professor Andrea Thomson). Any paper documentation obtained will be scanned and uploaded to the Microsoft Team channels and the files will be password-protected. The first private Microsoft Teams channel will include consent forms, video files, transcripts with identifiers, collateral data sources provided by participants, the Primary Investigator's reflection notebook, and else anything with participant information. The second private Microsoft Teams channel will include transcripts with false names and analysis files. The third private Microsoft Teams channel will contain the list linking false with actual names. Information collected for this study will be kept for seven years, after which the Microsoft Team channels will be deleted by the Thesis Advisor.

9. Responsibilities of Participants

You may have worked with the Primary Investigator. I ask that you answer the interview questions as honestly as you can, while remembering that in her role, the Primary Investigator is a researcher and not a colleague. Your decision to participate in this project, or not, will not impact your relationship with the Primary Investigator in any way.

During the interview, I will ask you to share any resources that have assisted with recovery-oriented care provision that you utilize, if any. The resources may provide insight into what resources are available to guide recovery-oriented care and provide context to your experiences.

The goal of this study is to improve the education/orientation of future Registered Nurses and the services offered to clients. If you were a Licensed Practical Nurse prior to becoming a Registered Nurse, you are asked to answer questions based on your nursing baccalaureate education, and Registered Nurse orientation/employment.

10. Dissemination of Results

It is anticipated that the results of this study will be shared in the following ways: presentation/publication of a thesis, published articles, and conferences. The master's thesis will be emailed to study participants following thesis defence, upon request. Quotes may be used to highlight your experiences, but you will not be identifiable in any way.

11. Commercialization of Findings

The Primary Investigator will not commercialize findings. There are no conflicts of interest to disclose.

12. Questions or Problems

If you have any questions about participating in the study, or you wish to withdraw, you can ask to speak with the Primary Investigator:

Elizabeth Rowlands
Tel: (709) 743-7925
Email: rowlanec84@brandonu.ca

Or, if you have any questions, you can speak with the Thesis Advisor:

Professor Andrea Thomson
Tel: (204) 761-5843
Email: thomsona@brandonu.ca

If you have ethics-related questions or concerns about this study, please contact:

Brandon University Research Ethics Committee (BUREC)
Tel: (204) 727 9712
E-Mail: burec@brandonu.ca

Health Research Ethics Board (HREB)
Tel: (709) 777-6974
E-Mail: info@hrea.ca

Research Proposals Approval Committee (RPAC)
Tel: (709) 752-4636
E-Mail: rpac@easternhealth.ca

A copy of this consent form will be given to you to keep for your personal records and reference.

By consenting, you have not waved any rights or legal recourse in the event of research related harm.

Signature Page

STUDY TITLE: Practices of Novice Acute Care Psychiatric Mental Health Nurses in Providing Recovery-Oriented Care

PRIMARY INVESTIGATOR: Elizabeth Rowlands, BSc, BN, MN, RN, CPMHN(C)

THESIS ADVISOR: Andrea Thomson, BScPN, RPN, MPN

To be completed by the participant:

I have read the consent form.	Yes [ ] No [ ]
I have been given the opportunity to ask questions. .	Yes [ ] No [ ]
I understand I can withdrawal from the study anytime, prior to *two weeks* following the emailed transcript/summarized interpretation of data.	Yes [ ] No [ ]
I understand that I can withdraw from the study without affecting my employment status or my relationship with the primary investigator.	Yes [ ] No [ ]
I recognize that it is my choice to participate in the study.	Yes [ ] No [ ]
I understand my privacy will be protected and my records kept confidential.	Yes [ ] No [ ]
I agree to participate in this study.	Yes [ ] No [ ]
I consent to being video and audio recorded.	Yes [ ] No [ ]
I consent to being only audio recorded.	Yes [ ] No [ ]
I would like a copy of the thesis emailed to me.	Yes [ ] No [ ]

_____	_____	_____
Signature of Participant	Name Printed	Day Month Year

_____	_____	_____
Signature of Investigator	Name Printed	Day Month Year

Practices of Novice Acute Care Psychiatric Mental Health Nurses
in Providing Recovery-Oriented Care
Appendix F: Interview Questions

Preamble:

The focus of this interview is the experiences of novice Registered Nurses in relation to the provision of recovery-oriented care in an adult psychiatric mental health acute care setting. ‘

I understand that you may have worked in settings other than psychiatric mental health or with populations other than adults. Please focus your interview responses on your experiences in an adult psychiatric mental health acute care setting. Also, if you were a Licensed Practical Nurse prior to becoming a Registered Nurse, I ask you to answer questions based on your nursing baccalaureate education, and your Registered Nurse orientation and employment.

The first questions are to understand your educational background and experience as a Registered Nurse

1. What is your educational background?
2. How many years of experience do you have as a Registered Nurse?
3. Is your nursing position casual, float, or permanent?

Now I will be asking about recovery and recovery-oriented care working with adults in acute care settings.

4. Please explain your understanding of the concept of recovery.
5. What recovery-oriented practices do you utilize in recovery-oriented care?
6. Describe your experiences in providing recovery-oriented care?
    a. Prompts: Why were these experiences important to share? Do you have a story that illustrates your experiences providing recovery-oriented care?

7. Did you find the way that you provide recovery-oriented care was altered, following these experiences?
8. What factors impact your ability to provide recovery-oriented care in an acute care setting?
    a. Prompts: Why do these factors impact your ability to provide recovery-oriented care? In light of these factors, in your experience, what sort of support are novice nurses receiving?
9. In your experience, how did the nursing undergraduate education you received prepare you to provide recovery-oriented care to psychiatric mental health clients?
10. In your experience, how did the orientation you received, when hired as a Registered Nurse, prepare you to provide recovery-oriented care to psychiatric mental health clients in an acute care setting?
11. Are there any resources that you have utilized to assist you in the provision of recovery-oriented care? If so, from whom did you receive them? Can you email the resource to me?
    a. Prompt if resource was shared: Why was it important to share this resource?
12. In your experience, what needs to be maintained, improved upon, or changed, for novice nurses to be able to provide recovery-oriented care in an acute care setting?
13. What advice do you have for other novice nurses in the provision of recovery-oriented care?
14. Is there anything else about recovery-oriented care in an acute care setting that you would like to tell me about, that I haven't asked?

Practices of Novice Acute Care Psychiatric Mental Health Nurses
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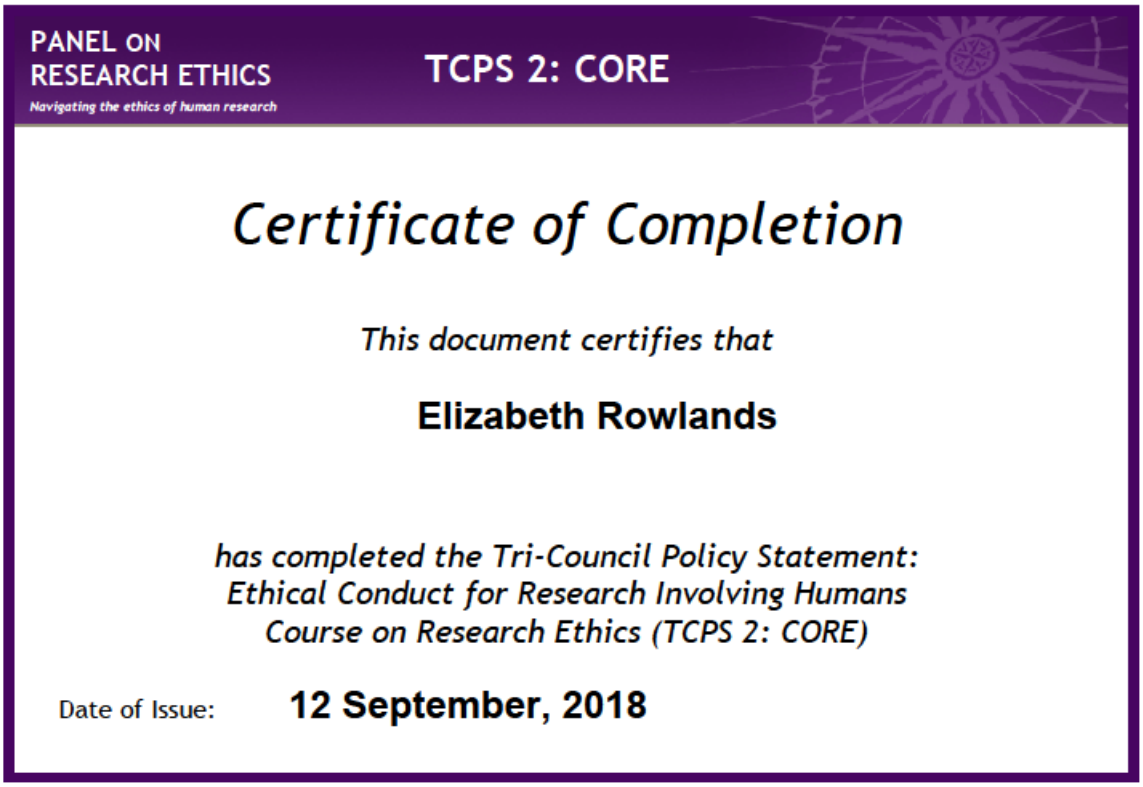
Appendix G: Primary Investigator's TCPS 2 Core Certificate



PANEL ON RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Elizabeth Rowlands

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

Date of Issue: **12 September, 2018**

Practices of Novice Acute Care Psychiatric Mental Health Nurses
in Providing Recovery-Oriented Care
Appendix H: CRNNL Invitation Letter

(Placed on Brandon University letterhead)

Practices of Novice Acute Care Psychiatric Mental Health Nurses in Providing Recovery-Oriented Care

Principle Investigator: Elizabeth Rowlands
Thesis Advisor: Andrea Thomson

Dear CRNNL Members,

I am currently a student in the Master of Psychiatric Nursing degree program offered by the Faculty of Health Studies of Brandon University in Brandon, Manitoba. I am currently conducting a research study exploring if novice Registered Nurses (RNs) are enabled to provide recovery-oriented care and what factors influence their ability to do so in adult psychiatric mental health acute care (PMH) settings. The information gathered in this study will be included in my thesis.

In the literature, although the provision of recovery-oriented practice is a guiding principle in psychiatric mental health care, a gap exists between policy and implementation. It is unclear whether RNs receive adequate recovery education in their comprehensive programs or have the confidence to provide recovery-oriented care.

I am recruiting RNs with around five years of experience or less who have current experience working on adult PMH acute care units. Study participation involves an interview with me via Microsoft Teams, lasting approximately 60 minutes.

To participate, please contact me at rowlanec84@brandonu.ca or (709) 743-7925.
This study has been reviewed by research ethics boards. For questions regarding ethics, you can contact the Brandon University Research Ethics Committee (BUREC) at (204) 727-9712 or burec@brandonu.ca or the Health Research Ethics Board (HREB) at (709) 777-6974 or info@hrea.ca. You may also speak with my thesis advisor, Professor Andrea Thomson, at (204) 761-5843 or thomsona@brandonu.ca.

Thank you for taking the time to consider this request.

Sincerely,

Elizabeth (“Beth”) Rowlands, BSc, BN, MN, RN, CPMHN(C)
Master of Psychiatric Nursing Student
Faculty of Health Studies
Brandon University