Master's Projects and Capstones          Theses, Dissertations, Capstones and Projects

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# Recovery-Oriented Care and Inpatient Psychiatric Nursing Practice

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## Clinical Leadership Theme

The goal of this project is to improve patient outcomes and patient experience at San Mateo Medical Center's Acute Inpatient Psychiatric Unit by implementing evidenced-based, recovery-oriented care principles into everyday patient care. Seed, Torkelson, and Karshmer (2009) stated that the Clinical Nurse Leader (CNL) role "can be instrumental in moving mental health care delivery forward with a focus on improving patient outcomes and recovery" (p. 123). The *Master's Essentials and Clinical Nurse Leader Competencies* identifies collaboration with interdisciplinary teams to plan, implement, and evaluate improvement opportunities as a core CNL competency (AACN, 2013). In addition to collaboration, the CNL is prepared to "evaluate the efficacy and utility of evidenced-based care delivery approaches and their outcomes at a microsystem level" (AACN, 2013, p.11). The success of this project will be heavily influenced by the way in which it is introduced and promoted, therefore collaboration and evidence of improved patient outcomes is essential.

## Statement of the Problem

Currently, San Mateo Medical Center's Acute Inpatient Psychiatric Unit has not fully adopted the recovery-oriented care philosophy, which is evidenced-based and has been identified as best practice. The recovery-oriented care is a model of care that instills hope of recovery through patient-healthcare team interactions and addresses the culture and drive of the healthcare team. The purpose of educating psychiatric inpatient nursing staff on recovery-oriented care principles is to improve the patient experience by altering the patient-nurse relationship. "Patients who feel defeated or 'stuck' often lack realistically attainable improvements in their day-

to-day existence" (Wallbridge, Furer, & Lionberg, 2008, p. 874). Knuston, Newberry, and

Schaper (2013) suggest that the use of a recovery-oriented model promotes hope at the most ba-

sic level.

## System Setting

San Mateo Medical Center (SMMC) is a public medical center and provides inpatient and

outpatient care to residents of San Mateo County, California. As a public facility, the primary

payer sources are Medicare and Medi-Cal.  Over half of San Mateo County's residents self-iden-

tify as either Hispanic or Asian (United States Census Bureau, 2015).  The medical center is

comprised of 228-inpatient beds, of which 30-beds are located on the acute inpatient psychiatric

unit (San Mateo Medical Center, 2015).  The acute psychiatric inpatient unit serves individuals

who are 18-years or older and require hospitalization due to serious mental illness.  The unit is

staffed with psychiatrists, registered nurses, certified nursing assistants, social workers, recre-

ational therapists, a nurse educator, and a nurse manager. Within the last year there has been

turnover within several roles, which historically had not been the norm.  Due to the acuity of the

patient population and unit history, patient and staff safety are the key point of focus for many

staff members and stakeholders.  Stakeholders include the Deputy Director of Psychiatry, Med-

ical Director of Psychiatry, Clinical Services Manager, and nursing staff.

## Rationale

In August 2015, a needs analysis was conducted on the inpatient psychiatric unit at San

Mateo Medical Center (SMMC) using McLoughlin's (2013) Recovery Self-Assessment- Regis-

tered Nurse (RSA-RN). The RSA-RN was created from tailoring the Recovery Self-Assessment,

which measures perceptions of the degree to which programs implement recovery-oriented prac-

tices **(**McLoughlin, Du Wick, Collazzi, & Puntil, 2013). Instruments, such as the RSA-RN, play

a key role in identifying the present state, which assists in successfully planning the next steps

needed to move mental health staff towards providing recovery-oriented care (see Appendix D

for additional information regarding the content of the RSA-RN). The results of the needs as-

sessment showed that 34% of staff do not believe that nurses within their department of nursing

use a language of recovery. Nurses surveyed were also asked if he or she considered the hospital

"recovery-oriented" of the nurses surveyed 40% reported that they did not feel that the hospital

was recovery-oriented. The results of the RSA-RN provide baseline data and support the need for

additional education regarding the principles of the recovery-oriented model.

For the past 15 years, major organizations such as the World Health Organization

(WHO), Substance Abuse and Mental Health Services Administration (SAMHSA), and U.S. fed-

eral government have been committed to shifting mental health services from the medical model

of care to the recovery-oriented model of care (Moller & McLoughlin, 2013). However, not all

identified recovery-oriented practices have been fully implemented throughout mental health

services, specifically in acute care settings. The RSA-RN needs assessment conducted on the in-

patient care unit at San Mateo Medical Center revealed that recovery-oriented care has not been

fully integrated into patient care practices. Therefore, an educational one-day workshop for all

psychiatric staff focused on the recovery-oriented care philosophy will assist with successfully

moving the unit toward recovery-oriented care and improve the patient experience.

**Cost Analysis**

The delay in implementation is costly to individuals living with mental illness, mental healthcare professionals, and organizations. The recovery-oriented care philosophy promotes healthy nurse-patient alliances, which has the potential to reduce the rate of inpatient assaults, decrease readmission rates, and increase staff engagement. By promoting education and brain-storming, the recovery- oriented care workshop is the initial intervention that is vital for San Mateo Medical Center's adoption of the recovery-oriented philosophy and ultimately the benefits of providing recovery-oriented care will far outweigh the cost (see Appendix A for an overview of costs associated with this project).

**Literature Review**

By using the following PICOT statement, I was able to find multiple articles that high-lighted the key role recovery-oriented care principles that provide a higher quality of care within the acute psychiatric setting:

> In an acute adult psychiatric inpatient unit (P), how does the use of recovery-oriented care principles (I) compared to the use of traditional, non-recovery-oriented care principles (C) affect nursing staff's Recovery Self Assessment- Registered Nurse (RSA-RN) scores (O) within one month after nursing staff have attended the recovery-oriented principles workshop. (T)?

Patient safety is the key focus of most acute psychiatric inpatient units, leaving other aspects of care in the background. According to Seed and Torkelson (2012), acute care psychiatric settings have historically emphasized managed care and have increasingly focused on the med-

ical model of care and this trend continues at my hospital. Patient and staff safety are both the

trigger and topic for a majority of our quality improvement projects, which often leads to solu-

tions that reduce the therapeutic and recovery oriented qualities of the milieu. Therapeutic patient

care environments embrace the recovery model of care and possess the following components:

"self-directed, individualized and patient-centered care, empowering, holistic, non-linear,

strength-based, peer supported, respectful, and hopeful" (Seed & Torkelson, 2012, p. 395). Im-

plementing recovery model principles, such as recovery oriented language and patient-centered

treatment planning, on the acute psychiatric inpatient unit is supported in the following studies

completed by Anvig and Biong (2014), Jensen et al. (2013), Dickens and Picchioni (2011), and

Porter Novelli (2006).

Advig and Biong (2014) assert that recovery-oriented practices in mental health services

relies heavily on the relationship between the person and the care provider. The authors' focused

on the components of conversations that occur and how those components impact patient recov-

ery. Qualitative data was collected during multistage focus groups and were analyzed using qual-

itative content analysis. The results of the study included the key components of conversation

that contribute to recovery-oriented care (Advig & Biong, 2014).

Jensen et al.( 2013) highlighted the role of person-first language in recovery-oriented

care. The authors of "Championing Person-First Language: A Call to Psychiatric Mental Health

Nurses" outline the definition of recovery and the principles of recovery-oriented psychiatric

mental health care, which are: dignity, respect, and the ways in which nurses convey a person's

uniqueness, strengths, abilities, and needs.

Dickens and Picchioni (2011) analyzed the role terminology has in stigmatizing or empowering individuals who receive mental healthcare services. It was identified that there are a variety of terms used mental healthcare professionals, regulatory bodies, and other healthcare service groups. Dickens and Picchioni (2011) searched multiple databases using key terms, such as patient, client, consumer, and service user. After reviewing all studies, 11 cross-sectional survey studies were selected for further analysis. The goal of the study was to bring clarity as to the current state of knowledge regarding the impact of terminology. The authors concluded that the quality of information was lacking and emphasized the importance of respecting individual preferences during interactions.

Porter Novelli's (2006) HealthStyles Survey revealed the current beliefs regarding mental health and recovery. The HealthStyles Survey has been administered annually since 1995 and is licensed by the Centers for Disease Control and Prevention (CDC). According to the Health-Styles Survey (2006), one-third of adults believe a person with mental illness can recover from his or her mental illness. The studies participants were diverse and did not focus solely on healthcare professionals' beliefs. However, the study did highlight the prevailing beliefs of society, which significantly impacts the model of care delivered in mental health settings.

## Project Overview & Methodology

The project aim is to increase staff's knowledge and use of recover-oriented principles by conducting a one-day workshop focused on the relevance, impact, and principles of the recovery-oriented care philosophy (see Appendix C for additional information regarding the project's strengths, weaknesses, opportunities, and threats). Once staff have completed the workshop, I

expect the results of the RSA-RN question "nurses use a language of recover", will raise from 20% from baseline data. The number of nurses who report that they did not feel that the hospital was recovery-oriented will be reduced 20% from baseline data. The measure of impact will be collected and analyzed one-month after nursing staff have attended the workshop. It is important to introduce recovery- oriented principles now, because recovery-oriented care has been identified as best practice by organizations, such as American Psychiatric Nurses Association, World Health Organization, and Substance Abuse and Mental Services Administration.

Introducing recovery-oriented care to a healthcare environment is the initiation of a culture shift.  Chen et al. (2011) stated, "moving from a medical model of care to a recovery model of care will require a culture change on inpatient acute care settings that will come with challenges" (p. 98).  Ronch (2003) believed the following:

> Leading culture change is complex and requires that the leaders go beyond merely voicing the need for change or publicly articulating the particular values that they wish to see realized in the changed culture. The leader of culture change must envision and plan for the entire process of change so that it is global, comprehensive and sustainable. As organizational culture is always changing, so the process of qualitative change may have an identifiable kickoff ceremony but should also have no conclusion (p. 2).

Systems often become overwhelmed with new quality initiatives, particularly with culture change (McLoughlin, Du Wick, Collazzi, & Puntil, 2013).  In order to obtain the long-term goal of moving the inpatient psychiatric care to recovery-oriented care, the change interventions must meet the staff members' current state of readiness and slowly expand as they grow.  Healthcare

staff must learn about recovery-oriented care principles, understand how to incorporate the principles into nursing practice, and believe that the principles have a positive impact on patient care.

Lippitt's change theory comprised of four elements, including: assessment, planning, implementation, and evaluation was utilized for this project (Lippitt, 1958) . The assessment portion has three phases, which include diagnosing the problem, assessing the motivation and capacity for change, and assessing the change agent's motivation and resources (Lippitt, 1958). For this project, these three phases were addressed by meeting with key stakeholders, such as the nurse manager, nurse educator, deputy director and a diverse small sample of nursing staff to identify potential barriers, driving forces, and change agents, as well as communicate the initial plan for change, a recovery-oriented principles workshop. The planning element follows the assessment and focuses on the details of the interventions that must take place and identifies the party responsible for completing each intervention. The change agents identified during the assessment are vital to the implementation of change, therefore the change agents were assigned to various interventions outlined in the planning phase. During the implementation section, the recovery-oriented principles took place. According to Mitchell (2013) the emphasis of implementation should be on communication, feedback on progress, teamwork, and motivation; therefore, the workshop was designed to introduce and discuss small interventions towards recovery-oriented care to allow time for evaluation of the implementation and address the needs of the staff during the change. The final stage of Lippitt's change theory is evaluation, which evaluates the impact of the interventions and marks the end of the change strategy. During the evaluation period, the RSA-RN was implemented to assess the effectiveness of the intervention conducted.

**Timeline**

In January 2015, I met with a lead researcher who had an extensive background in the field of recovery-oriented care in acute inpatient settings. After learning about the researcher's recent projects and reviewing recommended research regarding recovery-oriented care, I presented the idea to the Deputy Director of Psychiatry, an identified key stakeholder. Once I had received her approval and support, I presented the project to the Chief Nursing Officer, Medical Director of Psychiatry, and Clinical Services Manager of Acute Inpatient Psychiatry. By Summer 2015, all buy-in from administrative stakeholders was obtained. In Fall 2015, I attended the American Psychiatric Nurses Association's Recovery to Practice workshop and networked with other mental health professionals in the process of implementing the recovery-oriented care model at their organization. Based on the layout and content of the APNA's one-day workshop, I was able to start developing an educational plan for San Mateo Medical Center's Department of Psychiatry.  In September 2016, a one-day recovery-oriented workshop was held two consecutive days for all Department of Psychiatry staff members, including: nurses, recreational therapists, psychiatrists, and social workers (see Appendix B for additional details regarding the project's timeline)

**Nursing Relevance**

Recovery-oriented care has been identified as best practice; however, there has been a lag in the care model's full implementation at the unit level. The cause for the delay is likely due to the drastic difference between the traditional medical model and the recovery-oriented care model, as well as the common challenges encountered during any culture change. However, this project provides an opportunity to gain insight into what front-line nurses see as barriers to im-

plementing recovery-oriented interventions and what key changes must occur in order to provide recovery-oriented care. In addition, the workshop's table top discussions produced concrete examples of how current nursing interventions can be altered to become more closely aligned with the recovery-oriented care philosophy.

## Summary Report

The project aim was to increase psychiatric staff's knowledge and use of recover-oriented principles by conducting a one-day workshop focused on the relevance, impact, and principles of the recovery-oriented care philosophy. Various disciplines within the San Mateo Medical Center's Department of Psychiatry were the target audience for the one-day workshop, including: nurses, recreational therapists, psychiatrists, and social workers. The need for the quality improvement intervention was supported by baseline data collected in August 2015 through the utilization of the McLoughlin's (2013) RSA-RN. The results of the needs assessment showed that 34% of staff do not believe that nurses within their department of nursing use a language of recovery. Nurses surveyed were also asked if he or she considered the hospital "recovery-oriented", of the nurses surveyed 40% reported that they did not feel that the hospital was recovery- oriented.

After nursing staff attended the one-day workshop, I expected the results of the RSA-RN question "nurses use a language of recover", to raise 20% from baseline data. In addition, I anticipated that the number of nurses who report that they do not feel that the hospital is recovery-oriented would reduce by 20% from baseline data. The measure of impact was collected and analyzed one-month after nursing staff attended the workshop. However, additional baseline data

was collected immediately prior to the one-day workshop and only 10% of participants reported that he or she felt that the hospital was not recovery-oriented. In addition, 34% of surveyed nursing staff did not believe that nurses within the psychiatric department use a language of recovery. As planned, follow- up assessments were sent electronically to participants one month following the workshop and despite the ability for anonymity, few participants completed follow-up assessments. Therefore, there is a lack of objective data to support the impact of the intervention.

Without post-intervention data, objectively measuring the success of the education intervention is not possible. In addition, the two sets of baseline data were significantly different in regards to the percent of nursing staff who consider the hospital not to be recovery-oriented. There are several factors that may have contributed to the data variation. For example, the Department of Psychiatry experienced significant staff turnover rates between August 2015 and September 2016.

The project was also designed to assist with identifying key change strategies that are most effective with the SMMC psychiatric nursing cohort. Identification of effective interventions was done through the use of post-evaluations that focus on participants' reactions to the workshop content, style of delivery, and overall format of the training. The evaluation results indicated that nursing staff preferred the workshop's eight hour format and found the use of keynote content experts to be effective for learning.

The purpose of this project was to introduce recovery-oriented care as the care philosophy for inpatient psychiatric patient care at SMMC. The introduction of recovery-oriented care to a healthcare environment is the initiation of a culture shift, which may present significant chal-

lenges. In order to overcome challenges and sustain progress towards change, the culture change has to have the following components: 1) fits with the organization's mission and procedures; 2) staff perceive benefits of the change; 3) and stakeholders support the change. At this point in time, my CNL project has these components; however, I plan to maintain and sustain these attributes by conducting monthly nursing council meetings. The purpose of the council meetings is to support staff and move the recovery-oriented care initiative forward. During the meetings, staff identify and alter current policies, procedures, and practices that are not aligned with the philosophy of recovery-oriented care. In order to maintain stakeholder support, the work of the nursing council meetings is shared at the department and organizational level.

## Conclusion

Recovery-oriented care is significant to psychiatric nursing practice and has been recognized by numerous professional organizations as best-practice. This CNL project was successful at providing a forum for the Department of Psychiatry to discuss: a) current nursing practice and patient experience; b) the relevance of the recovery-oriented care philosophy; c) ideal future state of psychiatric nursing practice and patient care; and d) perceived barriers in transitioning from current to future state. In addition, it served as an effective official introduction to recovery-oriented care principles and set the stage for future improvement work. For future improvement projects similar to this I plan to place a higher emphasis on the collection of qualitative data, partially due to the lack of  meaningful quantitative post-intervention data and the potential for qualitative data to provide insight into perceived barriers to implementing recovery-oriented interventions and what key changes must occur in order for nurses to provide recovery-oriented care.

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*Appendix A*

*Appendix A*
*Budget*

**TOTAL PROJECT COST**



| PLANNING LABOR FEES | |
| --- | --- |
| Planning (Hrly Wage $50 X 15 Hours) | $750 |
| **TOTAL COST** | **$750** |

| FACILITY FEES & NON- LABOR COST | |
| --- | --- |
| Venue | $800 |
| Food & Beverage | $1,000 |
| Materials- Handouts & Pens | $100 |
| Presenter Honorarium & Travel Expenses | $3,100 |
| **TOTAL COST** | **$5,000** |

*Appendix B*
*Project Timeline*

| TASK | 1/2015-3/2015 | 4/15-6/15 | 7/15-9/15 | 10/15-12/15 | 1/16 | 2/16 | 3/16 | 4/16 | 5/16 | 6/16 | 7/16 | 8/16 | 9/16 | 10/16 | 11/16 | 12/16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Conduct research regarding Recovery-Oriented Care (Project Manager) | ■ | | | | | | | | | | | | | | | |
| Meet with stakeholders (Project Manager) | | ■ | ■ | | | | | | | | | | | | | |
| Attend American Psychiatric Nurses Association Recovery to Practice (Project Manager, Educator, & Director) | | | | ■ | | | | | | | | | | | | |
| Create draft agenda for Recovery Oriented Care Workshop (Project Manager, Educator, Manager, & Director) | | | | | | | ■ | | | | | | | | | |
| Contact prospective presenters regarding availability (Project Manager & Educator) | | | | | | | | | ■ | | | | | | | |
| Finalize date of workshop (Project Manager, Educator, Manager, & Director) | | | | | | | | | | ■ | | | | | | |
| Create invitation & send to Department of Psychiatry (Project Manager) | | | | | | | | | | | ■ | | | | | |

| TASK | 1/2015-3/2015 | 4/15-6/15 | 7/15-9/15 | 10/15-12/15 | 1/16 | 2/16 | 3/16 | 4/16 | 5/16 | 6/16 | 7/16 | 8/16 | 9/16 | 10/16 | 11/16 | 12/16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finalize content of workshop (Project Manager, Educator, Manager, & Director) | | | | | | | | | | | | | | | | |
| Review content with presenters and stakeholders (Project Manager, Educator, Manager, & Director) | | | | | | | | | | | | | | | | |

*Appendix B Cont.*
*Project Timeline*

| TASK | 1/15-3/15 | 4/15-6/15 | 7/15-9/15 | 10/15-12/15 | 1/16 | 2/16 | 3/16 | 4/16 | 5/16 | 6/16 | 7/16 | 8/16 | 9/16 | 10/6 | 11/16 | 12/16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Order food & beverage for workshop (Project Manager & Director) | | | | | | | | | | | | | ■ | | | |
| Complete documentation for CEUs | | | | | | | | | | | | | ■ | | | |
| Print handouts, evaluations, & sign-in sheets | | | | | | | | | | | | | ■ | | | |
| Workshop- September 26th | | | | | | | | | | | | | ■ | | | |
| Compile all ideas/ action items & share with participants | | | | | | | | | | | | | | ■ | | |
| Schedule Follow Up Meetings (Project Manager, Manager, & Director) | | | | | | | | | | | | | | ■ | ■ | ■ |
| Implement "quick wins" identified during table-top discussions | | | | | | | | | | | | | | ■ | ■ | ■ |
| Conduct RSA-RN evaluation | | | | | | | | | | | | | | ■ | | |

*Appendix C*
*SWOT Analysis*

| **Strengthes** | **Opportunities** |
|---|---|
| - Stakeholders fully support the project<br>- Resources have been allocated for the workshop<br>- Content experts have been identified and are open to assisting with the workshop | - Increase in new graduate nurses<br>- Staff interest in making patient stays more meaningful<br>- Increase in average patient length of stay |
| **Weaknesses** | **Threats** |
| - Not all nursing staff will be able to attend one of the two workshops<br>- Recovery-Oriented Care is a philosophy; therefore, full implementation will require a culture change | - When an incident occurs on the unit, historically root-cause analyses lead to more restrictive and less therapeutic environments<br>- Limited time of staff and administration |

*Appendix D*
*Recovery Self Assessment- RN Version*
*(RSA-RN)*

*Please indicate the degree to which you feel the following items reflect the activities, values, and practices of you and your department of nursing.*

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Strongly Disagree | | | | Strongly Agree |

1.  Helping people build connections with their neighborhoods and      1  2  3  4  5
    communities is one of the primary activities in which nursing staff at
    this facility is involved.

2.  This nursing department offers specific services and programs for      1  2  3  4  5
    individuals with different cultures, life experiences, interests, and needs.

3.  People in recovery have access to their nursing care plans/treatment plans.   1  2  3  4  5

4.  This department of nursing provides education to community employers      1  2  3  4  5
    about employing people with mental illness and/or addictions.

5.  Every effort is made to involve significant others (spouses, friends, family   1  2  3  4  5
    members) and other natural supports (i.e., clergy, neighbors, landlords) in
    the planning of a person's nursing care and services, if so desired.

6.  People in recovery can choose and change, if desired, their primary nurse,   1  2  3  4  5
    or nursing team with whom they work.

7.  Most nursing services for this facility are provided in an environment that   1  2  3  4  5
    mirrors a person's natural environment (i.e., home, community,
    workplace).

8.  People in recovery are given the opportunity to discuss their sexual and   1  2  3  4  5
    spiritual needs and interests with nursing staff.

9.  All nursing staff at this facility regularly attend trainings on      1  2  3  4  5
    cultural competency.

10. Nurses at this facility listen to and follow the choices and preferences of   1  2  3  4  5
    patients/program participants.

11. Progress made towards goals (as defined by the person in recovery) is      1  2  3  4  5
    monitored on a regular basis by the primary/team nurse.

12. This department of nursing provides structured educational activities to     1  2  3  4  5
    the community about mental illness and addictions.

13. Nursing staff do not use threats, bribes, or other forms of coercion to influence a   1  2  3  4  5
    person's behavior or choices.

14. Nursing staff and patients/program participants are encouraged to take risks and   1  2  3  4  5
    try new things.

15. Persons in recovery are involved with facilitating nursing staff train-    1  2  3  4  5
    ings

    Persons in recovery are involved with facilitating nursing     1  2  3  4  5
    and education programs at this facility.

16. Nursing staff are knowledgeable about special interest groups and activities in the   1  2  3  4  5
    community.

17. Nurses can schedule patient groups, meetings, and other activities in     1  2  3  4  5
    the evenings or on weekends so as not to conflict with other
    recovery-oriented activities such as employment or school.

18. Nurses actively attempt to link people in recovery with other persons in     1  2  3  4  5
    recovery who can serve as role models or mentors by making referrals to self-help,
    peer support, or consumer advocacy groups or programs.

19. This facility's nursing department provides a variety of  treatment options     1  2  3  4  5
    (i.e., individual, group, peer support, holistic healing, alternative treatments, med-
    ical) from which patients/program participants may choose.

20. The achievement of goals by people in recovery and staff are formally acknowl-     1  2  3  4  5
    edged and celebrated by the nurses or nursing department.

21. People in recovery are routinely involved in the evaluation of the nursing pro-     1  2  3  4  5
    grams, services, and nursing staff who provide services.

22. Nurses use a language of recovery (i.e. hope, high expectations, respect)     1  2  3  4  5
    in everyday conversations.

23.   Nursing staff play a primary role in helping people in recovery become        1   2   3   4   5
      involved in non-mental health/addiction related activities, such as church groups,
      special interest groups, and adult education.