Developing Psychiatric Nursing Competencies on an In-Patient Hospital-Based Psychiatric Unit

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Developing Psychiatric Nursing Competencies on an In-Patient Hospital-Based Psychiatric Unit

Beverly J. Sedlacek

Andrews University

Spring, 2017
Developing Psychiatric Nursing Competencies on an Community-Based In-Patient Hospital-Based Psychiatric Unit

Beverly J. Sedlacek

Andrews University
DEVELOPING PSYCHIATRIC NURSING COMPETENCIES
ON AN IN-PATIENT HOSPITAL-BASED
PSYCHIATRIC UNIT

A Project Dissertation
Presented In Partial Fulfillment
Of The Requirements For The Degree
Doctor Of Nursing Practice

By
Beverly J. Sedlacek

APPROVAL BY THE COMMITTEE:

_______________________________
Chair: Henrietta Hanna

_______________________________
Member: Eileen Willits

_______________________________
Date approved
DEDICATION

I would like to offer this dedication to my husband, David, who has been an inspiration and avid supporter from start to finish on this journey. I don’t know how many boxes of cereal he consumed on this journey, but I do know there were few complaints. I love you more than I can distill into words. My two sons, Eric and Michael, along with their spouses Sonja and Courtni have been quite the support team. Their unwavering love, understanding, encouragement, and belief in me were invaluable.
ABSTRACT

**Problem Statement:** Offering staff development training for psychiatric nurses has not kept pace with the advances in psychiatric knowledge and skills in nursing.

Purpose: The purpose of this quality improvement doctor of nursing (DNP) project was to implement a competency-based staff development program on a community hospital-based inpatient psychiatric unit to determine if the psychiatric/mental health nursing knowledge, nurse-patient relational skills, and attitudes of the nurses would improve or change.

**Methods:** A mixed method of quasi-experimental, non-randomized pre-test/post-test and semi-structured interview design was used, which utilized a convenience sampling approach. Data were collected in two phases. Three domains of the Mental Health Learning Needs Assessment (MHLNA), a competency-based assessment instrument that allowed self-assessment by nurses, was used to determine competency level of psychiatric mental health nursing knowledge and skills. Study participants completed a pre-test, using the chosen three domains of the MHLNA instrument, and participated in a five-week training program consisting of weekly sessions. Upon completion of the classes, the same three domains of the MHLNA were given as a post-test, along with three short-answer questions to determine knowledge and relational skills gained. At the end of three months, the Nurse Manager and Clinical Resource Nurse were interviewed and asked to evaluate the nursing staff based on the chosen three domains of the MHLNA. The study participants were also interviewed and asked three questions to determine if they had noticed a difference in their nursing knowledge, skills, and attitude three months after the training.

**Results:** The analysis of data derived from the paired t-test indicated there was no difference in the knowledge, skills, and attitude of the participants after attending a competency-based in-
service training program (p=0.05). Qualitative data analysis, however, indicated that participants reported a positive difference in their knowledge, skills, and attitude of the mentally ill, with three themes identified from comments made by the participants.

**Significance:** The results may serve as a basis for quality improvement in patient-centered care and on-going staff development training for the nurses on the community hospital-based inpatient psychiatric unit.
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Developing Psychiatric Nursing Competencies on an
In-Patient Hospital-Based Psychiatric Unit

I. Purpose of the Study

Equipped with psychiatric mental health nursing knowledge and skills, nurses have a long tradition of providing relationship-based patient-centered care (American Nurses Association [ANA], 2014) in a variety of psychiatric settings. The nurse “is the therapeutic agent with psychiatric patients (compared with treatment procedures and physical interventions used by the medical-surgical nurse)” (Fogger, 2015, p. 79). Administrators at a community hospital located in the Midwest have commented to me about their concerns that the inpatient psychiatric unit needs to improve the quality of its patient care, which included more interaction by nurses with the patients. In an attempt to address these concerns, the hospital decided to subcontract the unit to a larger hospital with expertise in providing mental health care. This researcher is the psychiatric mental health nursing faculty responsible for classroom and clinical learning for students at a nearby small university, which utilized the unit for clinical placement. In this capacity, it has been observed that nurses spent little time interacting with patients and demonstrate limited psychiatric nursing therapeutic knowledge and skills when they do. The psychiatrist, who was director of the unit for many years, ran the unit with tight control by using chemical restraints and encouraged the nurses to call security instead of utilizing therapeutic interactions and interventions with patients. The behavioral techs do most staff-patient relational interventions, and these interactions often lack understanding of therapeutic psychiatric mental health nursing principles.

The new unit Nurse Manager expressed frustration at the control and influence the long-time employed psychiatrist had on nursing care, as well as the nurses’ lack of interactions with
patients and general laissez-faire attitude. She was aware that the nurses’ focus of care was medically focused and showed little understanding of psychiatric mental health nursing principles. She first implemented processes to improve overall patient care, such as a change in format of shift report as well as information shared, safety initiatives for patients and visitors, and encouraging more nurse-patient interactions. In the two years since she has taken charge, there has been a noticeable improvement in processes, but resistance to nurse involvement with patient care persists. The Clinical Resource Nurse, who has been working on the unit for many years, was unable to articulate a model or philosophy of nursing care in conversation with me that would give support to the preeminence of the nurse-patient relationship in caring for the patients.

The psychiatrist, who controlled the unit and the nurses, retired and was replaced by a new psychiatrist, who provides more patient-centered care. From a medical perspective, the quality of care has dramatically improved.

**Purpose Statement**

The purpose of this scholarly project was to implement a competency-based staff development program on a community-based, hospital, in-patient psychiatric unit to determine if the psychiatric/mental health nurses’ knowledge, patient relational skills, and attitudes would improve or change.

**Goal and Objectives**

The goal of this project was to develop competency-based staff development training for nurses working on a community-based hospital inpatient psychiatric nursing unit to improve psychiatric nursing knowledge and skills.
II. Review of the Literature

As in all specialties of nursing, psychiatric mental health nursing has seen advances in knowledge and skills. Staff development or in-service training serves as a means for the nurse to further refine, update, and improve present knowledge and skills. In-service training, as defined by Muller (2009), is the informal training of nurses to improve their professional knowledge, skills, and attitudes according to the demands of the nursing unit (p. 351) and, according to Abruzzese (1996), is the key to quality nursing care. Muller (2009) noted that the purposes of in-service training are to 1) facilitate the more effective functioning of nurses within a team context in a unit; 2) to rectify shortcomings in the nurses’ knowledge, skills, and attitudes; 3) to prepare the nurses for the changes that are implemented by the nursing service; and 4) to manage risks before complications arise (p. 351).

Unfortunately, staff development (or in-service training) in psychiatric mental health nursing has not kept pace with the expanding body of evidence-based knowledge and therapeutic skills needed to serve the vulnerable population of the mentally ill (Letlape, Koen, Coetzee, & Koen, 2014). Examples of this expanding body of knowledge include an understanding of the side effects of the most current atypical antipsychotics and the recovery model, which focuses on the psychosocial interventions to promote recovery, such as managing disturbed behavior, offering support to families, as well as personal care of the client (Bowers et al., 2006; Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Continuing professional development among psychiatric mental health staff nurses is also needed to stay current in practice but is lacking (Hughes, 2005).

To explore the available research on staff development or in-service training for psychiatric mental health nurses, a search was conducted on Cumulative Index to Nursing and
Allied Health Literature (CINAHL), Medline, and PubMed using the following terms: staff development, in-service training, psychiatric nursing, psychiatric mental health nursing knowledge, and psychiatric mental health nursing skills. This search yielded results that revealed less than five international research articles and in the United States none related to staff development of psychiatric nurses in an inpatient psychiatric unit. Much of the extant literature focused on specific safety issues, such as violence, aggression, and self-harm.

**Violence, Aggression and Self-Harm**

Internationally, research focused on specific training topics such as violence, aggression, and self-harm. Bloor, McHugh, Pearson, & Wain (2004) explored the impact of the training of nurses in the management of violence and aggression in Russia. After the training, nurses were found to be significant change agents in supporting organizational change by questioning antiquated practices used to manage violent and aggressive patients.

Flood et al. (2006) developed a practice model that included training aimed at reducing aggression, self-harm, and absconding. The training resulted in a significant decrease in each of the areas. Patterson, Whittington, and Bogg (2007) and Kool, van Meijel, Koekkoek, van der Bijl, and Kerkhof (2014) used a training program to positively influence staff’s attitude toward patients who engage in self-harm behaviors. In a retrospective analysis of seclusion and restraint records in three inner-city psychiatric hospitals in the United Kingdom, there was no evidence that course attendance reduced unit violence in the short or long term (Bowers, Brennan, Flood, Lipang, & Oladapo, 2006). Needham et al. (2004) found that after staff training in in-patient aggression measures, nursing interventions can play a vital role in the management of patient aggression, which may be viewed as positive for patients and nurses alike.
In the United Kingdom, Willetts and Leff (2003) found that there was an improvement in the knowledge and skills of psychiatric nurses after in-service training for the management of schizophrenic patients. Bowers et al. (2006) found no evidence that attendance at a physical aggression management and prevention course reduced violence in an acute psychiatric ward.

In South Africa, Letlap et al. (2014) confirmed the benefits and need for ongoing in-service training for psychiatric nurses. It was the first study conducted in South Africa, highlighting the need for ongoing in-service training in psychiatric nursing, since 1986. The study findings concluded that ongoing in-service training is necessary and has career, social, physical, and psychological advantages for psychiatric nurses.

Björkdahl, Hansebo, and Palmstierna (2013) used the City Model, a theoretical nursing framework of the Swedish violence prevention and management staff-training program called the Bergen Model, to train nursing staff on 41 psychiatric wards in Sweden. After the training, a 13-item questionnaire was given on 19 of these wards to ascertain if the staff and patient perception of violence prevention were improved. Findings revealed only one statement had positive results for patient and staff. Interestingly, the statement “The staff try to understand why a patient is acting aggressively” (p. 401), speaks to the essence of psychiatric nursing-therapeutic communication (Peplau, 1997).

In a qualitative study, Cleary, Horsfall, O’Hara-Aarons, Jackson, & Hunt (2011) interviewed psychiatric nurses working on an inpatient mental health unit over three weeks. The purpose of the structured interview was to determine the nurses’ perceptions of mental health services and professional development. The results indicated the nurses valued and sought out more opportunities to participate in staff development. Nurses also expressed a desire for continuing professional development to be further studied. Study limitations included sampling
Role and Function of the Nurse

There is confusion today about the role and function of psychiatric nurses. Perraud et al. (2006) described factors that led to the paradigm shift from interpersonal/therapy-based models of psychiatric nursing care to a biological causation with a concentration on physical assessment, pathophysiology, and pharmacology (p. 216). There are conflicting roles and skills for the psychiatric nurse in each of the two views. When biological causation is the focus, the priorities of the nurse often exclude the therapeutic nurse-patient relationship. With the interpersonal/therapy-based model, the nurse-patient relationship is the starting point (Cutcliffe, 2008), with the patient always the focus. Current trends today in health care suggest that relational skills are vital but challenging to develop and maintain. With the focus of healthcare on cure instead of care, the therapeutic relationship has been relegated to the background (Krauss, 2001). Peplau (1997) identified the primacy of the nurse-patient relationship, which “is central in a fundamental way to providing nursing care” (p. 163). “In this era of managed care, cost containment, and biotechnology, the patient-caregiver relationship is neither well appreciated nor understood” (Krauss, 2001, p. 49). It is important that inpatient psychiatric units make a decision about which of these identities that they will adopt. The model they choose will determine their philosophy of psychiatric nursing care, as well as their staff development needs.

That being said, no studies have been done on psychiatric nursing staff development or in-service training related to improving either the relational skills of psychiatric nurses or the use of...
of medication management on a hospital-based in-patient psychiatric unit except one study related to medication side effects (Phillips, 2012). Therefore, this study is an important beginning in demonstrating the significance and importance of staff development in psychiatric nursing programs.

**Clinical Questions/Problem, Intervention, Comparison and Outcome [PICO] Question**

The following PICO question was the focus of the project:

Does a competency-based mental health staff development program on a community hospital-based inpatient psychiatric unit improve the psychiatric mental health knowledge, skills and attitude competencies of nursing staff?
III. Conceptual and Theoretical Framework

Knowles’ Theory of Adult Learning (1973) was the theoretical framework used for this project. Popularizing the term andragogy, which means adult education, Knowles (1973) transformed the focus of education from teacher-centeredness to learner-centeredness and posited that there is an art and science to adult learning. Underlying assumptions of andragogy include adults are self-directed or intrinsically motivated, which leads to growth in the self-concept, the use of experience provides the basis for the learning activity, are problem-focused rather than subject-focused, which motivates the learner to learn. Knowles (1973/1984) also identified six core principles that characterize the adult learner, which include the learner’s need to know, the self-concept of the learner, prior experience, readiness to learn, orientation to learning, and motivation to learn.

The course curriculum took into account Knowles’ core characteristics of the adult learner to structure learning activities that relate to the individual “learner’s need to know.” The curriculum recognized that the resulting learning must contribute to increased competency as perceived by the student (Jarvis, 1987). The course curriculum was designed to link adult learning principles to the life experiences, knowledge, and clinical experiences of the participants.

In addition to Knowles’ Adult Learning theory, knowledge, skills, and attitudes were evaluated. According to Quinones & Ehrenstein (1997) “Knowledge, skills, and attitudes (KSAs) are the abilities and characteristics that enable a job holder to accomplish the activities described in a task statement (job description) which describes what the job holder does” (p. 154).
In learning outcomes typology: Knowledge (cognitive)—verbal knowledge such as facts, organization of knowledge, and allocation and regulation of cognitive resources are important; Skills (psychomotor)—compilation [the linkage between routine development and procedure], automaticity [the ability to perform a task without conscious monitoring, and with other tasks]; Affective (attitude)—attitudes about learning, self-efficacy, perception of ability to perform, and goal setting; motivation (Kraiger, Ford, & Salas, 1993).

**Conceptual and Operational Definitions**

The following three conceptual definitions were used to guide the project.

1. “Learners’ need to know” information is defined as for the adult learner is information that will assist in solving a problem and can be applied presently in life (Knowles, 1973/1984). The MHLNA instrument was used to measure the learner’s need to know.

2. **Learning needs assessment** is defined as assessment done to provide information that is utilized to form the basis of needs-based educational programs to fill educational gaps and improve nursing practice (Cunningham, Fitzpatrick, & Kelly, 2006). The MHLNA instrument was used to measure what the learner identified as present inadequacies in psychiatric mental nursing knowledge that is needed to develop psychiatric mental health nursing competencies. The course classes were designed to emphasize content areas based on findings from the participants’ self-assessment.

What the nursing profession defines as competent care is important for every nurse to know. Nurses “need to know” the most current competency expectations as nursing knowledge and skills advance.

3. **Competency** as defined by The National Council of State Boards of Nursing
[NCSBN] (2006) (as cited in McKnight, 2013) is “the ongoing ability of a nurse to integrate knowledge, skills, judgment, and professional attributes in order to practice safely and ethically in accordance with the scope of nursing practice” (p. 460). The MHLNA, a current competency-based assessment instrument, was used to inform the content of the competency-based staff development-training program used in this study.

The operational definitions for this study were derived from three of the eight domains of the MHLNA instrument. They are domains 1, 3, and 6. Only three domains were chosen due to time constraints of the academic calendar for the researcher to complete the project.

1. Domain 1 includes nine competencies necessary to provide holistic mental health nursing care. The necessary knowledge/skills identified include: “data assessment and analysis, establishing a caring goal-directed therapeutic milieu, utilizing therapeutic communication recognizing cultural diversity, guiding patient through therapeutic changes, supporting a sense of resiliency, gathering and recording assessment data, therapeutically evaluating effectiveness to achieve competency in this domain of holistic mental health” (McKnight, 2013, p. 461). The MHNLA instrument was used to assess competencies of Domain 1.

2. Domain 3 includes eight competencies for administering and monitoring therapeutic interventions, which are critical for quality mental health care: “Administering therapeutic mental health interventions of education, monitoring, and group therapy; utilizing appropriate technology for safety; administering medication; and collaborating with patients and family members for holistic therapeutic care” (McKnight, 2013, p. 461). The MHNLA instrument evaluated Domain 3 competencies.

3. Domain 6 includes nine competencies for ensuring quality mental health care services,
the fundamental basis of best practice in holistic patient-centered care: “Identifying hazards in the workplace, expanding the knowledge base to ensure safe and therapeutic care, critically evaluating current mental health research to improve quality of care, patient advocacy, documentation of mental health reviews, utilization of evidence-based practice, and the ability to recognize changes in mental health nursing practices” (McKnight, 2013, p. 470). The MHNLA instrument was used to evaluate Domain 6 competencies.

Research Question

Clinical Questions/Problem, Intervention, Comparison and Outcome [PICO] Question

The following PICO question was the focus of the project:

Does a competency-based mental health staff development program on a community hospital-based inpatient psychiatric unit improve the psychiatric mental health knowledge, skills and attitude competencies of nursing staff?
IV. Methodology

Project Design

A mixed method, quasi-experimental, non-randomized, convenience sample design was used to determine the impact of a competency-based staff development program on the attitude, knowledge, and skill level of the psychiatric nurses on the community hospital-based inpatient psychiatric unit in a Midwest community hospital. Data were collected in two phases. In the first phase, the Mental Health Learning Needs Assessment (MHLNA) instrument was used to collect the pre-test data. The pre-test MHLNA was administered to participants two weeks before the implementation of the staff development program, entitled “Growing Together: Developing Mental Health Nursing Competency.” The post-test MHLNA, along with three short-answer questions were given immediately following the last class of the staff development program. Phase two occurred three months later, when the researcher individually interviewed the unit Nurse Manager and the Clinical Resource Nurse to discuss their observations of nursing staff since the staff development course ended. The interview included a review of the competencies of domains 1, 3, and 6 found in the MHLNA instrument. The participants were next interviewed and asked three questions to determine if the training made a difference in their nursing care.

Independent and Dependent Variables

The independent variable in this project was the competency-based staff development program, entitled “Growing Together: Developing Mental Health Nursing Competency.” Domains 1, 3 and 6 of the eight domains of the Mental Health Learning Needs Assessment (MHLNA) instrument, were identified as dependent variables used to measure knowledge, skills, and attitude of the nursing staff and described below:
1. Domain 1: Providing Professional Holistic Mental Health Nursing Care, which includes nine competencies related to the nursing practice of professional holistic mental health nursing care.

2. Domain 3: Administering and Monitoring Therapeutic Interventions, which includes nine competencies of the nursing practice of administering and monitoring therapeutic interventions.

3. Domain 6: Ensuring Quality Mental Health Care Services, which specifies nine competencies of the nursing practice of ensuring quality mental health care services.

Instrumentation

The Mental Health Learning Needs Assessment (MHLNA) (McKnight, 2013) is a competency checklist for self-evaluation of psychiatric mental health therapeutic nursing skills. The checklist was developed with “eight domains of mental health nursing practice, which encompasses the field of professional mental health nursing practice. In each of the eight domains, there is a list of the knowledge/skill necessary to fulfill competency for that domain. To select the level of competency of the listed skill, individuals need only move to the column next to the knowledge/skill description, and rate their self-assessed level of competency on a scale of one to three, marking the block indicating that level of competency” (McKnight, 2013, p. 461). According to McKnight (2013), the comprehensive MHLNA is designed so that individual domains may be completed to ascertain the individual’s learning needs (p. 470). Three of the domains, 1, 3, and 6 were used in this study to assess both psychiatric mental health nursing knowledge and skills of the nurses. “Accuracy rates for self-disclosure in the MHLNA in clinical practice indicated high accuracy rates of 95% in self-reports of skill base deficits” (McKnight, 2013, p. 470) (See Appendix A). There are no known studies found in the literature
that has used the instrument to establish validity and reliability since its development. This instrument was used with the author’s permission (See Appendix E).

Three months after the competency-based staff development program ended, this researcher interviewed the unit Nurse Manager and the Clinical Resource Nurse. The purpose of the interview was to determine if there had been an improvement in the previously identified gaps in psychiatric nursing knowledge and skill of the nurses on the unit, based on their assessment of the nurses using the MHLNA as a guide. These gaps included safety initiatives for patients and visitors and nurse-patient interactions. The participants were then interviewed and asked how the training has impacted their nursing care.

**Participants and Sample**

A convenience sample of full- and part-time nurses who worked on the in-patient psychiatric nursing unit of the community hospital located in the Midwest was used.

The inclusion criterion for the study was any full- and part-time nurse who worked on the in-patient psychiatric nursing unit of the community hospital located in the Midwest. Exclusion criteria were nurses in unit management and nurses working outside of the unit.

Ten nurses initially agreed to participate in the study, but only six completed the entire staff development program. The demographic data reveals two males and four females, one African, one Asian, and four Caucasians. Three nurses had eleven years or less of experience in psychiatric mental health nursing, with one nurse who has been working in her first job for one year. Three nurses had more than fifteen years’ experience working in the field.
Interventions and Data Collection

Although the Nurse Manager reviewed the MHLNA, and thought the nurses would benefit from a course covering all of the domains, she finally chose three of the eight domains for the researcher to focus on for this study, which were domains 1, 3 and 6.

Recruitment flyers were placed on the unit announcing the study one week after IRB approval (Appendix I). The Nurse Manager also sent an email to all the nurses announcing the study and encouraging them to participate. Each nurse was given an information letter (Appendix F), which identified that the purpose of the staff development program was for research. Once the nurse agreed to participate in the study, he/she was given the consent form, which included a confidentiality statement, the purpose of the study, and ease of withdrawing from the study if desired (Appendix G).

The email address of each nurse who agreed to participate in the study was collected so that instructions on how to take the pre-test MHLNA on-line could be sent. Instructions included assignment of a number and a link to access the on-line pre-test (Appendix H). There was a space on the pre-test where the participant number could be entered. For anonymity, only the researcher and the nurse had access to the number. Once the participants completed the pre-test, the data was tabulated and stored in a password-protected document, on a password-protected computer. Based on the tabulated results, each of the five classes was configured to emphasize what the participants identified as lacking in knowledge and skills and required more emphasis during the classes.

Each of the five classes was taught three times weekly for five weeks, as well as recorded via Zoom program in the hospital conference room located in the basement (which is locked and inaccessible to patients). For the convenience of the nurses, the classes were offered on two
consecutive days at the end of the third shift, the end of the first shift on one day and before the start of the second shift on the second day. Several nurses came on their days off to participate in the classes. When three nurses could not attend the live class because of other commitments, they were sent Zoom links to view the video recording of the class. Class number one began one week after the data had been collected. Knowles’ Theory of Adult Learning served to undergird the teaching strategies used in this competency-based staff development-training program.

There were a variety of teaching strategies used in the course classes, based on Knowles Adult Learning theory with particular attention to “learner’s need to know,” self-motivation and problem solving. Teaching strategies chosen for the classes include PowerPoint presentations, case studies, discussion, reflection on previous experiences, problems that are presently faced in practices, and videos. The following class outline, based on competencies from on domains 1, 3, and 6, with objectives for each class, is presented below:

a. Class One (Domain 1: Providing Professional Holistic Mental Health Nursing Care)
   i. Learning Objectives
      1. Nurses will be able to:
         a. Identify two areas from assessment data that may be utilized to formulate nurse-patient relationship.
         b. Identify three strategies that will foster de-escalation.
         c. Verbalize 3 strategies that will foster a therapeutic unit milieu.
      2. Description of Topics
         a. Assessment of a patient for risk of self-harm and harm others, emotional state, and immediate needs.
b. Identifying the role and value of milieu management of in-patient psychiatric hospitals.

c. Observations

d. Skills practice

3. Teaching strategies

a. The researcher utilized a PowerPoint presentation (Appendix J) to introduce the subjects of utilization of assessment data to develop nurse-patient relationship and discussed a clinical case: Mrs. Rhodes, Hospitalized for Depression. Identification of three strategies to foster de-escalation was next discussed. Reflection on practice focused on two “What If” questions. These questions encouraged the participants to think of what could be changed on the unit, based on how seclusion and constraint is presently handled. Reflecting on practice, the participants were also asked to set a seclusion reduction goal for the month. Three strategies to foster a therapeutic milieu on the unit were next discussed, which included discussion about nurses spending more time on the unit and encouraging patients to share concerns, reactions, and fear of losing control. Reflection on practice focused on the present policy of debriefing patients and staff after a seclusion/restraint incident. The class lasted 60 minutes.

b. Class Two (Domain 1: Providing Professional Holistic Mental Health Nursing Care)

i. Learning Objectives

1. Nurses will be able to:
a. Identify three examples of nursing care where cultural competence is shown.

b. Identify three common emotional states of distress, such as anxiety, anger, tension, fear, grief, helplessness, and hopelessness.

c. Identify 3 intervention strategies that will assist patients during emotional states of distress.

2. Description of Topics

a. Impact of culture on the therapeutic process.

b. Influence of family involvement.

c. Human responses to distress and effective responses.

3. Teaching strategies

a. The researcher utilized a PowerPoint presentation (Appendix K) to facilitate discussion about cultural awareness and the impact of bias on nursing care. Self-awareness and active listening are required to assist patients to connect with their feelings and emotions. Nurses must be attuned to patient’s expression of primary feelings that may be inappropriately expressed. An opportunity to help the patient to identify what he/she may be feeling is often missed when the secondary behavior is addressed instead of the underlying feelings. A video demonstrating listening and connecting with the heart of a patient was shared: Gladys Wilson and Naomi Feil (Memorybridge, 2009, 5:46). This class lasted 48 minutes.
c. Class Three (Domain 3: Administering and Monitoring Therapeutic Interventions)
   i. Learning Objectives

   1. Nurses will be able to:
      a. Identify a way in which technological teaching aids have been useful with patients.
      b. Report at least 2 adverse medication effects, which include side effects, toxicity, and potential drug incompatibilities.
      c. Demonstrate one effective intervention with a patient who is either acutely psychotic, depressed, or in a manic phase of bipolar illness.
      d. Identify three problem-solving interventions that may be implemented with patients.
      e. Identify three educational strategies to be used to support patient in making health choices and involvement in care.
      f. Identify one strategy to improve collaboration among unit staff.

   2. Description of Topics
      a. Review of antipsychotic medication and side effects
      b. Working with voices, delusions, and the management of mood swings
      c. Skills practice

   3. Teaching strategies
      a. The researcher utilized a PowerPoint presentation (Appendix L) to begin the discussion about technological teaching aids presently used. Participants have successfully used medical e-learning programs in the past and discussed the pros and cons of their use with the patients. Group
discussion continued with the focus on adverse side effects with the atypical drugs. Of primary concern are the metabolic side effects such as diabetes mellitus, secondary to use of the atypical antipsychotic medications. As part of providing quality patient care, nurses need to be knowledgeable about these adverse side effects to educate patients as well and monitor and care for those who are at risk. Participants were aware of several side effects and which medications put patients at significant risk, but none of them were monitoring nor educating patients about these risks.

This 58-minute class also included a case study of Tony, a newly diagnosed psychotic patient, and concluded with strong reactions from participants about the lack of consistency between the shifts and the resultant difficulty with patients. See comments addressed later.

d. Class Four (Domain 3: Administering and Monitoring Therapeutic Interventions)

i. Learning Objectives

1. Nurses will

   a. Demonstrate one effective intervention with a patient who is either acutely psychotic, depressed, or in a manic phase of bipolar disorder.

   b. Identify three problem-solving interventions that may be implemented with patients.

   c. Identify three educational strategies to be used to support patient in making health choices and involvement in care.

   d. Identify one strategy to improve collaboration among unit staff.
2. Description of Topics
   a. Discuss most effective strategies for patients with various diagnoses as they use technological teaching aids.
   b. Discuss most commonly occurring side effects of anti-psychotics, antidepressants and mood stabilizers, and necessary assessments.
   c. Discussion of a variety of evidenced-based interventions that may be actually used with patients who are acutely psychotic, depressed, or in a manic phase of bipolar disorder.
   d. Identify and encourage sharing of strategies nurses use to assist patients in problem-solving. Discuss evidenced-based strategies that support patients to problem solve commonly seen problems, such as aftercare, relationships with others, and stabilization of illness.
   e. Identify and encourage sharing of strategies nurses use to support patients’ choices and involvement in care. Discuss strategies that would promote patient participation in health and self-care.
   f. Identify successes and gaps in collaboration of nurses with other team members that negatively affect patient care. Discuss ways to improve the gaps in collaboration among staff that will ultimately improve patient care.

3. Teaching strategies
   a. The researcher utilized a PowerPoint presentation (Appendix M) to continue the discussion from class three concerning interventions to be utilized for case studies featuring George, a person with schizophrenia, Mr. Gerry a patient diagnosed with bipolar disorder, manic phase, and
setting appropriate boundaries with Ray, a disruptive patient in a community meeting. This one-hour class ended with a discussion about collaboration with peers in sharing the workload and how to speak to the necessity of asking for help from others.

e. Class Five (Domain 6: Ensuring Quality Mental Health Care Services)

i. Learning Objectives

1. Nurses will

   a. Identify one means of how to expand psychiatric nursing knowledge and skills.

   b. Identify one way to learn about evidence-based interventions

   c. Identify one growth area where more knowledge and skill improvement is needed.

   d. Identify present successes and gaps in collaboration of nurses with other team members that negatively affect patient care. Discuss ways to improve the gaps in collaboration among staff that will ultimately improve patient care.

2. Description of Topics

   a. Discussion about current standards and practices based on evidence.

3. Teaching strategies

   a. This researcher utilized a PowerPoint presentation (Appendix N) to generate discussion about what participants do to expand their knowledge of psychiatric mental care and practice: reading journals, spending time in library medical databases. Evidence-based practice was defined and how to research the literature was reviewed. Examples of the current evidence-
based best practices regarding suicide, seclusion, and restraint were examined. A challenge was issued for participants to determine and to use best practice standards of practice. This ninety-minute class concluded with a lively discussion concerning a present challenge one of the participants has with another team member. Other participants corroborated her story of being rudely treated and the staff’s refusal to talk with her about patient issues. This rude treatment has caused stress for the nurses. We discussed boundaries, documenting by email attempts to resolve the problem, and following the chain of command until there is a resolution. Participants were supportive of these suggestions and are willing to assist the participant by encouraging her to set boundaries.

Upon completion of the training, nurses were emailed a link to take the post-test and reminded to add the number assigned from the pre-test MHLNA when completing the post-test MHLNA online. At the end of the post-test, the participants were asked to respond in writing to the following questions:

a. What has been most helpful about this training?

b. What has been least helpful about this training?

c. Please describe specific knowledge and skills that you have grown in or improved in as a result of this training.

Participants who attended all five classes, completed the post-test, and answered the three short answer questions received a $25.00 gift card.

The quantitative and qualitative data were collected and analyzed. The quantitative data were analyzed using the paired t-test, and the qualitative data from the participants analyzed to
determine major themes. Data from the domain totals and individual items in pre- and post-test were compared for statistical significance using the paired t-test. The Statistical Package for the Social Sciences 24.0 (SPSS) for Windows (SPSS-Inc. 2006) was used to analyze the data from the pre- and post-tests. Conventional content analysis, a widely used qualitative research technique was used to interpret meaning from the qualitative data (Hsieh & Shannon, 2005). This type of content analysis is used when the researcher avoids using preconceived categories but allows the categories and names of categories to flow from the data (Kondracki & Wellman, 2002).

Phase II of the study took place three months after the conclusion of the staff development program. The unit Nurse Manager, the Clinical Resource Nurse, and the participants of the study were individually interviewed, and each session recorded and transcribed. The leaders were asked if there had been any changes from their pre-training observations and post-training observations of the nursing staff, based on domains 1, 3, and 6 of the MHLNA.

The study participants were interviewed by telephone and asked the following questions: In looking back on the training, has it made a difference in the way you care for patients? What was the most valuable part of the training for you? If further training were available for you, what topics would help you the most? Conventional content analysis was used to evaluate the qualitative data (Hsieh & Shannon, 2005).

**Project Purpose/Objectives**

The purpose of the project was to determine the impact of a competency-based staff development-training program on the psychiatric mental health knowledge of psychiatric mental health nurses on a community hospital-based inpatient psychiatric unit in a Midwest community
hospital. In addition, the researcher sought to determine if the staff development-training program would impact the relational skills of the psychiatric mental health nurses in interacting with the patients.
V. Analysis and Results

Quantitative Data

Table 1 shows the paired samples of pre- and post-test results from domains 1, 3, and 6. Domain 1 results show a decline in the mean score, while domain 3 shows a slight increase in the mean score. Domain 6 showed no difference in the mean score. Several influences may account for the drop in Domain 1. The MHNLA allows for self-evaluation of knowledge/skills. The participants may have rated themselves higher in the pre-test in knowledge and skills than they had. Therefore, the staff development program could have served as a reality check to the lack of psychiatric knowledge and skills participants possess and the fact there were more knowledge and skills to learn, hence the drop in mean score.

Domain 3 shows a slight increase in the mean score. The small increase as seen in domain 3 may be attributed to the possibility that participants may have learned new knowledge and skills as a result of attending the staff development program. Domain 6 showed no difference in the mean score. The unchanged mean score may reflect the possibility that perceived and actual knowledge and skill level of participants may have been congruent. Another likely explanation is that each training session lasted only for one hour. In all likelihood, five hours were insufficient to teach the 25 content areas in Domains 1, 3 and 6 well enough to effect significant change.

Based on these statistical findings, the null hypothesis which states there is no improvement in the psychiatric mental health knowledge and skills competencies of nursing staff on a hospital-based psychiatric unit after completing a competency-based staff development training program is accepted at $p = 0.05$. 
Typically, in a community-based in-patient hospital, there may only be one psychiatric unit, which would require enough full and part-time nursing staff to cover all shifts. With a small pool from which to recruit, one would expect the numbers in the study to be low. Given that there was such a low power in this study because of the sample size, there is a possibility of committing a Type II error. There is not enough evidence to conclude that the research hypothesis is true.

Table 1

*Paired Samples Statistics*

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Mean</th>
<th>N=6</th>
<th>Std Deviation</th>
<th>Std Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing Professional Holistic Mental Health Nursing Care</td>
<td>2.4259</td>
<td>0.55961</td>
<td>0.22846</td>
<td></td>
</tr>
<tr>
<td>• Pre-test</td>
<td>2.3889</td>
<td>0.54772</td>
<td>0.22361</td>
<td></td>
</tr>
<tr>
<td>• Post-test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain 3</td>
<td>Administering and Monitoring Therapeutic Interventions</td>
<td>2.3542</td>
<td>0.43601</td>
<td>0.17800</td>
</tr>
<tr>
<td>• Pre-test</td>
<td>2.4583</td>
<td>0.47871</td>
<td>0.19543</td>
<td></td>
</tr>
<tr>
<td>• Post-test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain 6</td>
<td>Ensuring Quality Mental Health Care Services</td>
<td>2.400</td>
<td>0.47329</td>
<td>0.19322</td>
</tr>
<tr>
<td>• Pre-test</td>
<td>2.400</td>
<td>0.53666</td>
<td>0.21909</td>
<td></td>
</tr>
<tr>
<td>• Post-test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 denotes a strong correlation of the two paired samples with p=0.05. This strong correlation indicates that there are relatively small changes in pre and posttest scores. Only
Domain 6 showed a strong correlation with significance, which would indicate there is no change in pre and post test scores.

Table 2

*Paired Samples Correlations*

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Correlation</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre Domain 1 &amp; Post Domain 1</td>
<td>6</td>
<td>0.785</td>
<td>0.064</td>
</tr>
<tr>
<td>Pre Domain 3 &amp; Post Domain 3</td>
<td>6</td>
<td>0.684</td>
<td>0.134</td>
</tr>
<tr>
<td>Pre Domain 6 &amp; Post Domain 6</td>
<td>6</td>
<td>0.850</td>
<td>0.032</td>
</tr>
</tbody>
</table>

Table 3 results show no significant improvement in the psychiatric mental health knowledge and skills after completing a competency-based training program: domain 1 (t(5)=2.50, p <001) domain 3, t(5) =0.00.0697, p <.001) and domain 6 (t(5) =0.000, p <.001)

Table 3

*Paired Samples Test*

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std Error Mean</th>
<th>95% Confidence Interval of the Difference</th>
<th>T</th>
<th>Df</th>
<th>Sig. (2 tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre Domain 1-Post Domain 1</td>
<td>0.03704</td>
<td>0.36289</td>
<td>0.14815</td>
<td>-</td>
<td>0.34379</td>
<td>0.41786</td>
<td>0.250</td>
</tr>
<tr>
<td>Pre Domain 3-Post Domain 3</td>
<td>0.10417</td>
<td>0.36586</td>
<td>0.14936</td>
<td>-</td>
<td>0.48811</td>
<td>0.27978</td>
<td>0.697</td>
</tr>
<tr>
<td>Pre Domain 6-Post Domain 6</td>
<td>0.00000</td>
<td>0.28284</td>
<td>0.11547</td>
<td>-</td>
<td>0.29683</td>
<td>0.29683</td>
<td>0.0000</td>
</tr>
</tbody>
</table>
Table 4 shows the results of individual participants’ pre- and post-tests for domains 1, 3, and 6. With the small sample size and the high risk of a Type II error, looking at the results from each participant is instructive. Participant #1 showed a decline in each of the post-test domain scores. While participants #2, 3, and 6 showed a drop in the post-test score in domain 1. Participants #1, 2, and 6 showed a decrease in post-test scores in domain 3. Participants #1 and 6 showed a decline in post-test score in domain 6. Of interest is participant 5, who showed a significant increase in post-test score on each of the domains. Participant #5 was one of the two nurses who chose to work in the psychiatric mental health nurse from the beginning of her career and has been in the field for 26 years.

Table 4

Case Summaries

<table>
<thead>
<tr>
<th>Participant #</th>
<th>Domain 1</th>
<th>Domain 1</th>
<th>Domain 3</th>
<th>Domain 3</th>
<th>Domain 6</th>
<th>Domain 6</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
<td>Pre-test</td>
<td>Post-test</td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td>1</td>
<td>2.00</td>
<td>1.78</td>
<td>2.00</td>
<td>1.88</td>
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</tr>
<tr>
<td>2</td>
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<td>2.75</td>
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<td>3.00</td>
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<tr>
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<td>2.76</td>
<td>2.44</td>
<td>2.38</td>
<td>2.50</td>
<td>2.20</td>
<td>2.40</td>
</tr>
<tr>
<td>4</td>
<td>3.00</td>
<td>3.00</td>
<td>2.75</td>
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<tr>
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<td>2.67</td>
<td>2.00</td>
<td>2.75</td>
<td>2.00</td>
<td>2.40</td>
</tr>
<tr>
<td>6</td>
<td>1.78</td>
<td>1.67</td>
<td>2.00</td>
<td>1.88</td>
<td>2.00</td>
<td>1.40</td>
</tr>
</tbody>
</table>
Qualitative Data

Conventional content analysis was done with qualitative data from the written answers from the three questions in phase one and the three verbal responses recorded from three questions in phase two of the study. Two raters read and listened to the data, with 75% inter-rater reliability in phase one and 100% inter-rater reliability in phase two.

The three questions participants were asked to write answers at the conclusion of the post-test include: “What did you like most about the training?” “What did you like least about the training?” “Please describe knowledge and skills that you have grown in or improved in as a result of this training.”

What Did You Like Most about the Training?

The content analysis revealed three themes from the written comments by participants in this question: Dialogue with coworkers, therapeutic interventions, and therapeutic communication.

• Dialogue with Coworkers. This theme is first identified in the three question answers of the post-test and is repeated in the comments made in the interview done three months later.

“The open discussion and the presentation was [sic] good and interesting.”

“The opportunity to revisit the "ideal" we all strive for, and the chance to hear different perspectives from my co-workers.”

• Therapeutic Interventions

“The discussion of specific psychiatric nursing strategies.”

“How to descalete [sic] a patient.”
• Therapeutic Communication

“Having more interaction [sic] with the patient to build a working relationship [sic] with them.”

**What Did You Like Least about the Training?**

There was only one theme noted in comments concerning this question. The following comment is representative of the others made:

“All topics treated were useful, therefore I will say I like [sic] everything.”

**Please Describe Knowledge and Skills That You Have Grown in or Improved in as a Result of This Training**

Based on the content analysis, two of the three themes were seen in the participants’ responses to this question: therapeutic communication and therapeutic interventions.

• Therapeutic Communication

With the de-emphasis of psychiatric nursing in nursing curricula, graduates often feel they lack the knowledge and skill to work in psychiatric nursing (Poster, 2004). Listed below are comments made by participants, which reflect their growing awareness of the need to establish therapeutic communication.

“I believe that therapeutic communication knowledge and training [sic] is lacking as a new RN.”

“I feel like I know a bit more about what I don't know. I would like to study more so I can be better equipped [sic] to communicate therapeutically with clients.”

“Listening with one's heart is critical and most important.”

“I would like to study more so I can be better equipped to communicate therapeutically with clients.”
“The importance of that initial establishing of rapport with the admitted pt [sic] without the computer and its issues taking over!”

• Therapeutic Interventions

“[The researcher] was able to teach so many ways to de-escalate patients [sic], ways in which different fields could work together, about over- medicating, use of restraints... the list could go on.”

“I especially enjoyed the medication review.”

“I have gained more knowledge in handling psychiatry [sic] patients.”

“The importance of that initial establishing of rapport with the admitted pt [sic] without the computer and its issues taking over!”

The researcher gave participants the opportunity to freely speak about the topics shared during the classes. Verbatim quotes were recorded for their usefulness and are instructive, demonstrating the interaction between the participants and the content. For example, class one covered providing professional holistic mental health nursing care. The primary goal of this domain is the Promotion of Mental Health and the Prevention or Diminution of Mental Disorder. These topics triggered a conversation with comments from participants such as, “I don’t want to turn this into a gripe session, but we are too busy to develop relationships with patients. We have all this paperwork to complete!” “We have to document, document, document, because we don’t want to be liable.” “It’s all about the money now.” One nurse reported: “They want us to give PRNs so they (next shift) can have a good day. I refuse to do so. If the client needs more meds, then the doctor should order it on a regular basis.” “I came into psych to make a difference in the lives of the patients. I feel discouraged because others don’t share that same passion.”
Domain 1 continued to be the focus of class two. This class included a discussion of culture and how to address a variety of emotional states of patients. Therapeutic assessment is the heart of mental health nursing practice (McKnight, 2013) and therapeutic assessment consists of more abstract concepts such as mood, affect, and thought content (Tanner, 2014). Understanding abstract concepts in patient assessment are markedly different than numerical assessment used in medical-surgical and critical care settings (Tanner, 2014). Discussion of the importance of identifying and acknowledging the emotional state of patients on the unit began with examples of interactions with patients this researcher had on the unit. Comments from participants included, “Most of the time we don’t see them as normal human beings, thinking like we are thinking, only their brains are diseased.” “We don’t listen to them to know how they are feeling.” We might be thinking we are listeners, but we may not be. “We want to shut down people when they have negative feelings.”

Class three was based on domain 3 Administering and Monitoring Therapeutic Interventions. Items from this domain, which generated the greatest comments, include technology on the behavioral health unit, medication side effects, and problem-solving with patients. There was ambivalence noted about the use of medical e-learning programs (med e-learning) shown on tablets. “My feelings about the tablets are they are good alternatives to class. The ‘zone out’ factor [of the patient] is more challenging. They can’t zone out as in a class.” “We don’t have many choices with med e-learning, not nearly as many as they do, say in med-surg. We don’t even have one on anxiety.” “If they have many hospitalizations, they have already seen the ones (the programs) we have.” “The med e-learning becomes a means to check off the box, saying we have talked about depression with the patient, rather than actually talking to a patient.” “Is the tablet any better? I don’t know.” “Did you learn anything you
hadn’t learned before, is the extent of my evaluation.” “The Electronic Medical Records (EMR) is a better use of technology than the medical e-learning program.” “The patients on the medical side benefit more from the e-learning programs than patients on the psych unit.” In response to the question, “How can technology be incorporated more effectively in psych?” one nurse suggested, “If we could make information like a game, it would be fun for the patients.”

Another question posed by the researcher was, “Is there any other technology that can be used in this psychiatric unit?” One nurse said, “I think the only thing that is most helpful to the psych patients is the one-on-one interaction, counseling environment. Nothing that is electronic is as effective because that is so removed from humans interacting with a human.”

In the discussion about dangerous side effects of the second-generation antipsychotic medications, participants were familiar with the more common side effects, such as dry mouth, drooling, tremors, and stiffness. However, the more severe metabolic syndrome associated with taking second-generation antipsychotics, the participants had little to no awareness. Liorente and Urrutia (2006) explored the complex relationship between psychiatric disorders, antipsychotic medications, and risk factors for metabolic syndrome and diabetes mellitus. Findings indicate that the prevalence of diabetes mellitus and its risk factors are two to four times higher in people with schizophrenia than in the general populations. Usher, Foster, and Park (2006) stress the importance of the psychiatric mental health nurse’s role in prevention and ongoing management of metabolic syndrome. However, the psychiatric mental health nurse must first become aware of the syndrome to assist in early symptom detection and of the need for ongoing monitoring and treatment needs.

Another item covered in this class was problem-solving techniques used to work with patients. Participants were not as clear about seeing the benefit of problem-solving with patients.
One participant shared how she told a patient who was acting out on the unit, “You’re going to get hit upside the head with a brick when you treat people mean out in the street.” Another participant stated, “When I feel like I’m not getting through to a patient, I will trade off with another nurse.” However, for the most part, the focus of the participants shifted to the problems of how the staff works together. “We have no cohesiveness as far as the three shifts go.” “The pendulum is always swinging when staff is working with patients. No consistency, no continuity.”

Safety is a priority on psychiatric units, and adverse events on a psychiatric unit are related to patient violence (Staggs & Dunton, 2012). The concluding discussion of the class involved the difference in the response of the unit leadership when a physician and nurses are victims of patient violence. Recently, a patient was taken to jail when he assaulted a doctor, in contrast to another patient who did not suffer the same consequences after assaulting a nurse. After given some time off, the nurse had to return to the unit and interact with the perpetrator, although from a distance. Participants want to feel respected, valued, and safe at work, but often do not.

Class four continued domain 3 items, with case studies of patients with a variety of diagnoses presented and intervention strategies discussed. In addition to addressing interventions, participants had much to say about treatment plans that must be written within twenty-four hours of admission. “Treatment plans are not very helpful or useful.” “Only the nurses can see them.” “Nurses are put on the spot to follow through on treatment plans made up by other team members.” “We only chart to the treatment plans once a week.” Another example participants gave involved getting the physician to write an order for a nursing action. Participants agreed it is easier to have a physician’s order to ensure that there would be follow-
through of the nursing action than to get nurses to follow up independently from shift to shift. Participants were challenged to consider the action of asking the doctor to write orders for nursing decisions, to get others to comply is giving their power away.

Class five concluded with items from domain 6: Ensuring Quality Mental Health Care Services Monitoring Therapeutic Interventions. Evidenced-based practice was defined, and two specific examples of the current research that affect practice were given: suicide and seclusion and restraint practices.

A domain item that generated much discussion is the roles of team members. Participants sensed other team members, particularly the aides, did not understand their job responsibilities. “We need to have staff meetings where roles are explained and clarified. Sometimes the other staff don’t (sic) know what all that the nurses have to do. Some aides think the nurses sit on their rears and play with the computer rather than talk to the patients.” “Yesterday I had time, and I did sit and talk with a patient.” “The aides are on the front lines with the patients all the time and never get a break. The aides will take the brunt of the patients acting out.” There’s always an agenda at staff meetings, never time for team building. The schedule would be more structured. That’s not good for the patients. Some patients love it, but is it therapeutic?” “I would love to be out on the floor, but I can’t chart and talk to the patients at the same time. It’s too dangerous to take the computer out with me on the unit to sit and talk while I chart. I really wouldn’t be there anyway.” “My feelings about patients who are escalating is they just need to be heard.” “So, if someone has time, we often hear, 'Someone is escalating, quick get the drugs.' Shouldn’t we just listen first? What does that teach the patients? ‘When I’m upset get my drugs,’ instead of teaching them, ‘I need to figure out a way to be heard
and take care of myself or take 100 breaths or time out for myself.’ I can appreciate the need to keep the unit calm, but to turn to drugs right away, is upsetting to me.”

One competency in domain 6 referred to the participants’ personal continuing education. Only one participant belonged to the professional organization, The American Psychiatric Nurses Association (APNA), and she was the only participant who occasionally read professional literature. Skills to Improve On was another domain competency that a participant offered a comment: “Drugs! I wish I could learn about side effects. But I hate learning about them. They are important to know though!”

**Phase Two Results**

**Unit Management**

Because of the expected small sample size, the unit Nurse Manager and the Clinical Resource Nurse were interviewed to discuss their observations of any change noted in nursing staff since the completion of the training. On December 5, 2016, about 95 days after the training was completed, the two interviews took place in the office of the Nurse Manager, lasting about one half-hour for each. Both the Nurse Manager and the Clinical Resource Nurse were asked the following question to begin our interview: “Before the training, what do you recall seeing from the nursing staff?” The leaders were next asked to evaluate the nurses based on the competencies of the domains 1, 3 and 6 of the MHLNA.

**Before the Training, What Do You Recall Seeing from the Nursing Staff?**

The Nurse Manager reported:

“Lack of engagement. The computers were in the way for therapeutic communication.”

The Clinical Resource Nurse had a more glowing report of the improvement of the nursing staff since the training. In each of the domains, most of the items where she noted “no
improvement” the Clinical Resource Nurse clarified the nurses were already doing well. “I give the nurses a lot of credit always for working in a psychiatric unit. We all are learning and strive for improvement every day. Things are always changing, subjected to new rules. I would like to have seen more interaction on the unit with the patients. Being more present on the unit. Bottom line.”

**Domain 1 Providing Professional Holistic Mental Health Nursing Care**

Nurse Manager. As we explored Domain 1, the Nurse Manager thought there was some improvement in seven of the nine items listed. The seven areas of improvement include items such as assessing, collecting and analysis of client data; recognition of the influence of culture on the therapeutic process and delivers culturally sensitive care; understands and responds to human emotional states of distress, such as anger, tension, anxiety, fear, grief, helplessness, and hopelessness; guides the client through behavioral, developmental, emotion, or spiritual change, while acknowledging and supporting, participation responsibility, and problem solve choices; supports the client’s sense of resiliency, empowering the client enhancing self-esteem, and promoting hope; gathers and records comprehensive physical/mental health assessment data for purposes of planning, implementing, and evaluating client for therapeutically beneficial outcomes; and reflectively critiques therapeutic effectiveness of nurse-client relationships by evaluating client/nurse responses to the therapeutic process and evaluating effectiveness. No improvement was noted in two items, which she attributed to the unit admitting more challenging and violent patients.

The Clinical Resource Nurse thought the nursing staff had more interactions with the patients and more presence on the unit since the training. There was also a noticeable improvement in the patient team meetings. “The nurses are speaking up and actually making
recommendations to the doctor. The nurses feel more comfortable and more invested in the patients.” It is interesting to note the improved interaction with the physician may be related to the replacement of the previous psychiatrist, with a new, caring psychiatrist on the unit, whose attitude was one of respect for patients and nursing staff. “They also appear to have more emphasis on their care plans around therapeutic goals.” She noted some improvement in three of the nine items in domain 1. These items included: assesses collects and analyzes client data to provide optimal therapeutic care, and supports the client’s sense of resiliency, empowering the client, enhancing self-esteem and promoting hope.

**Domain 3: Administering and Monitoring Therapeutic Interventions**

* Nurse Manager. Of the eight items in domain 3, there was some improvement in six and no improvement in two. The six items where improvement was noted included: assessment and monitoring clients at risk for self-care deficits and mobilizing resources in response to client needs; utilizes appropriate technology to initiate safe, effective, and therapeutic nursing interventions that promote wellness and recovery provides support and safety for clients in a therapeutic manner; incorporates elements of knowledge of family dynamics, cultural values, and beliefs in the provision of therapeutic care; and collaborates with the client, health care providers, interdisciplinary staff, and the community to access and coordinate resources in therapeutic care.

* The Clinical Resource Nurse. Of the eight items in domain 3, five showed some improvement according to the Clinical Resource Nurse. It is significant to note, in light of the higher acuity level on the unit, the three items which showed no improvement included: assesses and monitors clients at risk for self-care deficits, and mobilizes resources in response to client needs, as well as item seven, incorporates elements of knowledge of family dynamics, cultural
values, and beliefs in the provision of therapeutic care. The Clinical Resource Nurse commented she would like to see nurses run more patient groups on the unit on first and second shifts in the item related to group therapy process and interventions.

**Domain 6: Ensuring Quality Mental Health Care Services Monitoring Therapeutic Interventions**

The **Nurse Manager**. Domain 6 had some improvement in only four of the nine items. Of those four items where there was no improvement, the Nurse Manager thought the nursing staff was already doing an excellent job of advocating for patients and functioning well as part of an interdisciplinary team. She is optimistic that the nursing staff are developing awareness of the expectation of spending more time on the unit, and don’t seem to be as resistant to spending time on the unit when asked.

The **Clinical Resource Nurse**. In four of the eight items the Clinical Resource Nurse saw improvement. These items included: identification of hazards in the workplace setting that may interfere with care or with nurse’s ability to perform with skill, safety, and compassion toward others and takes appropriate action; expands knowledge base of innovations and advances in psychiatric care and practice to ensure safe and therapeutic care, documentation of ongoing review, and evaluation of mental health care and nursing care activities; and recognition of changes in mental health nursing that effect practices and develops strategies to manage these pertinent changes.

**Participants**

The small sample size also prompted the researcher to interview the study participants three months after the training to ask the following questions: “In looking back on the training, has it made a difference in the way you care for patients?” “What was the most valuable part of
the training for you?” “If further training was available for you, what topics would help you the most?” Arrangements were made with each participant to set up a telephone interview. Each nurse was individually interviewed for approximately ten minutes on the following dates: December 20, 2016, December 22, 2016, December 27, 2016, January 3, 2017, January 6, 2017, and January 15, 2017. With permission from each participant, comments were recorded and based on the content analysis, the following themes were identified for these three questions: improvement of patient care, teamwork/dialogue with coworkers, and the passion of the researcher in presenting the course content.

“In Looking Back on the Training, Has It Made a Difference in the Way You Care for Patients?”

The content analysis of the responses to this question revealed that most of the participant comments focused on domain 1: Providing Professional Holistic Mental Health Nursing Care, with one of the three themes identified: improvement of patient care.

- Improvement of patient care

Participants report improvement in giving patient care. The participants identified being more aware of the need to attend to the patient, as evidenced by the following comments:

“I’m more sensitive to things related to the patient, such as cultural diversity”

“I think it has. The discussion about patient care reminds us to be more sensitive.”

“This training brought back what we are doing this for. I need to try to get back to the ideal of care. It stayed with me more.”

“Yes! Talking about the work renewed my pride in psychiatric nursing.”

“What was the Most Valuable Part of the Training for You?”

Content analysis revealed two of the three themes present in participant responses: improvement of patient care and teamwork/dialogue with coworkers.
• Improvement of patient care

“The insight into how to handle the patients and to treat each case, as it comes. To spend more time also in the middle; to look at the patient and to bond with them in order to build trust with them.”

“Learning ways to get around talking about diet and lifestyle without being judgmental and controlling.”

“Your passion for the work was inspiring”

“More shape and substance to what we do as psych nurses.”

“Psych nursing (versus med surg nursing) is so much more nuanced. Talking about what we do made it more concrete.”

“Your (the researcher) insight and passion”

• Teamwork/Dialogue with Coworkers

“The discussions were helpful. The camaraderie. Your examples and stories. Your questions, which gave everybody a chance to give feedback.”

“One of the things I found really valuable was to hear the thinking of my coworkers. It was great to hear their challenges. It brought me closer to my colleagues.”

“The questions we dialogued about. It was valuable talking to others. The team dialogue.”

“To spend time with patient and coping skills now.” When asked for clarification, the participant replied, “How to build your confidence as a nurse in talking to patients.”
“If Further Training was Available for You, What Topics Would Help You the Most?”

Three themes were noted in response to this question based on content analysis: improvement of patient care, teamwork/dialogue with coworkers, and the passion of the researcher in presenting the course content.

- **Improvement of patient care**
  
  “Deal more about [sic] nurse-patient relationships. Expand on it more. We can deal with uh…treat nurse-to-nurse relationship, colleague-to-colleague relationships. We can also deal with how to manage the unit as a charge nurse.”
  
  “Substance abuse. It’s a big deal to a lot of these patients. I’d like to know how we can [sic] support them more.”
  
  “More team building exercises. Maybe a day long retreat can happen, with you (the researcher) leading out.”
  
  “Learning the different ways to talk to patients with different illnesses.”
  
  “More information about side effects of the medications patients are on. More team building activities.”

- **Teamwork/Dialogue with Colleagues**

  Hearing thoughts and concerns of other co-workers seemed to be vital for participants. This theme was identified in written comments made in the three short-answer questions in the post-test, but clearly expressed three months later.

  “To hear what my coworkers were thinking and the challenges they identified. It made me feel closer to my colleagues.” There was a sense that there was no opportunity for team building and meaningful dialogue to take place.

  “Team dialogue—it was valuable to talk to others.”
Typically, there is unpredictability and chaos that can quickly develop on the unit, with acutely ill patients requiring closeness and containment. It has been suggested that emotional needs nurses give to the patients are mirrored in their need to receive it from the psychiatric nursing team (Deacon, Warne, & McAndrews, 2006). Knowing the team members “have my back” is a significant value and if there is no fostering of team building, there will be a gap. This difference was articulated by comments made:

“More team building. Perhaps we can have a one-day session that you (the researcher) can organize in a more relaxed atmosphere.”

The acute inpatient psychiatric units are often busy, unpredictable, and at times, chaotic. The health-care environment is especially important for the work that occurs in a locked acute psychiatric unit. There is need to have a good relationship including interaction and communication with each other in order to facilitate a mutual understanding of the competence among them. (Johansson, Skärsäter, & Danielson, 2013). “We need to hear some positive things that we do instead of all the negative.”

• The Passion of the Researcher in Presenting the Course Content

This theme is significant, as there is a need to communicate about psychiatric nursing positively and passion is an effective means of sharing with others the positive contribution nurses can make in the lives of the mentally ill (Harrison, Hauck, & Hoffman, 2014).

“Your (the researcher) actual insight and experience.”

“Your attitude was a big plus.”

“Your passion (researcher) for the work was inspiring.”

One participant reported, “The discussions, your examples, and stories helpful.” Carrega & Byrne (2010) identified that storytelling through scenarios and case studies are commonly
utilized as evidence-based and problem-based learning strategies in nursing education, and provide a real-life approach that is authentic and engaging. Likewise, Harrison et al. (2014) suggests positive stories do make a difference and are a means to articulate our positive professional identity to others. This researcher’s findings support that storytelling is a reliable teaching and learning instrument that can inspire interest in psychiatric nurses, as noted by the theme “passion of the researcher.” “It gave more shape and substance to what we do.”

Psychiatric nursing has a focus on interpersonal and therapeutic communication skills rather than psychomotor skills associated with most other nursing specialties (Bondy, Jenkins, Seymour, Lancaster, & Ishee, 1997).

“Psych nursing versus med-surg nursing is so much more nuanced.

“Talking about it made it more concrete.”
VI. Discussion

There is a paucity of research on the efficacy of staff development training for nurses working in psychiatric nursing, as well as in community-based in-patient hospital psychiatric units. The purpose of this project was to determine whether a nurse staff development training program, based on psychiatric mental health nursing competency, would make a difference in the skill level of nurses working in a community hospital-based in-patient psychiatric unit. The quantitative results showed no statistically significant difference in self-report of knowledge, skill or attitude improvement of the participants in the study when comparing the pre-test with the post-test. While McKnight (2013) reports there is a 95% accuracy rate in self-reporting of skills base deficits, the study’s post-test results were expected to show a greater variance from pre-test results. It was expected that given exposure to current psychiatric nursing competencies, participants’ scores would reveal a statistical difference. The findings in this study suggest other variables may have had an impact on the results. These other variables include the limited amount of time given to teach all of the competencies, immediately giving the post-test following the last class did not allow adequate reflection of learning that did take place and sufficient time for participants to internalize the information taught. It may have been more useful to collect repeated measurements of the knowledge, skills, and attitudes of the nurses after each class.

After the training, the participants’ self-report as noted in the qualitative data, indicates that there is a difference in their self-awareness of how they relate to patients, which is a positive reflection of their attitude change. With the de-emphasis of didactic and clinical components in nursing programs, entry-level nurses often lack psychiatric nursing knowledge and skills (Poster, 2004). McConlogue (2014) also found that new graduates are often encouraged to get
experience on a medical-surgical unit before working in psychiatric nursing. Nurses with insufficient preparation, who were only exposed to undergraduate education in psychiatric nursing, now are responsible for management of patients with mental illness, a responsibility they may be ill-equipped to handle (Waite, 2003). It is important to provide an intensive orientation for nurses who begin working on a psychiatric unit. This intensive orientation must be grounded in psychiatric mental health nursing knowledge and skills with an emphasis on the centrality of the therapeutic relationship. Cleary et al. (2011) determined that professional education has the potential to promote job satisfaction and positively impact patient care.

Self-reflective comments of what is presently happening as participants interact with patients include:

“We don’t listen to them (patients) to know how they are feeling.”

“Most of the time we don’t see them as normal human beings, thinking like we are thinking, only their brains are diseased.”

“We want to shut down people when they have negative feelings.”

Comments participants made about their interactions with the patients show a change in attitude toward care during and after the training:

“Yesterday I had time, and I did sit and talk with a patient.”

“My feelings about patients who are escalating is they just need to be heard.”

I can appreciate the need to keep the unit calm, but to turn to drugs right away, is upsetting to me”.

“Discussion about patient care reminds us to be sensitive.”

Talking about it (psychiatric nursing knowledge, skills, and attitudes) made it more concrete.”
“I feel like I know a bit more about what I don’t know. I would like to study more so I can be better equipped to communicate therapeutically with clients.”

“I have gained more knowledge in handling psychiatry (sic) patients. Listening with one’s heart is critical and important.

Comments about the motivation and skill level of the nurses made by the unit leadership before the project began also highlighted the need for staff development in psychiatric mental health nursing. The motivation and skill level of individuals who work in psychiatric nursing have not been evaluated and updated (Harrison et al., 2014) and need to be vital part of staff development.

Throughout the training, participants made comments that reflect a positive shift in their attitude toward the patient. This positive change in attitude toward individuals with mental illnesses will affect the nurses’ interactions with patients and ultimately the quality of integrated nursing care provided (Chiu-Yueh, Huei-Lan, & Yun-Fang, 2015).

The Nurse Manager and the Clinical Resource Nurse were asked to review their assessment of the psychiatric nursing knowledge and skills of the nurses before the study and ninety days after. On several items in each of the domains of the MHLNA, they both reported no change, meaning the nurses were doing well on that item. The possibility of greater variability in analyzing the results would have been made possible if the three-point scale was expanded to a five-point Likert-type scale, which might have given a greater variability in interpreting the results.

As previously noted, the hospital desired to improve patient care on the unit, hence the subcontracting of services to a qualified vendor. Under the new leadership, the unit leadership did not have a philosophy of nursing that would shape the delivery of nursing care on the unit
thus improve patient outcomes. The qualitative results indicate the nursing staff would benefit from a clearly articulated philosophy of nursing care that would guide nursing care.

**Meeting the DNP Essentials**

Executing this project enabled the researcher to integrate the Essentials of Doctoral Education for Advanced Nursing Practice (AACN, 2006). Listed below are the DNP Essentials and the outcomes:

**Essential I – Scientific Underpinnings for Practice**

- Utilized scientific evidence and the Mental Health Learning Needs Assessment to develop, implement and evaluate a competency-based staff development training course for acute care psychiatric mental health nurses working on a community based hospital in-patient unit.

**Essential II – Organizational and System Leadership for Quality Improvement and Systems Thinking**

- Based on observations over several years of nursing staff on the acute care psychiatric unit, unit management were approached to discuss how to improve quality nursing care to patient outcomes. Developed a staff development training module taking into account the principles of the adult learner, to educate staff about current psychiatric mental health competencies.

**Essential III – Clinical Scholarship and Analytical Methods for Evidence-Based Practice**

- Reviewed peer-reviewed literature and databases, along with educational principles to design and implement an evidence-based staff training course, based on the latest psychiatric mental health competencies for nursing staff.
Essential IV–Information Systems/Technology and Patient Technology for The Improvement And Transformational Health Care

- Evaluated current electronic tools for patients on a psychiatric mental health acute care unit. Assessed evidence-based information about the use of technology on a psychiatric unit. Provided training on the appropriate use of technology on the acute care psychiatric unit. Discussed ways for the participants to use technology to enhance effective, efficient quality patient care.

Essential V–Health Care Policy for Advocacy in Health Care

- Presented the inequities of care for the mentally ill and how nurses can make a difference by getting involved in professional organizations. Stressed the importance of the development of protocols for security “call-outs,” where security is called to the unit to deescalate a patient, with the goal of nurses taking charge of potential out-of-control situations.

Essential VI–Interprofessional Collaboration for Improving Patient and Population Health Outcomes

- Collaborated with the unit administration to develop staff development training course. Employed leadership and consultative skills with intraprofessional and interprofessional team to empower nurses to nursing excellence.

Essential VII–Clinical Prevention and Population Health for Improving the Nation’s Health

- Developed staff training course to educate and empower participants to become culturally aware of how mental illness will affect different cultures. Importance of health promotion for the mentally ill added to staff training program emphasized.
Essential VIII–Advanced Nursing Practice

- Provided guidance, mentoring, and support to participants to inspire the nursing staff to achieve quality patient care. Developed strategies within the staff training module that would empower the staff to promote effective problem-solving and appropriate emotional expressions by patients. Patients appropriately expressing feelings will serve to support increased control over their care. Inspired the nursing staff to the commitment to lifelong learning, which is necessary to achieve quality patient care and to enhance job satisfaction.

In summary, the researcher has achieved the DNP Essentials outcomes in the research, development, implementation, and analysis of the findings of this scholarly project.

Limitations

This study has several limitations. First, the very small sample size (n=6) opens this study to questions of reliability. Recruiting a larger sample size may prove to be problematic due to the staffing needs of community hospital-based inpatient unit. The number and size of the unit may preclude a large population in which to draw a large sample size to study. Instead of a quantitative study with significance, a qualitative study may provide rich data from which clinical application can be made.

Due to the limitation of the one-hour class time, there were many topics only superficially covered. Finally, the relatively short length of the program (five weeks) limits the time that nurses have to translate the information into practice on the unit, thus negatively affecting statistical significance of the quantitative results. The study results cannot be generalized beyond the specific setting in which the study took place. Statistical results from the
data indicated no change in knowledge and skills. However, anecdotal comments from the
participants suggest there has been a transition of knowledge and skills into practice.

Another limitation of the study was the lack of evaluation of learning immediately
following each training session as the participants interacted with the content. Knight suggested
that sessions must be evaluated for evidence of specific clinical learning (as cited in Cleary et al.,
professional development is to enhance the outcome of patient care by improving practice,
through activities like reflection, evaluation, and consideration of the evidence base’ so that
patients receive care that is effective and consistent” (p. 174).

Finally, the relationship the researcher has with the nursing staff may be viewed as a
limitation. Based on the strength of the relationship the staff may have felt obligated to
participate in the study.

Recommendations

In reflecting on the study, several problems areas were identified that would be
instructive for the future. The Nurse Manager recognized there was a need for training and
initially wanted all of the domains covered during the five-hour training. Instead, only three of
the MHLNA domains were covered, with each domain covering a minimum of eight
competencies. Five hours was insufficient time to adequately cover the 24 competencies of
domains 1, 3, and 6. This research would indicate that either more time is needed for the course
or that a fewer number of identified competencies should be covered in the training. This would
provide greater benefit to the participants and perhaps yield more statistically significant results.

Based on the study findings and literature review, continuing research on the importance
of staff development training for psychiatric nurses is essential. Assessment of the benefit of
staff training efforts done over a longer period of time would be useful to determine the efficacy of the training. Expanding the MHLNA from a three point to a five point Likert-type scale would give a greater variability in analyzing results and perhaps register a statistically significant change in data results.

Should the study be repeated again, it would be more effective if, based on the MHLNA self-report, only competencies with the lowest scores were included in the course instead of all of the competencies within the domain or more classes were added to the course so the topics might be given more in-depth coverage in classes. Future studies should include both quantitative and qualitative measures. The unit would greatly benefit from developing and implementing a mission statement and philosophy of nursing that would clearly guide the role and function of the nurse and the impact on improving quality patient care.

Nurses should be expected to continue their professional development by attending continuing education programs with a focus on the psychiatric nursing specialty. Intentional efforts at team building are important and should be encouraged to foster team cohesiveness and effectiveness.
VII. Implication For The DNP Advanced Practice Role

With their knowledge, skills, experience, and mental health expertise, DNP advanced practice nurses (APRN) are in a unique position to evaluate the effectiveness of patient health care and policies supporting policies promoting quality improvement. Based on their education of translating research into practice and the use of evidence in which to inform practice, the DNP APRN is uniquely qualified to establish ongoing evidenced-based educational programs (ANA, 2014). The DNP is equipped to take into account the needs of the adult learner, styles of the student, readiness to learn, as well as resistance to learning, in designing an evidenced-based staff development program to empower nurses to provide quality nursing care.

Although needed, mere educational opportunities alone are not sufficient to change psychiatric nursing practices on acute psychiatric inpatient units (Bee et al., 2005). As a role model and mentor, the psychiatric mental health DNP may have a positive impact on the nursing staff to improve patient outcomes. Applying quality improvement measures may have not only a positive influence on the local institution but also nationally. The psychiatric mental health DNP may help to set much needed national policy around nurses showing proficiency in psychiatric standards as other specialties. Critical care nurses are required to maintain various certifications. It should be necessary for psychiatric mental health nurses to demonstrate competency in psychiatric medications and potential adverse side effects, as well as the nurse-patient relationship, which is the hallmark of psychiatric nursing.

With their knowledge, skills, experience, and mental health expertise, psychiatric mental health advanced practice nurses are in a unique position to establish ongoing evidenced-based educational programs (ANA, 2014).
Further research is needed with a larger sample size, a control group, and with repeated measures, to determine the impact of competency-based staff development training on improving psychiatric nursing knowledge and skills on a community-based in-patient psychiatric unit.
First, I would like to acknowledge the Lord Jesus Christ, who has given me opportunity to achieve my life-long aspiration of completing this terminal degree. I am extremely grateful for how he guided me through this process and helped me to grow in the process. I would like to acknowledge Dr. Henrietta Hanna, my committee chair, for her competence and her kind, calm demeanor. She listened to me fret and obsess about my work for hours. She was instrumental in guiding me and helping me to gain clarity of thought and direction. Dr. Hanna often talked me off the ledge and for this I am appreciative. Without her guidance, I do not know how I would have completed this program, especially bringing this project to completion. I would like to acknowledge Dr. Karen Allen and her inspirational leadership in walking with me through this program from the application stage to completion. I want to thank my support community, Andrea, Audrey, and Joanne, who held me up in prayer and listened to me for hours.
References


Appendix A

Mental Health Learning Needs Assessment

Domains 1, 3 and 6
Sylvia E. McKnight, DNP, MSN, BA, RAN
Adapted with author’s permission by Beverly Sedlacek

<table>
<thead>
<tr>
<th>Levels of Competency</th>
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<tbody>
<tr>
<td><strong>Level 1 – Low</strong></td>
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<tr>
<td>Has little to no knowledge of subject</td>
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<tr>
<td><strong>Goal/Expected Outcome</strong></td>
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<tr>
<td>Increase Knowledge</td>
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<tr>
<td><strong>Level 2 – Intermediate</strong></td>
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<tr>
<td>Has a general knowledge of subject</td>
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<tr>
<td><strong>Goal/Expected Outcome</strong></td>
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<tr>
<td>Increase Knowledge &amp; Application</td>
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<tr>
<td><strong>Level 3 – High</strong></td>
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<tr>
<td>Has a thorough knowledge of subject</td>
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<tr>
<td><strong>Goal/Expected Outcome</strong></td>
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<tr>
<td>Increase Synthesis of Recent Advances and Future Directions</td>
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(Darken square for appropriate level of competency)

**Domain 1: Providing Professional Holistic Mental Health Nursing Care**

**Rationale:** The primary goal of psychiatric and mental health nursing is the promotion of mental health and the prevention or diminution of mental disorder.

**Knowledge/Skills Necessary to Fulfill Competency:**

1. Assesses, collects, and analyzes client data to provide optimal therapeutic care
2. Establishes and maintains a caring goal directed therapeutic milieu
3. Utilizes a wide range of therapeutic communication skills for comprehensive therapeutic care
4. Recognizes the influence of culture on the therapeutic process and delivers culturally sensitive care and family involved supportive care
5. Understands and responds to human emotional states of distress, such as anger, tension, anxiety, fear, grief, helplessness, and hopelessness
6. Guides the client through behavioral, developmental, emotional, or spiritual change while acknowledging and supporting, participation, responsibility, and problem solve choices
7. Supports the client’s sense of resiliency, empowering the client, enhancing self-esteem, and promoting hope
8. Gathers and records comprehensive physical/mental health assessment data for purposes of planning implementing, and evaluating client for therapeutically beneficial outcomes
9. Reflectively critiques therapeutic effectiveness of nurse-client relationships by evaluating client/nurse responses to the therapeutic process and evaluating effectiveness; seeks continuing therapeutic skills development

**Totals For Each Level:**

___   ___   ___
### Levels of Competency

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<tr>
<th>Level 1 – Low</th>
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<td>Increase Knowledge Future Directions</td>
<td>Increase Knowledge &amp; Application</td>
<td>Increase Synthesis of Recent Advances and</td>
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(Darken square for appropriate level of competency)

## Domain 3: Administering and Monitoring Therapeutic Interventions

**Rationale:** The nature of mental health issues and psychiatric disorders is unique and is a challenge confronting psychiatric nursing staff in administering and monitoring therapeutic interventions in care. Safety is primary concern affecting all mental health care staff due to clients at risk for violence, self-harm, or self-neglect. Professional psychiatric nursing care requires staff to be alert to adverse reactions and changes in the client lacking the ability self-report. The Psychiatric Mental Health Nurse utilizes expert evidenced-base knowledge from nursing, health sciences, and related mental health disciplines to select and tailor nursing interventions to meet individual client needs.

### Knowledge/Skills Necessary to Fulfill Competency:

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<tr>
<td>Educates and assists clients in selection of choices that support positive changes in their affect, cognition, behavior, and/or interpersonal relationships</td>
<td>Assesses and monitors clients at risk for self-care deficits and mobilizes resources in response to client needs</td>
<td>Utilizes appropriate technology to initiate safe, effective, and therapeutic nursing interventions that promote wellness and recovery</td>
<td>Administers psychiatric medications safely and accurately, monitoring for therapeutic responses, reactions, side effects, toxicity, and potential medication incompatibilities</td>
<td>Utilizes therapeutic elements of group therapy process and interventions facilitate therapeutic care</td>
<td>Provides support and safety for clients in a therapeutic manner</td>
<td>Incorporates elements of knowledge of family dynamics, cultural values, and beliefs in the provision of therapeutic care</td>
<td>Collaborates with the client, health care providers, interdisciplinary staff, and the community to access and coordinate resources in therapeutic care</td>
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**Totals For Each Level:**

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## Levels of Competency

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<tbody>
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<td>Has little to no knowledge of subject</td>
<td>Has a general knowledge of subject</td>
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### Goal/Expected Outcome

- **Level 1**
  - Increase Knowledge
- **Level 2**
  - Increase Knowledge & Application
- **Level 3**
  - Increase Synthesis of Recent Advances and Future Directions

### Domain 6: Ensuring Quality Mental Health Care Services Monitoring Therapeutic Interventions

#### Rationale:
Mental health clients are particularly vulnerable as recipients of psychiatric care due to psychiatric disorders and mental health issues. It is important for mental health care staff to be aware of provisions in mental health care acts and legislation affecting their realm of practice to ensure quality care. The nurse is responsible as an advocate for the client’s right to receive the least restrictive form of care and respect the client’s right to pursue individual therapeutic goals.

#### Knowledge/Skills Necessary to Fulfill Competency:

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<thead>
<tr>
<th>Level 1</th>
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<tbody>
<tr>
<td>1. Identifies hazards in the workplace setting that may interfere with care or with nurse’s ability to perform with skill, safety and compassion toward others and takes appropriate action.</td>
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<td>2. Expands knowledge base of innovations and advances in psychiatric care and practice to ensure safe and therapeutic care.</td>
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<td>3. Critically evaluates current mental health research and utilizes this established research knowledge base in current practice to improve quality of care and outcomes.</td>
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<td>4. Documents ongoing review and evaluation of mental health care and nursing care activities.</td>
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<td>5. Understands the interdisciplinary team functions and the overall plan of care.</td>
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<td>6. Advocates for the client within the contextual boundaries of mental health care and the profession of Psychiatric Mental Health Nursing.</td>
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<tr>
<td>7. Utilizes sound evidenced based practice judgments in advocating safe, competent, culturally sensitive and ethical care.</td>
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<td>8. Monitors and maintains confidentiality of all client information. Recognizes changes in mental health nursing care that affect practice and develops strategies to manage these pertinent changes.</td>
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**Totals For Each Level:**
Appendix B
Letter of University Institutional Review Board Approval

June 7, 2016
Beverly Sedlacek
Tel. 256-783-4647
Email: sedlaceb@andrews.edu

RE: APPLICATION FOR APPROVAL OF RESEARCH INVOLVING HUMAN SUBJECTS
IRB Protocol #:16-078 Application Type: Original  Dept.: Nursing
Review Category: Exempt    Action Taken: Approved    Advisor: Henrietta Hanna
Title: Developing psychiatric mental health competencies on an in-patient psychiatric unit

Your IRB application for approval of research involving human subjects entitled: “Developing psychiatric mental health competencies on an in-patient psychiatric unit” IRB protocol # 16-078 has been evaluated and determined Exempt from IRB review. You may now proceed with your research.

Please note that any future changes (see IRB Handbook pages 11-12) made to the study design and/or informed consent form require prior approval from the IRB before such changes can be implemented. Incase you need to make changes please use the attached report form.

While there appears to be no more than minimum risks with your study, should an incidence occur that results in a research-related adverse reaction and/or physical injury, (see IRB Handbook pages 12) this must be reported immediately in writing to the IRB. Any research-related physical injury must also be reported immediately to the University Physician, Dr. Reichert, by calling (269) 473-2222.

We ask that you reference the protocol number in any future correspondence regarding this study for easy retrieval of information.

Best wishes in your research.

Sincerely,

Mordukai Ongo
Research Integrity and Compliance Officer

Institutional Review Board - 4150 Administration Dr Room 322 - Berrien Springs, MI 49104-0355
Tel: (269) 471-6361 Fax: (269) 471-6543 E-mail: irb@andrews.edu
Appendix C

Letter of Hospital Institutional Review Board Approval

Lakeland Hospitals
Niles and St. Joseph IRB #1

To: Beverly Sedlacek, Andrews University
Nursing Scholarly Project

Re: Developing Psychiatric Nursing Competencies
On An In-Patient Hospital-Based Psychiatric Unit

Date: June 10, 2016

This is to inform you Lakeland Hospitals Niles and St. Joseph, IRB# 1 has approved the above research study to be conducted at Lakeland Health Care. The study has been determined to be exempt from review according to our Standard Operating Procedures and Claim of Exemption Checklist.

Please send a final report upon completion of the study.

The IRB operates in compliance with GCP and applicable laws and regulations to the best of its knowledge. The IRB consists of members of the clinical and scientific communities, non-scientists, as well as members of the community as required by Federal regulations to assure a fair and thorough review process.

Lakeland Hospitals Niles and St. Joseph, IRB# 1 is registered with the Office for Human Research Protections (OHRP). Please refer to OHRP’s Web site for at http://ohrp.osophs.dhhs.gov/irbasur.htm for a list of registered IRBs.

Please call me if you have any questions. The IRB wishes you success with this research.

Jann Tofte, IRB Chairperson
Lakeland Hospitals Niles and St. Joseph, IRB# 1
Andrews University  
4150 Administrative Drive, Room 322  
Berrien Springs MI 49104-0355  
April 13, 2016

Dear Review Board:

The Lakeland Behavioral Health Unit support and welcome the opportunity for Beverly Sedlacek to utilize the behavioral health nursing staff to take part in her research entitled, “Developing Psychiatric Nursing Competencies On An In-Patient Hospital-Based Psychiatric Unit.” Beverly will provide nursing education to the behavioral health nurses in our department who agree to participate in the research study. The study provides an excellent opportunity for the nursing staff to further develop their skills specific to psychiatric nursing. We sincerely appreciate your interest in completing your project on our Behavioral Health Unit.

Sincerely,

Jean Brosnan  
BSN, RN  
Manager of Behavioral Health

Eileen Willits  
VP Patient Services CNE and CO CQO
Appendix E

Letter of Approval from Instrument Author

On Feb 15, 2016, at 2:32 PM, Sylvia McKnight <smcknight541@gmail.com> wrote:

Ms. Sediacek,

As a researcher I have discovered I am one to the few to research Mental Health Learning needs assessments for professional practice. Please feel free to utilize the instrument for implementation to develop mental health nursing skill base. Good luck in your research and studies.

Best regards,

Dr. S. McKnight DNP,MSN,BA,RN-BC

On Mon, Feb 15, 2016 at 12:58 PM, Beverly Sediacek <sedlacek@andrews.edu> wrote:

Hi Dr. McNight,

I am in the process of doing a literature review for my scholarly project and was thrilled to come across your well-written article! I have interested in assisting the nursing staff on the small in-patient psych unit to develop skills that are obviously missing in caring for this vulnerable population. In fact, I am always apologizing to students on behalf of nursing that this is NOT psych nursing, as they observe and interact with nurses on the unit. The nurses hardly interact with the patients and when they do, it is not always in a therapeutic manner. I want to do something about that!

By way of my background, except for my first year out of college, I have only done psych and have a passion and tender love for this vulnerable population. I stumbled into teaching, and although not my first love, I have an opportunity to share my passion with students for this population. I am grateful for this. Although I am in the twilight of my career and completing my DNP is a bucket list pursuit, I want to make a difference for those coming behind me.

As I continue in my literature review, I am wondering if your research has been done elsewhere? Have you any other resources that you might point me to as I continue my literature review. I have a meeting with my chair later this week and would love to share with her your work and discuss the feasibility of using your assessment tool.

Thanks so much!

Respectfully,

Beverly Sediacek, PMHCNS-BC
Assistant Professor of Nursing
Andrews University
Marsh Hall, Room 201
8475 University Boulevard
Berrien Springs, MI 49104
269-471-3579

carlsarah@andrews.edu
Appendix F

Andrews University
School of Health Professions
Department of Nursing

Information Letter
Research Project

“Developing Psychiatric Nursing Competencies on an In-patient Psychiatric Unit”

Principal Researcher
Beverly Sedlacek, PMHCNS, BC

Advisor:
Dr. Henrietta Hanna

Background
Given the complexities and stressors of 21st century living, psychiatric mental health and substance use knowledge, skills, and abilities are integral to provide quality, holistic care to populations in need of nursing care. As in all specialties of nursing, psychiatric mental health nursing has seen an increase of knowledge and skills. Unfortunately, staff development efforts on the psychiatric unit lags behind. There is a paucity of research related to staff development efforts for nurses working on an in-patient hospital based psychiatric unit.

Purpose
The purpose of this scholarly project is to implement a competency-based staff development program in a community-based hospital in-patient psychiatric unit to determine if the psychiatric mental health nursing knowledge and skills of nursing staff will improve.

Procedure
If you decide to take part in this study, you will complete a pre-test, attend a one-hour class for five weeks, complete a post-test, and answer 3 short-answer questions. Upon completion of the course, you will receive a $25.00 gift card. There will be a variety of teaching strategies utilized, which include didactics, videos, role-play, case studies, and reflection on practice.

Possible Benefits
Benefits of taking part in the study include improved psychiatric mental health nursing skills, which will lead to improved patient outcomes and ongoing competency-based staff development training for nurses.

Possible Risks
There are minimal risks associated with the study for participants. Nurses may experience feelings of inadequacy related to lack of psychiatric mental health nursing knowledge and skills.
Confidentiality

No one will know what you say or even if you decided to be in the study. Your name will not be linked to the information you share in your pre-test and post-test. It is possible that the study will be published in a journal. Beverly Sedlacek will present what she learns to the nurses on the unit, but you will not be identified by name. Your test results could be used in a future study. That can only happen if the appropriate ethics committee approves.

Voluntary Participation

Involvement in this study is totally voluntary and refusal to participate involves no penalty or loss of benefit to which you are otherwise entitled. You may withdraw from the study at any time without loss of benefit to which you are otherwise entitled if you have completed participation in the research. Simply telling the researcher you are no longer interested is satisfactory.

Questions or Concerns

If you have any questions or concerns please feel free to contact the researcher
Beverly Sedlacek
Phone: 256-783-4647.
Address: 8570 University Drive
Marsh Hall, Room 200
Berrien Springs, MI 49103
Appendix G

Andrews University
School of Health Professions
Department of Nursing
Informed Consent

Principal Investigator: Beverly Sedlacek  Advisor: Dr. Henrietta Hanna
Phone Number: 256-783-4647  Phone Number: 269-471-3366
Address: 8475 University Drive  Address: 8475 University Drive
Berrien Springs, MI 49103  Berrien Springs, MI 49103

Mentor (on site): Dr. Grabowski

Do you understand that you have been asked to be in a research study? Yes____ No____
Have you read and received a copy of the attached Information Letter? Yes____ No____
Do you understand the benefits and risks involved in taking part in this research study? Yes____ No____
Have you had an opportunity to ask questions and discuss this study? Yes____ No____
Do you understand that you are free to withdraw from the study at any time, without having to give a reason? Yes____ No____
Has the issue of confidentiality been explained to you? Yes____ No____
Do you understand who will have access to the information? Yes____ No____
Do you understand that all records of the research will be kept for at least seven years in a locked cabinet at the university office of the researcher? Yes____ No____
This study was explained to me by: Beverly Sedlacek Yes____ No____
I agree to take part in this study Yes____ No____
I agree that information from this interview can be used for secondary analysis if the appropriate ethics committee approves. Yes____ No____

Signature of Research Participant: ___________________________ Date: ________________
Printed Name: _____________________________________________

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee: ______________________ Date: ________________
Appendix H

**Instructions**

**Mental Health Learning Needs Assessment**

**Pre-and Post-Test Instructions**

**Pre-test Instructions:**

This pre-test is designed to measure your knowledge and skills of psychiatric mental health nursing. The Mental Health Learning Needs Assessment allows you to identify your current knowledge and skills. Rationales for each domain are described to guide you in selecting the appropriate level of competency for each skill. In each of the 3 selected domains, there is a list of the knowledge/skills necessary to fulfill competency for that domain. To select the level of competency of the listed skill, you need only move to the column next to the knowledge/skill description, and rate your level of competency on a scale of one to three, marking the block indicating that level of competency. At the end of each domain, total your scores. It will take about 20 minutes to complete. Once you have completed the pre-test, simply log out.

**Post-test Instructions**

Now that you have completed the course, “Growing Together: Developing Mental Health Nursing Competency,” please complete the following post-test. It is the MHLNA, which you completed for the pre-test. To select the level of competency of the listed skill, you need only move to the column next to the knowledge/skill description, and rate your level of competency on a scale of one to three, marking the block indicating that level of competency. At the end, please complete the 3 short-answer questions. It will take about 25 minutes to complete. Once you have completed the pre-test, simply log out.
Appendix I

Recruitment Flyer

ATTENTION ALL NURSES:
NEED VOLUNTEERS TO PARTICIPATE IN RESEARCH STUDY

I. Beverly Sedlacek of Andrews University
II. Department of Nursing DNP Student

“DEVELOPING PSYCHIATRIC NURSING COMPETENCIES SKILLS THROUGH STAFF DEVELOPMENT TRAINING”

III. Receive $25.00 Gift Card for Your Participation

A. 5 WEEKLY SESSIONS BEGINNING AUGUST 1, 2016

There is a paucity of research that discusses staff development training for nurses in psychiatric mental health nursing. Beverly Sedlacek, from Andrews University DNP program plans to offer a five-week training on latest knowledge and skills in psychiatric mental health nursing and requests that you participate in the study.

If you are willing, please contact
Beverly Sedlacek at 256-783-4646.
Appendix J

Growing Together
Class 1 PowerPoint Presentation

Growing Together: Developing Mental Health Nursing Competency
Class 1
Beverly Sedlacik
Andrews University
DNP Research Project

Goals For This Class
- Nurses will be able to:
  - Identify two areas from assessment data that may be utilized to formulate nurse-patient relationship.
  - Identify three strategies that will foster de-escalation.
  - Verbalize 3 strategies that will foster a therapeutic unit milieu.

CURRENT TRENDS
Nurse-Patient Relationship
- With shortened hospital stays, current trends in mental health emphasize a recovery model of care with active involvement of the consumer (ANA, 2015).
- Recovery Model as defined by the SAMHSA.
  - A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Recovery Model

Situation
- Mrs. Rhodes, a 34-year-old white married mother of three is hospitalized for depression. Her husband travels a great deal, and she feels isolated and overwhelmed by some of her children’s behaviors and other parenting challenges. She has become increasingly withdrawn and tearful. Her husband recognizes that she is depressed and suggested hospitalization. She complains of feeling tired all the time yet has difficulty sleeping.
Situation (cont.)
- Emma begins the session.
- "Hi, Mrs. Rhodes," she says. "Sorry to hear you're not feeling well. I just want to ask you a few questions and kind of see where we're at with things." She takes a seat behind a desk and boots up the computer. "Sorry, this is going to take a minute to boot up. But let's go ahead and start. I understand you've been feeling depressed. Can you tell me about that?"
- Mrs. Rhodes looks at the floor and takes several deep breaths, shaking her head. "I don't even know where to begin," she sighs.
- "Take your time," Emma says. "I might need a new computer anyway. Sorry about that."
- "What's the computer for?"

Situation (cont.)
- "What's the computer for?"
- "Just so I can make notes in your record. It's part of the EMR requirements we have to follow. It's very standard. We should probably start now though, so we don't run out of time. What's been going on?"
- "I don't know," Mrs. Rhodes says.
- Melanie from the IT department peeks through the glass door behind Emma and taps on it softly and apologetically.

Relationship Formation
What data from your assessment would you use to begin to form a relationship with this patient?

Objective 2: PATIENT ESCALATION AND DE-ESCALATION

CURRENT TRENDS
- Patients admitted to an inpatient unit must be an imminent danger to self or others or grave disability.
- Patients are discharged from the hospitals rapidly for less expensive treatment options.
- High patient turnover
- High patient acuity rates
- Use less restrictive measures prior to using seclusion and restraints.

AGGRESSION AND VIOLENCE
- On an inpatient psychiatric unit, one cannot always predict violence.
- Intervene when clear warning signs are evident.
- Assess and interpret inappropriate behavior within the context and knowledge of the patient's pathology.
AGGRESSION AND VIOLENCE (Cont.)
- Results from complex interactions among patients, nursing personnel, and culture of the unit
- Staff attitude reduces risk of aggression
- Reduce potential violence by enhancing the nurse-patient relationship
- Improve communication skills
- Advocate for clients
- Be available

AGGRESSION AND VIOLENCE (Cont.)
- Strategies to reduce potential for violence
- Continually assess the patients and milieu
- Provide patient education
- Collaborate with patients in treatment planning
- Provide meaningful patient activities and levels of stimulation
- Maintain safe unit staffing
- Nurse must be aware of own anger and methods to channel anger constructively

AGGRESSION AND VIOLENCE (Cont.)
- Nurses are ineffective if they become angry, aggressive, fearful, or withdraw from hostile or demanding patients
- View the patient's aggressive behavior as a form of communication
- Focus on assisting with coping skills
- Strengthen the therapeutic relationship
- Convey that help is available

MANAGEMENT OF INPATIENT AGGRESSION
- Reduce and prevent the use of restraints and seclusion
- Seventy-five percent reduction in seclusion and restraint events as a result of
  - Complete assessment at admission
  - Greater communication
  - Staff education
  - Therapeutic relationships with patients
  - Individualized care plans, preventive, and emphasis on self-management and responsibility

Objective 3: SECLUSION AND RESTRAINT

Questions to Ponder...
- What is presently being done on the Unit to manage milieu to prevent escalation of aggression, which results in seclusion and restraint?
- What are the latest competency necessary to create and reduce seclusion and restraint?
Reduction in Seclusion and Restraint
1. Leadership toward Organizational Change
2. Use of Data to Inform Practice
3. Workforce Development

Reduction in Seclusion and Restraint
1. Leadership toward Organizational Change
2. Use of Data to Inform Practice
3. Workforce Development
4. Use of S/R Prevention Tools

Reduction in Seclusion and Restraint
1. Leadership toward Organizational Change
2. Use of Data to Inform Practice
3. Workforce Development
4. Use of S/R Prevention Tools
5. Consumer Roles in In-Patient Settings
6. Debriefing Techniques — (National Association of State Mental Health Program Directors, 2006)
Reduction in Seclusion and Restraint

1. Leadership toward Organizational Change
2. Use of Data to Inform Practice
3. Workforce Development
4. Use of S/R Prevention Tools
5. Consumer Roles in In-Patient Settings
6. Debriefing Techniques

Reduction in Seclusion and Restraint

1. Leadership toward Organizational Change

To reduce the use of seclusion and restraint by defining and articulating a comprehensive philosophy of care, guiding values, and ensuring the development of a S/R reduction plan and plan implementation. The guidance, direction, participation and ongoing review by executive leadership is clearly demonstrated throughout the S/R reduction project.

Reduction in Seclusion and Restraint

2. Use of Data to Inform Practice

To reduce the use of S/R by using data in an empirical, non-punitive manner. Includes using data to analyze characteristics of facility usage by unit, shift, day, and staff member; identifying facility baseline; setting improvement goals and comparatively monitoring use over time in all care areas, units and/or state system's like facilities.

Reduction in Seclusion and Restraint

3. Workforce Development

To create a treatment environment whose policy, procedures, and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence and their impact on the development of these experiences in persons who receive mental health services and the experiences of our staff. This includes an understanding of the characteristics and principles of trauma informed care system. It also includes the principles of recovery oriented systems of care such as: person centered care, choice, respect, dignity, partnerships, self management, and full inclusion.

Reduction in Seclusion and Restraint

3. Workforce Development (cont.)

This intervention is designed to create an environment that is less likely to be coercive or conflictual. It is implemented primarily through staff training and education and HR department activities and includes safe S/R application training, choice of vendors and the inclusion of technical and attitudinal competencies in job descriptions and performance evaluations. This also includes the provision of effective and person centered psychosocial or psychiatric rehabilitation like treatment activities on a daily basis that are designed to teach life skills (See Goal One).

Reduction in Seclusion and Restraint

4. Use of S/R Prevention Tools

To reduce the use of S/R through the use of a variety of tools and assessments that are integrated into each individual consumer's treatment stay. Includes the use of assessment tools to identify risk factors for violence and seclusion and restraint history; use of a trauma assessment; tools to identify persons with risk factors for death and injury; the use of de-escalation or safety surveys and contracts; and environmental changes to include comfort and sensory rooms and other meaningful clinical interventions that assist people in emotional self management.
Reduction in Seclusion and Restraint

5. Consumer Roles in In-Patient Settings
To assure for the full and formal inclusion of consumers or people in recovery in a variety of roles in the organization to assist in the reduction of S/R.

Reduction in Seclusion and Restraint

6. Debriefing Techniques
To reduce the use of S/R through knowledge gained from a rigorous analysis of S/R events and the use of that knowledge to inform policy, procedures, and practices to avoid repeats in the future. A secondary goal of this intervention is to attempt to mitigate to the extent possible the adverse and potentially traumatizing effects of a S/R event for involved staff and consumers and all witnesses to the event. It is imperative that senior clinical and medical staff, including the medical director, participate in these events.

STAFF DEBRIEFING

- Immediately after the patient has been secluded or restrained.
- Assess staff for injuries.
- Evaluate the way the situation was handled.
- Provide support and feedback.
- Focus on specifics of the event.
- Discuss success and what did not work well.
- Reinforce safety education, and identify areas for improvement.

Reduction in Seclusion and Restraint

Which of these strategies would you like to see the unit adopt today??
1. Leadership toward Organizational Change
2. Use of Data to Inform Practice
3. Workforce Development
4. Use of S/R Prevention Tools
5. Consumer Roles in In-Patient Settings
6. Debriefing Techniques

What if...???

- If you could change what is currently done on the Unit when seclusion or restraint is necessary, what would it be?
- If you could set a seclusion restraint reduction goal for the month, what number would you choose?

MILIEU CONCERNS
MILIEU CONCERNS
- What can nurses do to better manage the Unit milieu?
- Nurses must spend time interacting with patients at frequent, regular intervals.
- Encourage patients to share concerns, reactions, and fears of losing control.

Did you know??
- Best practices suggest after a patient has been secluded or restrained:
  - A milieu meeting should be called to discuss openly that a patient was restrained and/or secluded.
  - The reason for and purpose of seclusion and restraint should be presented.
  - Encourage all patients to approach staff if upset and angry to help de-escalate the issues early.

CLINICAL SUPERVISION
- Avoid burnout and job-related stress.
- Structured mechanism allowing nurses to reflect on day-to-day practice as well as validate clinical decisions.
- Vital component of effective psychiatric care.
- Formal relationship-based education and training work-focused.
- Used to assist the nurse to manage their patient care, provide support, assist the nurse to develop and evaluate through corrective feedback.

CLINICAL SUPERVISION (Cont.)
- Address emotional impact of patient encounters.
- Examine issues within the team and broader workplace setting.
- One-to-one or group meetings.
- Provide checks and balances system to promote professional development.
- Nonhierarchical, nonjudgmental, focused on the nurse.
Appendix K

Growing Together
Class 2 PowerPoint Presentation

Objectives
- Nurses will be able to:
  - Identify three examples of nursing care where cultural competence is shown.
  - Identify three common emotional states of distress such as anxiety, anger, tension, fear, grief, helplessness, and hopelessness.
  - Identify 3 intervention strategies that will assist patients during emotional states of distress.

Situation

Culture
- Culture is defined as a way of life of a group of people—the behaviors, beliefs, values, and symbols that they accept, generally without thinking about them, and that are passed along by communication and imitation from one generation to the next.
- Cultural Competence is knowledge and understanding of another person’s culture; adapting interventions and approaches to health care to the specific culture of the patient, family, and social group.

Culture awareness begins with self-examination, which is an in-depth exploration of one’s culture and ethnicity:
- What am I reacting to so critically to this situation?
- What makes it hard for me to accept this family the way they are?
- What is making me so uncomfortable with this individual or family?
- Do I truly understand what this individual or family wants or needs?
- What do I need to learn about this culture so that I can better meet individual and family care needs?

EVERYONE has some bias. Offering culturally sensitive care must start with awareness.
Emotions

- Common human emotional states of distress such as
  - Anxiety
  - Anger
  - Tension
  - Fear
  - Grief
  - Helplessness
  - Hopelessness

Emotions

- How skilled are you at identifying negative feelings in yourself and with others
- What are some of the challenges for the mentally ill in expressing feelings and emotions?

Emotions

- Focus on
  - Grief
  - Helplessness
  - Hopelessness

Attentive Listening

- Listening with your whole self
- Listening as if the person you are listening to is the only person in the world at the time
- It is better to be honest if you are not able to listen attentively at the time

Listening from the Heart

An example of listening from the heart

Gladys and Naomi

Emotions And The Mentally Ill
Empowering Patients to Discuss Emotions

Discussing Feelings and Emotions
- How to empower patients to discuss feelings and emotions
- Active Listening
- Empathy
- Reflecting back to patient

Discussing Feelings and Emotions

Simple Formula for Reflecting Feelings:

"You feel [insert emotion] because [insert content]."
Appendix L
Growing Together
Class 3 PowerPoint Presentation

Class Objectives
- Nurses will be able to:
  1. Identify a way of which technological teaching aids have been effective with patients.
  2. Report at least 3 adverse medication effects, which include side effects, toxicity, and potential medication incompatibilities.
  3. Demonstrate one effective intervention with a patient who is either acutely psychotic, depressed, or in manic phase of bipolar illness.
  4. Identify three problem-solving interventions that may be implemented with patients.
  5. Identify three educational strategies to be used to support patient in making health choices and involvement in care.
  6. Identify one strategy to improve collaboration among unit staff.

Technology
- Technology
  - How have you seen technology be useful in working with patients?
  - How can technology be used more effectively with patients?
  - How is assessment of effectiveness done with patients after viewing a video?
  - How can patient education be improved using technology?

Adverse Medication Side Effects
- What side effects have you seen most frequently on the unit?
- What have been the most serious side effects you have seen patients have since you have been working on the unit?
- How have these side effects been treated?
- How do you keep up to date with the most current medications and potential side effects?
Common Atypical Antipsychotic Adverse Side Effects

• Atypical antipsychotics
  • Have been widely prescribed for the management of patients with schizophrenia, bipolar disorders, other psychiatric disorders or conditions with severe behavioral disturbance.
  • Widely used in part due to their lower propensity to induce extrapyramidal symptoms and tardive dyskinesia compared to typical antipsychotics.
  • Do not represent a homogeneous class, and differences in side effects should be taken into account when assessing the patient.

1. Weight gain
   • 40-60% of people with schizophrenia are overweight or obese.
   • Patients treated with atypical antipsychotic medication may see a weight gain of 20 pounds within a year after starting meds. Zyprax is the common culprit for excessive weight gain.
   • Interventions include
     • Patient’s BMI should be recorded before medications are started or changed, and at every visit for first 6 months.

2. Diabetes mellitus
   • Diabetes occurrence is not always associated with weight gain, so monitoring weight alone may be insufficient to screen for diabetes risk.
   • Zyprax and Clozaril acutely impaired insulin sensitivity.
   • Assessment of the effects of medication on glucose and insulin metabolism includes: HbA1C, random glucose, oral glucose tolerance test.

3. Hyperlipidemia
   • Serum lipid levels may be influenced by multiple factors, including genetics, diet, weight gain, and exogenous agents like alcohol and medications.

4. QTc interval prolongation
   • Prolongation of the QTc interval of the electrocardiogram (ECG) may be associated with the development of torsade de pointes, a ventricular arrhythmia that causes syncope and may progress to ventricular fibrillation and sudden death. The average QTc interval in healthy adults is approximately 400-450 ms. A QTc interval of 500 ms or greater is considered to be a substantial risk factor for torsade de pointes.
   • A baseline ECG before treatment is initiated in any of the following cardiac risk factors are present: known heart disease, a personal history of syncope, a family history of sudden death at under age 40 years (especially if both parents had sudden death), or congenital long QTc syndrome. A subsequent ECG is indicated if the patient presents with symptoms associated with a prolonged QTc interval (e.g., syncope).
Common Atypical Antipsychotic Adverse Side Effects

5. Myocarditis
   - Case reports suggest that clozapine is associated with an increased risk of myocarditis.

6. Sexual side effects
   - Antipsychotic-induced sexual dysfunction is related to the effects of the drugs on alpha-1 and alpha-2 adrenergic, H1 histamine and dopaminergic receptors, in particular to the blockade of DO receptors in pituitary lactotroph cells, which leads to an excess of prolactin secretion.

7. Extrapyramidal side effects
   - When atypical antipsychotics are used at recommended doses, they are associated with significantly lower rates of extrapyramidal side effects compared with (generally high-potency) conventional antipsychotics. Some atypical antipsychotics (e.g., risperidone and olanzapine) have a dose-response relationship for extrapyramidal side effects, while with others (e.g., clozapine, quetiapine) this relationship is not apparent.

In Conclusion

- Clinicians have to take into account these differences when choosing an antipsychotic for an individual patient and when screening and monitoring for physical problems.
- "The right drug for the right patient"

Nursing Interventions

Case Study
Case Study
- Tony, a 20 year old male quit college 2 months ago and returned to live at his parents home. He has become increasingly withdrawn, suspicious, and isolated since his return and his parents have taken him to the emergency department. His parents report that he has been looking at them strangely as if he did not know them, refusing to talk to anyone, spending a lot of time in his room alone, refusing all help. The father brought the client to the hospital against his will following a verbal argument during the course of which the client attempted to stab the father with a kitchen knife. The father had successfully subdued him and removed the weapon. On arrival at the emergency department, the client was agitated and exhibiting acutely psychotic symptoms. He reports that they told him to kill his father before his father kills him. Verbalizations are often incoherent. Affect is flat and he continuously scans the environment. He is admitted to the behavioral health unit with a diagnosis of schizophreniaform disorder, provisional.

Problem-Solving Steps
- Five steps include the following:
  1. Discuss with patients their present and previous coping mechanisms
  2. Discuss with patients the meaning of problems and conflicts
  3. Use supportive confrontation and teaching
  4. Assist patients with exploring alternative solutions and behaviors
  5. Encourage patients to test new adaptive coping behaviors

Case Study
- A common scenario which frequently occurs:
  23 year-old man with a history of schizophrenia, was admitted to the unit for the third time to the psychiatric unit in 18 months, following refusal to take medication because he no longer needed them. He became increasingly more paranoid and withdrawn, accusing the family of trying to harm him. Family reports that he was doing well as long as he was taking medications. He was again started on a medication regimen that has been effective. In checking in with him today, how would you utilize the problem solving process with him?

Problem-Solving Steps
- Five steps include the following:
  1. Discuss with patients their present and previous coping mechanisms
  2. Discuss with patients the meaning of problems and conflicts
  3. Use supportive confrontation and teaching
  4. Assist patients with exploring alternative solutions and behaviors
  5. Encourage patients to test new adaptive coping behaviors
Making Healthy Choices

- In light of the health risks of the mentally ill,
  - Have you talked with patients about their physical health?
  - How have you talked to patients about making food healthy choices while in the hospital?
  - How have you talked to patients in discharge teaching about continuing to make healthy choices?
  - How have you collaborated with patients about their care?

Collaboration

- Does collaboration happen on the unit?
- Is advocacy for the patients advanced when collaboration among the disciplines happen?
- Is health care improved because of collaboration
Appendix M

Growing Together
Class 4 PowerPoint Presentation
Case Study (cont.)

- Mr. Gery is admitted to the behavioral health unit and began to make demands of staff and other patients. He insisted on taking all newspapers to his room to save for his project, as well as styrofoam cups and napkins from meal trays. By the end of the week he had quite a stash in his room.

Before we discuss how to deal with this patient, let's look at potential reactions to clients who have mania.

Working with Clients Who Have Mania

- Potential reactions working with clients who have mania may include the following:
  - Annoyance by the client's demanding behavior
  - Feeling outnumbered and outnumbered, even leading to question whether your judgments and actions are appropriate
  - Difficulty with objectively identifying manic symptoms
  - I disagree emphatically with colleagues about how to handle a client's manipulative behavior
  - Angry and unsure of your judgment when a client consistently exceeds established limits
  - I avoid clients who have mania if they are not assigned to me.

Returning to the Case Study

Case Study

- Mr. Gery, a 52 year-old engineer, was brought to the emergency psychiatric clinic by two adult sons at 2:00 a.m. Their mother had called them to come help with their father, who was ill in 3 days. When they arrived at their parents' home, they found their father working in the backyard on a large landscaping project involving stonework, a waterfall, a fish pond, and extensive plantings of trees, shrubs, and flowers.

- According to the sons, Mr. Gery had three prior episodes of manic behavior, beginning when he was in the Army many years earlier. He was stabilized on LCGO3 for years, but stopped taking it about a year ago because he felt good.

Case Study (cont.)

- Mr. Gery is admitted to the behavioral health unit and began to make demands of staff and other patients. He was started on an anti-psychotic and a mood stabilizer. He insisted on taking all newspapers to his room to save for his project, as well as styrofoam cups and napkins from meal trays. By the end of the week he had quite a stash in his room.

Setting and Enforcing Limits

- Effective limit setting requires that all team members participate in establishing limits and determining and enforcing the consequences of exceeding them.
  - Establish limits only when and where there is a clear need.
  - Limits must help client growth
  - Establish reasonable and enforceable consequences for exceeding limits
  - Explain the limits and consequences to clients in language they can understand. Explain why the limits are necessary and allow clients to express their feelings about them
  - Enforce the limits consistently.
  - Evaluate the continued need for limits frequently. Turn control over to clients as soon as the client's behavior indicates the ability to exercise self control.

Rationale
**Case Study**

- During a community meeting, Ray states, "I can't stand that fat slob of a nurse. She acts like God went on vacation and appointed her to substitute for Him." When confronted by the group leader, Ray responds, "So what if I yell when I get angry? I'm paying a lot of money to be here. If you don't like it, leave.

**Setting and Enforcing Limits**

- Effective limit setting requires that all team members participate in establishing limits and determining and enforcing the consequences of exceeding them.
- Establish limits only when and where there is a clear need. Limits must help client growth.
- Establish reasonable and enforceable consequences for exceeding limits.
- Explain the limits and consequences to clients in language they can understand. Explain why the limits are necessary, and allow clients to express their feelings about them.
- Enforce the limits consistently.
- Evaluate the continued need for limits frequently. Turn control over to clients as soon as the client's behavior indicates the ability to exercise self-control.

**Your Response**

- How would you handle this situation?

**Rationale**

- Clients with BPD tend to instigate problems as they become involved in therapeutic relationships. The anger may manifest itself in accusations, frequent displays of temper, inability to control anger (acting out), irritability, sarcasm, argumentativeness, devaluing others, and over-reaction to minor irritants. Clients are unable to tolerate their own "bad" image and, therefore, project it onto others, often raging at the perceived attributes of the other. Anger tends to be greatest toward those people who remind them of a nurturing/irritating parent.

**Problem-Solving Steps**

- Five steps include the following:
  1. Discuss with patients their present and previous coping mechanisms.
  2. Discuss with patients the meaning of problems and conflicts.
  3. Use supportive confrontation and teaching.
  4. Assist patients with exploring alternative solutions and behaviors.
  5. Encourage patients to test new adaptive coping behaviors.
Application to Collaboration
Definition of Evidence Based Practice

- Evidence-based practice (EBP) is an effective appraisal and use of research-based evidence and clinical expertise applied to patient values and preferences in order to generate the best clinical outcomes.
- It refers to the clinician's knowing the rationale and evidence to support the delivery of a patient-centered intervention—doing based on knowing, and knowing based on evidence. In this approach to practice, knowing is a conscious, mindful activity.

(Melnyk & Fineout-Overholt, 2012, 2005a)

Evidence-Based Practice

- Embracing EBP as a practice standard requires nurses to be active consumers of current evidence, critically applying evidence-based interventions in practice and refining traditional ways of providing care.
- Practice traditions can be loosely defined as interventions or actions for which the body of evidence no longer supports the action(s), yet the interventions continue to be present in practice.
- Practice interventions and traditions (otherwise also known as "sacred cow" practices) that are not based on current evidence need to be retired, or need to be put out to pasture.

Developing an EBP intervention

- Five major steps:
  - Ask a clinical question regarding the best approach to client care
  - Search and appraise the existing evidence
  - Combine the research evidence with
    - (a) clinical expertise and experience and
    - (b) patient preferences and values
  - Plan and carry out the intervention
  - Evaluate the outcomes

(Melnyk & Fineout-Overholt, 2005a)

Learning About Current Evidence

- Reading professional journals about the latest evidence-based interventions
- Inquiring about resources available to the unit
Appendix N

Growing Together
Class 5 PowerPoint Presentation

Growing Together: Developing Mental Health Nursing Competency
Class 5
Dorey Sadzinski
Andrews University
GHP Project

Class Objectives
- Nurses will
- Identify one means of how to expand knowledge and skills
- Identify one way to learn about evidence-based interventions
- Identify one growth area where more knowledge and skill improvement is needed
- Identify present successes and gaps in collaboration of nurses with other team members that negatively affect patient care. Discuss ways to improve the gaps in collaboration among staff that will ultimately improve patient care

Expanding Knowledge
- What kind of training do you engage in for expanding your knowledge of psychiatric mental health care and practice?
- Do you read professional journals or articles related to psychiatric nursing?
- Do you have access to a database from a medical library?

Evidence-Based Practice
- Institute of Medicine’s Report “To Err is Human”
- Landmark publication describing problems in health care that hinder the ability to provide safe, evidence-based, cost-effective care to all patients.
- Clearly articulate the need for health care professionals to embrace evidence-based practice (EBP) to improve outcomes of patient care.

Evidence-Based Practice
- What is evidence-based practice? It includes
  - The integration of best research and other forms of evidence to guide practice,
  - Clinical expertise as a component in care effectiveness
  - Consideration of patients’ preferences, values, and engagement in care decision as essential to providing optimal evidence-based care to patients and their families
Evidence Based Practice
Example: Suicide

Standard of Care
- Standard of care refers to what a reasonable and prudent psychiatric mental health nurse would do under similar circumstances, contextualized in the time period, the geographic location, and the nurse’s level of education and specialty (e.g., advanced practice nurse, RN; American Nurses Association, American Psychiatric Nurses Association, International Society of Psychiatric-Mental Health Nurses, 2007; Sadock & Sadock, 2007).

Standard of Care (cont.)
- Although there is no universally agreed upon list of minimum standard of care for inpatient suicide-specific safety, there are specific programs, interventions, and strategies that approach standard of care, such as:
  - Environmental safety
  - Suicide risk assessment
  - Monitoring and observation
  - Documentation
  - Means restriction
  (Bongar & Sullivan, 2013; Silverman et al., 1994).

Environmental Safety
- Reducing environmental risk factors
  - Eliminating structures that are potential anchor points
    - Include structures close to the floor
  - Reduce strangulation devices
  - Reduce access to dangerous objects
  - Reduce access to sharp objects
  - Reduce opportunities to jump
  - Eliminate closets, clothing poles, belts, hangars, privacy curtains
  - Keep medical devices in locked areas or under observation

Suicide Risk Assessment
- Tools and scales are often preferred by inpatient nursing staff for a number of reasons, such as rapid patient turnovers, brief lengths of stay, and provider anxiety.
- The critical development of the therapeutic alliance between the patient and the provider in conjunction with collaboration between the patient and provider assists in the proper development of the assessment and monitoring of suicidality.

Monitoring and Observation
- Although Mann and colleagues' (2005) review concluded there is little empirical work on efficacy of formal observation in reducing self-harm, several studies have underscored concerns about the effectiveness of monitoring.
- Currently, there are policy initiatives within the US DHHS Centers for Medicare and Medicaid Services focused on the monitoring of patients at risk for suicide, qualification of staff to determine risk, and reporting of sentinel events to a single agency (S. Simpson, pers. comm., July 5, 2011).
Monitoring and Observation

- Currently, there are policy initiatives within the US DHHS Centers for Medicare and Medicaid Services focused on the monitoring of patients at risk for suicide, qualification of staff to determine risk, and reporting of sentinel events to a single agency (S. Simpson, pers. comm., July 5, 2011).
- New patients and patients who are at substantial risk or unknown risk should be continuously monitored, since monitoring every 15 min does not prevent suicide.

Evidence Based Practice
Example:
Providing Structure

Documentation

- Documentation of assessment, tracking and management of suicidality is a standard of care and a risk reduction strategy.
- Nursing documentation should include the assessment of suicide risk, formulation of risk and rationale, positive and negative findings, clinical reasoning and related actions, suicide-specific milieu interventions, management of suicidality, decisions, indicators of progress toward treatment goals, disposition, discharge planning, patient education, recovery goals, and explanation of termination.

The Evidence

- PS is not well established as a psychiatric nursing intervention, and PS is not mentioned as an intervention label in the Nursing Intervention Classification. Although there are similarities in the description of nursing activities as part of related labels or key words, there is no possibility to conclude that PS should be a new NIC label on the basis of this review. It still remains unclear what nurses mean when they provide structure. The expectation is that a definition of PS and the description of the underlying mechanism of PS will influence the programmatic structure, such as maintenance of limits and rules, on wards and nursing activities related to PS. The ultimate goal of future research should therefore be to develop an evidence-based nursing strategy specifically aimed at improving the provision of structure as an intervention within mental healthcare settings.

Providing Structure

- “Providing structure” (PS) as a psychiatric intervention
  - To impose and maintain rules and limits
  - To assess the condition of the patient
  - To interact
Evidence Based Practice Example: Seclusion and Restraint

Seclusion and Restraint

1. There is no evidence that the use of seclusion or restraint is therapeutically beneficial (Pirmel, 2001).
2. Violent incidents are more likely to occur during unstructured, unmonitored periods (Janner & Deapen, 2012; Katz & Kirkland, 1992).
3. Denial of privileges often triggers violent retaliation (Katz & Kirkland, 1992; Papadopoulos et al., 2012).
4. Violence is less frequent and less severe on wards with strong psychiatric leadership, well-defined staff roles, a schedule of predictable activities (Katz & Kirkland, 1992).

5. Violence is less frequent when staff remain outside the nurses' station with the patients (Katz & Kirkland, 1992).
6. Less expressed emotion (EE) and family interventions can decrease the need for seclusion & restraint. Less EE environments improve outcomes in patients with schizophrenia, bipolar disorder, and depression (Scharf, Hanks, Hoey, 1989; Farrow, Louisiana, 1990; Stoddard, 2000).
7. Sensory-based approaches and multisensory treatment norms or comfort rooms may reduce seclusion/restraint, particularly in patients with dementia and severe developmental disorders (Chapman & Stromberg, 2001).
8. High social anxiety levels may cause disorganization in many low-functioning, symptom-laden patients (Van Putten, 1973).
9. Intensive behavior therapy combined with appropriate psychopharmacology proved effective with a vast majority of treatment-resistant patients (Stevenson, Hatahway-Wright, 1998).
10. As disturbed behavior (incontinence, screaming, verbalizing, attempting to assault staff) by patients, damage or destroying property) increases, patient autonomy (the degree to which patients can maintain basic symbols of adulthood) decreases, and patients should be given fewer and simpler choices (Timko & Mose, 1999).
11. Social learning program decreased seclusion, restraint, and injury (Goodness & McIntyre, 2002).
12. Greater community fingers were associated with greater improvements in patient's symptoms and functioning (Tucker, Ludwik, & Moore, 2001)
13. Most effective units were those where paraprofessional staff perceive the professional staff as motivated and non-dominant, where paraprofessionals view themselves as active participants who were praised for their work, and patients were involved in ward management (Bliehorn, Maroney, Hott, Gordon, 1991).

14. Non-static predictors of assaultive behavior include threatening language and increased motor activity (Jansen et al., 1996; Papadopoulos et al., 2012).
Interventions
- "Violence is less frequent when staff remain outside the nurses' station with the patients" (Katz-Buhler and Land, 1980, p. 201)
- Written and easily accessible schedules of activities.
- Previously unstructured time being gradually filled with formal and informal activities and groups.
- Staff identification boards with a photo of each staff member, title and credentials.
- Frequent reminders for staff to spend time interacting with patients rather than spending time in the nurses' station.
- Clearly written rights and expectations for patients.

Interventions
- In the area of early intervention, there was a gradual change in attitude toward resistance and sedation in which they were seen as last resort rather than first-line interventions.
- Earlier identification of signs of escalation and use of a wider scope of early interventions such as music, relaxation exercises and sensory soothing methods.
- Changes in communication centered around use of low-expressed emotion (lack avoiding verbal and non-verbal criticism, hostility and over-involvement; use of a supportive and non-threatening method for limit setting; and an emphasis on positive rather than negative communications, for example, instead of saying "You're late for breakfast," an accusatory tone of voice, staff were encouraged to respond in the same situation with "Good morning. I'm glad you were able to make it to breakfast. Well done!")

Summary
- I am the nurse: I know and must think about what I know. I must assume responsibility for my knowing. I must be consciously aware of, critical of, and accountable for the source of my knowing, and I must be prepared to publicly justify my actions with this knowledge.
- I cannot practice based solely on habit. I cannot justify my intervention with the statement "because that's the way it is done here."
- I cannot simply ask my supervisor or charge nurse how to handle a clinical problem and accept the recommendation without further query, discussion, and investigation. It means that I, as a practicing nurse, am an active and knowledgeable intervenor who is solely responsible for the care actions that I take.

Challenge
- Are you practicing by current best evidence in your daily practice?
- And if you are not, why not?
- What are the barriers that need to be removed to allow you to implement EBP interventions effectively in your daily practice?

Collaboration
- A BKG concept in nursing care today. Collaborating with families, other health care professionals is considered providing quality patient care.
- What are some of the successes of collaboration that you can identify have worked?
- What are some of the failures where collaboration has not been as effective? How can YOU improve on the gaps care?
Questions

• As a result of these classes, what knowledge and skills do you need to improve?

FINALLY...

A BIG THANKS is in order for helping out in this research project. Your cooperation made this project a success!

Beverly