THE TIDAL MODEL AND THE REFORM OF NURSING PRACTICE:

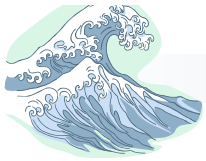
A study in the identification and implementation of nursing practices that substantially improve the therapeutic experience of patients on acute admission wards at the Queen Elizabeth Psychiatric Hospital, Birmingham & Solihull Mental Health NHS Trust

"The need to let suffering speak is a condition of all truth."

Theodor Adorno

June 2004

Bill Gordon: Lead Project Nurse,
Theresa Morton: Research Manager BSMHT
& Graham Brooks: Ward Manager Tolkien Ward QEPH



FOREWORD

The problems and challenges faced by service users and staff in acute psychiatric in-patient units today have been well documented. The Tidal Model is a nursing response to these challenges. The model uses water as a metaphor for human experience and provides a conceptual tool for structuring and implementing appropriate nursing responses to prevent both service users and staff from being 'engulfed' by the tide of thoughts and emotions and consequent behavioural and cognitive problems which are so much a feature of acute mental illness.

The model is firmly based in the establishment and management of human relationships, which has always been the particular territory of mental health nursing, but which has tended to be lost in more recent years with advances in psychopharmacology, increasing focus on evidence-based interventions grounded in psychology and profound changes in available nursing expertise and skills in in-patient areas.

Changes in the delivery of mental health services to people with acute mental health problems has taken the focus away from in-patient care and moved it towards community care. Whilst this has had many positive benefits for service users and their families, in-patient units have languished in the shadow of community services and have lost both medical and nursing leadership and the relationship knowledge base of experienced mental health nurses.

Paradoxically, the needs of those people who require admission to hospital have become more complex and severe as a result of available community treatment. This has been exacerbated by changes in nursing education, which have affected staffing, and skill mix in many areas. The result has been that those who most need a high level of mental health nursing expertise have been, in some circumstances, the least likely to receive it.

The Tidal Model project focuses on the introduction of the Tidal Model into one acute admission ward in the Queen Elizabeth Psychiatric Hospital, Birmingham & Solihull Mental Health Trust. The ward (Tolkien Ward) is in many ways no different to many other acute admission wards serving inner-city populations. It has 22 beds, 5 admitting consultants, and experiences the usual staffing problems, workload pressures and bed shortages.

Nursing staff complained of little time to engage with patients or to carry out their work to the standards they thought they should achieve. They lacked understanding of nursing models and structures for delivering and organising care and had little perceived control over their work. Therefore a decision was made to try and alter the way nursing care was delivered on the ward and the Tidal Model was chosen as a way to change nursing practice so that it would be more in-line with perceived professional standards, deliver care that was service user focussed and based on nursing approaches and values rather than those which were more associated with the medical field of psychiatry.

The Tidal Model project had 8 distinct phases:

1. A multi-disciplinary literature review was undertaken
2. The aims and objectives of acute admission wards as understood by nurses at the QEPH was then ascertained and examined
3. Nurses' perceptions of the quality of their relationship with patients on acute wards at the QEPH was then established and examined
4. Current nursing practices on QEPH acute admission wards as perceived by nurses was elicited and examined
5. Specific problems and difficulties that nursing staff were experiencing in their day-to-day work on acute wards were identified and examined
6. The Tidal Model was then implemented on Tolkien Ward in an attempt to address some of the problems and difficulties that have been identified

7. The Tidal Model implementation was evaluated by way of interviews with service users, staff evaluations and by means of statistical data obtained with the help of the Trust's Research Department
8. Preparation and publication of this report

The stages are described in detail in the report. The Tidal Model project has challenged the perceptions of nursing staff that there was no time to talk to patients. It has shown that structuring nursing care in different ways, for example by working collaboratively with service users from assessment through to care planning and evaluation, and making time to engage with and talk to patients, can improve service users' experiences of their care and improve nurses' perceptions of their contribution to a person's care. The Tidal Model implementation has also been associated with a significant reduction in untoward incidents, a shorter length of stay and a reduction in complaints from service users about nursing care and staff attitude. Some service users found that their care was much more focused than previously and that staff had more time to talk to them.

One of the most important features of the Tidal Model Project has been that it has been carried out on a normal ward, with the usual staffing problems and workload challenges. There have been times when the Tidal Model has not worked perfectly and times when it has felt too difficult to structure in the time for daily care planning. There have been occasions when service users have not wanted to or felt able to participate in their care. There have been challenges in relation to the skill set of staff and its compatibility with the Tidal Model. Despite this, the team have persevered, learnt by doing and have been able to see the benefits of using the Tidal Model. Service user evaluation, both formally through the Project and through other routes, has been positive.

There is still work to do. The Tidal Model Project has exposed a clear deficit in therapeutic relationship skills and knowledge amongst nursing staff. Currently significant amounts of time are spent on training staff to deal with violence and aggression that might be better spent in part learning how to reduce such incidents by better knowledge and awareness of service user needs.

This would be in-line with what service users have been saying to us for many years. The Tidal Model has yet to make an impact on some other professionals' perceptions of what nurses do and how they contribute to the wider multi-disciplinary team. Bed shortages and workload pressure remain. However, the tide seems to have turned in the right direction and staff are more skilled in negotiating the ebbs and flows of patient experience and the reality of working in acute admission units than they were previously.

The staff on Tolkien Ward, and Graham Brooks and Bill Gordon especially, have achieved what many thought was impossible – to change the focus of nursing care on an acute admission ward to enable therapeutic engagement with patients, structured nursing care, a safer environment and improved service user and staff satisfaction – whilst still doing 'the day job'. They have proved that it is possible to 'wave' rather than 'drown' in acute inpatient wards. I hope that other areas will read this report and be encouraged and enthused by the achievements of the project, the potential for mental health nursing and the experiences of service users.

Chris Halek
Deputy Director of Nursing & In-patient Programme Director
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CHAPTER ONE: INTRODUCTION

1.1 Background to this study

Over the past few years, policy documents from the Department of Health as well as empirical research studies suggest that acute psychiatric admission wards are experiencing difficulties in managing clients in their care. Amongst these difficulties is an increasing reduction of in-patient beds nationally and the increasingly complex problems that clients present on admission.

The acute admission wards in the Queen Elizabeth Psychiatric Hospital (QEPH) are clearly experiencing the same type of problems as other facilities nationally.

Bowers and Park (2001) state that one of the unfortunate and unintended consequences of the deinstitutionalizing of mental health care by shifting care out of the old Victorian asylums into the community [1], has been the relegation of acute in-patient care from the centre to the margins of mental health services. In their view economic and philosophical objections to hospital care have resulted in great uncertainty about the contemporary purpose of in-patient services and thus of the role of psychiatric and mental health nursing within that context.

On the other hand, they assert that adequate alternatives to in-patient services have not been developed. The result is that psychiatric hospitals are now paradoxically almost entirely associated with containment. The assumption that they can be appropriate places of refuge has virtually disappeared.

According to a recent Sainsbury report (1998) [2], patients [3] tend to experience their stay in acute wards as non-therapeutic. There is little individual care planning and the environment tends to be custodial in nature with little quality. In addition to this, working on acute in-patient admission wards 15-20 years ago was a relatively high status position for psychiatric nurses who worked with patients considered to be amenable to both intervention and care. This is no longer the case.

What used to be the jewel in the crown of psychiatric services has become the rump. According to Quirk & Lelliot (2001), acute wards are now places of risk, violence, restraint and custodial care where the quality of care has been compromised or is under threat. They are perceived to be relatively low status or dead-end work environments. Nurses who work on acute wards in comparison to their community colleagues are paid less, tend to be less well educated professionally and have fewer opportunities for career advancement. The result is

[1] See *Caring for People: Community Care in the Next Decade and Beyond* (DOH 1989).
[2] See *Acute Problems: A Survey of the Quality of Care in Acute Psychiatric Wards*, The Sainsbury Centre for Mental Health (1998). London. The Sainsbury Centre for Mental Health.
[3] In this paper the term '*patient*' will be used interchangeably with the term '*service user*', '*client*' and '*person*' Historically doctors and nurses have spoken in terms of having *patients*, social workers, counsellors and psychologists in terms of having *clients*, profit making business in terms of having *customers*, managers of service industries in terms of *service users* and ex-users of mental health services in terms of being *survivors* of those services

that the least able and the least experienced nursing staff care for the most acutely distressed patients[4] . According to Quirk & Lelliot (2001) –

"Nurse patient contact has declined; and patients are critical of conditions on the ward and view life there as both boring and unsafe".

In addition to this, they state that acute wards are characterised by rapid staff turnover, extensive use of bank and agency staff and low staff morale. The improvement of the quality of care on acute admission wards is thus a major on-going concern for the Department of Health (1999, 2002, 2003), which, in a recent Policy Implementation Guide (2002), openly admits that:

"In-patient services are not working to anyone's satisfaction"

According to Allen & Jones (2002), with acute mental health care in such a crisis we should consider every mental health nurse who works in the acute in-patient setting as a key resource for change. Until this view is adopted, many nurses who see themselves as seriously ill-equipped for the strenuous demands placed upon them in the acute setting, or undervalued because of a lack of relevant training and support as well as underpaid, will continue to leave acute in-patient work for less stressful, more prestigious and better rewarded jobs in the community.

As a result of this state of affairs, this study seeks to give a wide-ranging picture of the full context in which these problems have developed, in order to more effectively identify those nursing practices, and the theory underlying them, which will substantially improve the therapeutic experience of clients. By doing so it seeks to examine, in depth, a current issue of great concern to the Department of Health and to the nursing profession, an issue that has important implications for all the acute in-patient facilities at the QEPH and the way in which these impact on in-patient service users.

1.2 Looking inside the black box

Quirk & Leliott (2001), in their discussion of previous studies on the nature of current psychiatric in-patient care, point out that there is actually very little known about the quality of care being provided on UK admission wards. Despite various studies about daily life on acute wards, what is left is a patchy, inconsistent picture and a very opaque window looking in on how in-patient care is currently experienced by its recipients and by the nurses who work on acute wards. In the authors' words:-

"*There is a sense that hospital care is a black box, with people being admitted and discharged, but with little known about what happens to them while they are there*".

According to Higgins et al. (1999) patients report feeling bored, filling in time by sitting on their own doing nothing, watching television or talking with other patients. 40% of patients according to national survey undertaken by the

[4] According to Quirk & Lelliot (2001) - *"...Nurse patient contact has declined; and patients are critical of conditions on the ward and view life there as both boring and unsafe.* ". In addition to that, acute wards are characterised by rapid staff turnover, extensive use of bank and agency staff and low morale.

Sainsbury Centre for Mental Health (1998) reported having undertaken no social or recreational activity while on the ward. Another survey undertaken by Ford et al. (1998) reported that most patients had little to do all day and the nursing staff took little interest in them unless they were making a disturbance.

This study seeks to take a look inside at least one black box in the hope that by obtaining data as well as testimonies on the way things actually are on the acute wards at the QEPH, a real transformation of nursing practice can begin to impact on the wider vision for building and nurturing organisational change and developments already underway within the Birmingham and Solihull Mental Health NHS Trust (BSMHT).

1.3 Tolkien Ward

Tolkien Ward is one of four adult acute in-patient wards at the Queen Elizabeth Psychiatric Hospital (QEPH), which is in Edgbaston, Birmingham, United Kingdom, serving a population of approximately 450K. The QEPH provides in-patient care for the South of the city. In addition to the four acute wards the hospital contains an Intensive Care Unit, three Speciality Wards, three Elderly Care Wards and offers other services such as Neuropsychiatry, Psychology, Psychotherapy and Day Service Care. The QEPH has 93 acute in-patient beds within the four adult wards plus 10 on the ICU.

Tolkien Ward has 22 beds and its catchment area covers the Bourneville, Kings Norton, Cotteridge, Kings Heath, Billesley, Brandwood, Hall Green, Fox Hollies and Acocks Green areas of the city of Birmingham.

At the time of the implementation of the Tidal Model there were four area-based Consultant Psychiatrists whose patients were on Tolkien ward. There was also a Neuropsychiatry Consultant who had the use of two-three of the beds.

The nursing establishment for the ward during the project was:
One x ward manager (Grade G)
Two x deputy ward managers (Grade F)
11 x qualified nurses (Grades D/E)
11 x nursing assistants - mixture of full and part-time (Grade A)

CHAPTER TWO: LITERATURE REVIEW

2.1 The state we're in

According to the report *Acute Problems* by the Sainsbury Centre for Mental Health (1998), acute admission work in England is in great difficulty today. This is due to a number of inter-related reasons. Some of these are historical and economic and are directly related to a lack of investment in in-patient services over several decades, as both policy focus and resources have been re-allocated to the community. In addition to this, there has arisen a correspondingly inadequate system for training and educating nurses in ways appropriate to the very specialised nature of acute care at a time where there is an ever-increasing pressure on the in-patient system due to bed shortages [5].

Not surprisingly, under such circumstances, service users tend to experience their stay on busy acute wards as anxiety provoking and non-therapeutic. This is, in part, related to the fact that there is little skilled therapeutic involvement of nurses with patients on acute admission wards. The reason given for this by nurses is that they are just too busy doing other things like administration, answering the phone, writing up notes, attending meetings and dispensing medication. Much of the current literature into acute psychiatric care highlights a system under increasing stress [6].

Although acute admission wards are not currently in fashion within the NHS, a body of evidence is emerging that they are not only needed, but can potentially be a very effective type of intervention for some people under some circumstances. Nevertheless, according to Priebe and Turner (2003), skilled nurses[7] and planners are attracted away from acute in-patient work to community-based work because that is where the resources are and where nursing career opportunities lie. This leaves fewer resources to create and develop effective in-patient services.

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[5] The Sainsbury report makes ten recommendations in relation to these problems*:*
(1) Patient-centred care should be adopted as the fundamental principle underpinning the planning and delivery of acute care. (2) Care should be individualised, comprehensive and continuous. (3) A range of therapeutic resources must be available within acute care, based on the needs of patients. (4) The hospital environment must be designed to deliver a relaxed and secure atmosphere. (5) Wards should be organised as optimally therapeutic units. (6) Providers must review their provision to ensure that it meets the needs of women. (7) Staffing levels and skill mix must be geared to the provision of effective care. (8) Training in evidence-based practice is required for all clinical staff. (9) Each provider must designate a senior lead clinician or manager to take overall responsibility for bed management. (10) A range of crisis services should be available of which hospital - based care is one component.

[6] Just a few of the many papers and articles which discuss these issues are: Beech, P., & Norman, I.J., (1995); Bowers, L. & Park, A. (2001); Breeze J A, Repper J (1998); Cambell P (Sept 1999).; Davenport, Sarah (2002).; Ford, R., Duncan, H., & Warner, L., Hardy, P., Muijec, M. (1998); Goodwin, I., Holmes, G., Newnes, C & Waltho, D. (1999); Higgins, R., Hurst, K., & Wistow, G, (1997); Hummelvoll and Severinson (2001; Langdon, P. E., Uaguez, L. Brown, J. & Hope, A. (2001; Parsons, C. (2002).; Rix, Susannah & Shepherd, Geoff. (2003).

[7] **Nurse**: According to the dictionary a 'nurse' is a person trained to care for the sick or infirm or (outdated) a person employed or trained to take charge of young children. Historically nursing has often been the 'poor relation' amongst the professions in that nurses are not, according to Waters (1999) *" really distinguished as having an autonomous helping and enabling role ,but as extenders and monitors of the treatment of others - this in spite of the rhetoric to the contrary. Nurses are considered useful and caring ,but I am not sure if they are considered to take an active therapeutic role or to undertake a therapy that is of any real value according to the prevailing and powerful medical model*". Waters goes on to pin point what in fact is the crucial issue facing mental health nurses today. " *Who decides on the focus of nursing services within the context of a whole coordinated service for those experiencing the life-altering effects of mental illness? I agree with Barker that we must define for ourselves the proper focus of nursing, or continue to have it defined for us by the other mental health disciplines who have the power to dictate their agenda of the funding bodies and planners of MH services.*"

In addition to this, nursing as a profession has developed a degree of autonomy and respect within the community that it does not have within more medically dominated and poorly resourced NHS hospital settings. This tends to place acute in-patient nursing staff on the defensive. They tend to see their nursing role as subordinate and ancillary to that of the medical staff in the context of what is, often, a custodial environment.

According to Forrest (1994), one of the biggest problems in attempting to study or to improve acute in-patient services is how best to measure, understand and to work within their very complex dynamics in order to transform nursing practice. In reviewing the therapeutic day, Ehlert and Griffiths (1996) looked at the social environment and social activities on acute wards and found that many were poor and had little to engage anyone undergoing a severe mental health crisis. They also found that both nurses and patients held unfavourable views about the ward. They complained about inadequate staffing levels, the lack of support for staff and patients, the lack of patients' involvement in their own care, and the lack of therapeutic activities available for patients during the course of a day. Some patients stated they were unable even to have a cup of tea when they wished; others said they were bored most of the time and that there was little or nothing for them to do or read, and a few stated that they had no opportunities to involve themselves in activities that would enrich them spiritually.

Consistent with the Sainsbury report are the findings of the Standing Nursing & Midwifery Advisory Group in *Mental Health Nursing: Addressing Acute Concerns* (June 1999). The SNMAC also highlights the severe problems acute in-patient services are experiencing nationally. For effective reform of the acute in-patient system to take place, according to the report, what is clearly needed is a *'change in therapeutic culture'* within the acute in-patient setting [8].

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[8] Concern is expressed by the Department of Health in the report about the present standards of care provided in in-patient settings, particularly patient's dignity and access to therapeutic interventions. Amongst the factors which need urgent attention are:

- *A Deficiency of acute in-patient nursing skills:* The first section the report seeks to account for changes in the demands on the clinical skills of acute mental health nurses over the last few decades and the second reviews the policy framework, which provides the context for future developments in mental health nursing.
- *Pressure on beds:* Along with the Sainsbury Report, the DOH draws attention to the dramatic reduction in the number of in-patient beds since the closure of the large hospitals and the development of community care. In-patients are now much more likely to be severely ill, have a dual diagnosis, and have greater social needs. "*The complexity of the care that patients require is much greater than in the past and yet little attention has been given to the clinical skills and resources that nurses in in-patient facilities require in order to provide care this level."*
- *Nurse training and education:* The training and education of nurses has failed to take this situation into consideration. According to the report. " *In recent years the focus of education, training, status and career opportunities have all shifted from acute in-patient mental health to the community and specialist services. Acute in-patient care is seen as an area attracting specialist expertise despite the increasing complexity of care that in-patients typically require*"
- *Research base and nursing culture*: The poor research base of mental health nursing must be improved to make possible the development of evidence-based guidelines and polices. Research on the components of a therapeutic culture and the skills on the acute mental health nurse should be given priority. Education consortia need to ensure a balance of university-based and work-based courses on all grades of nursing staff in the specific skills that are required to car for patients in the acute phase of illness. Trust and Health Authorities are specially encouraged to review ward staffing levels, skill mix, training and clinical leadership to ensure that staff have the resources they require to provide high quality care.
- *Recommendations: "SNMAC recommends investigation in acute mental health nursing to enable educational opportunities and develop a career structure.*
    - *The poor research base of mental health nursing must be improved to make possible the development of evidence-based guidelines and policies.*
    - *Research on the components of a therapeutic culture and the skills on the acute mental health nurse should be given priority.*
    - *Education consortia need to ensure a balance of university-based and work-based courses for all grades of nursing staff in the specific skills that are required to care for patients in the acute phase of illness.*

But, such a change is clearly dependant on broader systemic and institutional changes within the mental health system as a whole, such as those recommended by the NHS Modernisation Agency booklets on developing and nurturing an 'improvement culture' within the NHS as an organisation [9]. It must become more collaborative and facilitative in its way of operating if it is going to deliver a more client-centred type of care. The way in which decisions are actually made at the management and operational levels will also need to change if a genuine transformation in therapeutic culture is to take place.

Quirk & Lettiot (2002), after looking closely at the available in both historical and sociological context have come to the conclusion that:

- *Despite the development of community care and associated processes of de-institutionalisation, the hospital remains the hub of mental health services in the UK*
- *However, previous quantitative and survey research indicates that quality of care in acute psychiatric admission wards has been compromised or is under threat and points to a bleak experience for people who are admitted. Indicators of this include that there have been increases in admission rates, the proportion of compulsory admissions, and bed occupancy rates*
- *There is also evidence of violence, sexual harassment and substance misuse in this setting, accompanied by rapid staff turnover, low staff morale, and an increasing proportion of 'difficult patients' (especially young men with schizophrenia)*

The authors, both nationally respected researchers, emphasise the fact that although nurse/patient relationships are perceived to be one of the most important aspects of care, yet nurse/patient contact has declined dramatically on acute in-patient wards over the last decades; and patients are now critical of conditions on acute wards and tend to view life there as both boring and unsafe.

  - *Trust and Health Authorities are specifically encouraged to review ward staffing levels, skill mix, training and clinical leadership to ensure that staff have the resources they require to provide high quality care".*

[9] According to the Improvement Leader's Guide to Building and nurturing an improvement culture (NHS Modernisation Agency Series 3 (2004). *"More and more we have realised the importance of building a culture of improvement. However transforming the culture of huge organisations like the NHS and social care with millions of staff is very complicated and will take a long time."* The HSS Modernisation Agency booklet lists a number of factors which make up 'the culture' of an organisation. These include*:*

- *A Culture is about how things are done within your workplace.*
- *The way things are done within your team is heavily influenced by shared unwritten rules*
- *Cultures reflect what has worked 'well' in the past.*

According to the booklet, working in a culture that does not promote improvement would include:

- *Slow and unresponsive decision-making processes that are not understood*
- *Not getting even the basics sorted out*
- *Not sharing information*
- *Seeing training and development as a cynical way of ticking 'the empowered workforce' box*
- *Acceptance of inefficient systems that someone tried to change five years ago: 'There's no point in mentioning that, nothing will happen;*
- *Keeping your head down and doing the minimum required of you.*

Characteristics of an improvement culture would include:

- *Patient or client centeredness.*
- *Belief in the power of human potential*
- *Innovation and change are encouraged*
- *Recognition of the value of leaning*
- *Effective team building and working*
- *Good communications*
- *Honesty and trust*

2.2 Childhood abuse, psychosis, & the dynamics of containment, control and milieu toxicity

Complicating the issue of 'why' managing care on acute in-patient words is now so dangerous and difficult are three interconnected factors, which often, according to Davenport (2002), tend to converge and support each other on acute wards:

1. The relational dynamics of 'adult' survivors of childhood sexual and physical abuse
2. The nature of custodial in-patient care on acute wards
3. The dynamics of psychotic mental states

Along with Davenport (2002), Wurr & Partridge (1996) also maintain that there is a high incidence of people on acute wards today, with various medical psychiatric diagnoses, who have experienced sexual and physical abuse in their childhood. More recently, Hammersley et al. (2004) have highlighted the growing clinical evidence that there is a strong link between childhood abuse and subsequent psychosis in later life [10].

Typical relational dynamics associated with a history of childhood sexual and/or physical abuse would include post-traumatic stress disorder (PTSD), psychological dissociation ('splitting'), drug and alcohol abuse, a pattern of re-victimisation and re-traumatisation, difficulties within relationships in which there is an imbalance of power and the over sexualisation of relationships in general.

According to Davenport (2002), the relationship between patients, many of whom have this history, living together on an acute admission ward in an intimate, but unsafe environment where there are outbreaks of violence and verbal abuse is easily sexualised and vulnerable to exploitation. This dynamic has a confusing impact upon nursing staff, who are normally not trained to deal with these phenomena and who thus get caught up in situations with little if any insight into what is happening. Relationships on the ward are thus easily subverted within a victim/perpetuator dynamic. According to Hammersley (2004) [11]

Some patients become powerless, while others are seen as predatory. Women patients are most often adversely affected. Staff find it particularly challenging to handle these difficulties with sensitivity; they can contribute to poor outcome, characterised by treatment dropouts, lack of meaningful therapeutic relationships and acting-out behaviour. For staff, the outcome is equally poor, with lack of job satisfaction, a high staff turnover and high sickness rates.

According to the now classic paper by Menzies Lyth (1988), a recognised feature of many hospital wards are institutionalised nursing practices and management attitudes that strengthen nursing staff's psychological defences against the

[10] See also Mullen P et al (1993); Read J (1997); and Read J, and Argyle M (1999)

[11] According to Hammersley (2004): "*I have personal experience as a nurse in both in-patient and outpatient settings of disclosures of childhood abuse being made by psychotic patients being dismissed, ignored or marginalised on the grounds that discussion of such issues will make symptoms worse.*"

experience of anxiety. One aspect of these defences is the *avoidance of patient contact* under plausible pretexts.

The Menzies Lyth study concerned general nursing, but Davenport (2002) convincingly applies the findings to acute psychiatric wards. Within this context, at any given time, a number of patients on the ward will be in the midst of a psychotic episode. Aspects of their behaviour and the way they relate to staff and others will be driven by the dynamics typically underlying psychotic states.

Davenport's (2002) thesis is that the dynamics of past abuse in individual patients when brought together with a custodial style of nursing care built upon nursing defences against anxiety, as well as the bizarre behaviour of some psychotic patients, makes the development of a therapeutic culture on acute wards exceedingly difficult. These three dynamics tend to work powerfully together to create a toxic or anti-therapeutic milieu based on denial rather than on trusting therapeutic relationships open to feelings, insight and new learning. The three tables below illustrate how these three dynamics often interact within acute in-patient settings:

Table 1: The dynamics of abuse

IN THE PRESENT	DYSFUNCTIONAL DYNAMIC
Difficulties in establishing trusting relationships with staff.	Manipulation of an unequal power relationship between parent and child for adult gratification leads to long-term difficulties in negotiating trusting relationships.
Poor personal boundaries	Violation of the child through a sexual act may lead to long-term difficulties recognising and maintaining personal boundaries
Re-victimisation syndrome	Early experience creates a strong on-going expectation of repeating the cycle of abuse in the present.
Low self-esteem, self-disgust and self-loathing	The original experience of abuse instils a sense of abuse, both past and present, being deserved
Sexualisation of therapeutic relationships	Early experience of a sexual relationship with a care giver creates the on-going expectation that future care giving relationships will also be sexual or become sexualised
Transference and counter-transference difficulties between staff and patients	Working with survivors of sexual abuse may evoke powerful feelings of rage, disgust and hatred, which may be displaced by the patient and experienced as disabling, confusing or frightening by staff.
After Davenport (2002) adapted	

Table 2: The dynamics of in-patient care on acute wards

IN THE PRESENT ON THE WARD	DYSFUNCTIONAL DYNAMIC
Ritual nursing tasks and procedures performed each day	Ward routine lends stability and consistency to nursing task performance and avoids excessive decision-making, but the progression to compulsive anxiety avoidance-ritual can depersonalise care, reinforce depersonalised ways of relating to patients and to the avoidance of engagement with them.
Resistance to change	Familiar ways of thinking and working are adhered to even when they are dysfunctional, making both patients and staff feel peripheral to and powerless within the routine process of institutional care.
Nursing detachment and denial of feelings	The necessary professional detachment and maintenance of personal boundaries becomes extreme and is characterised by therapeutic withdrawal, poor handovers, rapid staff turnover, failure to follow through care plans and the avoidance of difficult patients.
Collusive redistribution of social roles, e.g. scapegoating	Specific individuals are unconsciously chosen to fulfill a role for the ward and then act upon that role as assigned.
After Menzies Lyth, 1988 adapted	

Table 3: Dynamics of psychosis

THE INDIVIDUAL PATIENT	IMPACT ON WARD DYNAMICS
Psychological splitting	Nursing staff and patient groups are artificially split into good v. bad, us v. them, or victim v. perpetrator
Grandiose omnipotence	Patients (or staff) feel entitled to act as if they are all-powerful or all-knowing
Pathological projective identification	Parts of the self are experienced as intolerable and are projected out into others; others unconsciously respond in accordance with this projection. As patients often project intolerable aggression or rage, staff may be perceived as dangerous.
Persecutory states	Potentially good or popular figures are regarded with intense suspicion.
Inhibition of symbolisation (failure of verbal linking)	The use of pathological projective identification may disrupt rational thinking and good decision making and lead to disordered interpersonal behaviour.
After Davenport (2002) adapted	

The three dynamics described in the above tables can be aptly described as 'toxic' rather than healing or recovery-oriented. Stated briefly, the metaphor of *relationship toxicity* alludes to any interpersonal context within which verbal or physical violence/abuse (either as a perpetuator, victim or silent witness [12]) takes place on a regular basis, as well as to those institutional environments where relationships are characterized by denial, lack of trust, manipulation, defensiveness, poor personal boundaries, and depersonalisation [13].

By way of contrast, *genuinely therapeutic dynamics* are characterised by the core conditions necessary for personal growth, originally identified by Rogers (1951,1961 and 1980), such as mutual positive regard, trust and respect, clear boundaries, openness and honesty, willingness to learn and congruity of thought, feeling and behaviour [14].

The metaphor of relational toxicity has been used for a number of decades in the addictions-recovery movement pioneered by Alcoholics Anonymous in the 1930's (See Kurtz 1979) [15]. It has facilitated a worldwide self-help movement, which has developed very clear concepts about the kinds of relationships, thinking and behaviours that tend to promote recovery from both addiction and relationship disorders and those that do not. The mental health service user/survivor/recovery movement employs similar perspectives on personal growth in conjunction with a hard-won practical wisdom that has many analogues within the self-help addiction and co-dependency recovery movement.

These analogues are instructive and are gradually transforming our understanding of mental health issues, but also the role of service users in developing health-care policy and models of recovery absent from the conventional psychiatric model, which has tended to think primarily in terms of disease/cure in which the helping professional is in charge of the whole process.

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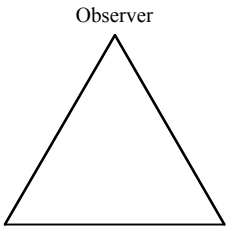
[12] According to Ney and Peters (1995) the typical abuse situation is not a dyad ,but actually a triangle involving the abuser, the abused, and a silent witness to the abuse or bystander who 'does nothing' to stop the abuse.

TRIANGLE OF ABUSE



According to Ney and Peters "*..the observer, the supposedly innocent bystander who is not innocent and often is not simply one person*" is a key component of the dynamic of abuse. Current research suggests that the triangle or triqueta of abuse and neglect can rotate with different circumstances and through time with the people occupying different roles in turn.

[13] See also Kurtz (1979/1991), Friel & Friel (1990), Kellogg (1990), Beattie (1987/1992), Twerski (1990) and Schaef (1986).

[14] Carl Rogers, the originator of what is today known as the *person-centered* or *client centered approach* to care, undertook, with his colleagues, a massive research study in the 1950s to determine what were the 'core therapeutic conditions' of personal growth and recovery. The conclusion of the study was that the school of therapy to which the helper belonged or the specific psychological techniques used bore little relationship to the outcome of counseling. What related more significantly to the positive outcome of counseling and psychological therapies *was the quality of the personal relationship, which developed between the client and the therapist, counselor or person offering help*. The key finding was that human beings become increasingly trustworthy *once they feel at a deep level that their subjective experience is both respected and progressively understood by others*.

[15] See Alcoholics Anonymous (1939/1976) and Narcotics Anonymous (1983)

However, the weight of the responsibility of the 'cure model' in the mental health field is, according to Olthuis (2001), absolutely immense [16]. In reality, this responsibility is just impossible to bear. It also tends to support a dependency and victim mentality in service users by undermining the need for people to take personal responsibility for their own lives, actions and recovery. Over-burdened by their sense of total responsibility for both the behaviour and the recovery of those they seek to cure, many helping professionals tend to see their role primarily in terms of controlling their clients and not in terms of sharing responsibility equally with them in a spirit of collaborative problem solving.

Within this 'control-cure paradigm', according to Olthius (2001), helping professionals naturally tend to interpret situations in such a way that if things go wrong (as they often do), the professional offering the service or 'cure' cannot be blamed. Blame will then be shifted on to colleagues or to the service user and to his or her intransigence. Applied to nursing within this paradigm, one-to-one sessions with patients often become battles of will between the nurse and the patient in which the nurse seeks to ease his or her conscience by pointing at the service users bad behaviour, and failure to co-operate.

And for their part, service users – saddled with the feeling that it is their duty to get better in order to save the nurses' ego – can end up over-complying with whatever help is offered as treatment, by saying and doing exactly those things designed to win the approval of the nursing and medical staff. This is how a 'good patient' should behave. Service users, especially those who have a history of childhood abuse, can thus be profoundly patronised and intimidated by the acute in-patient treatment setting, causing them, in turn, to either close down emotionally or to 'act out' in protest.

So, for Olthius (2001), if we are to overcome such non-therapeutic relationships and treatment environments, the premise is clear. The 'cure paradigm' of control should be replaced with a 'care paradigm' of caring-with. Olthius thus advocates a recovery-oriented and client-centred model based on a partnership between the person in need and those offering help. In addition to this, the responsibility for recovery lies ultimately with the service user not with the helping professional.

Table 4, following, Olthius (2001), contrasts two models or paradigms: the cure paradigm of control-over service users in contrast with the partnership paradigm of caring-with service users. In terms of the discussion above, it is clear that what Rogers (1951 and 1968) first identified as the core personal characteristics necessary to form therapeutic relationships (congruence or genuineness, unconditional positive regard and accurate empathic understanding) are most likely to flourish within the caring-with paradigm based on partnership than it is within the more dictatorial cure-control paradigm.

[16] Olthius (2001) is writing primarily from the perspective of a psychotherapist and counsellor, ,but the issues of cure versus care in the field of counselling and psychotherapy are the same as that within the 'mental health' field.

Table 4: Cure Model of Control versus Care Model of Compassion

CURE PARADIGM OF CONTROL	CARE PARADIGM OF COMPASSION
Power Over	**Power With (Mutual Empowerment)**
Cure	Caring-with
The Expert	The Helper
Technique	Personal- interaction
Detachment	Involvement/Engagement
Impersonal	Personal
One-Directional	Multi-directional
Instrumental Reason	Imagination/Empathy
Dictative/Dictatorial	Collaborative/Partnership
Compliance	Empowerment
Uni-Vocal (Only One Voice Heard)	Multi-Vocal (Many Voices Heard)
Institution-centred	Client-centred
When I Feel Responsible For Others, I…….	**When I Feel Responsible With Others, I…….**
Talk a lot	Listen a Lot
Tell People What to do	Invite
Fix Things/ Withdraw	Attune and Stay With
Protect	Encourage
Rescue	Share
Control	Go With the Flow
Carry Other Peoples Feelings	Show Understanding
Interpret Others Thoughts and Feelings	Encourage Self-Understanding
Make Decisions For Others	Encourage Responsible Decision-Making
After Olthius (adapted)	

2.3 Why don't nurses talk to patients any more?

Davenport's (2002) thesis concerning how the inter-relationship between childhood abuse, psychosis and the dynamics of containment impacts nursing practice on acute wards, when brought together with Olthius' (2001) contrast between a 'cure' versus a 'caring-with' model of interpersonal relations helps explain why nurses tend to avoid patient contact on acute wards even though they may be unaware that they are doing this.

Peter Cambell, a long-term survivor of the mental health system, gives a personal account of the frustration and anger many service users feel as in-patients, because of the fact that nurses claim not to have enough time to talk to them. His testimony is consistent with the current literature. According to Cambell (1999):

People with a mental illness diagnosis often say that they value relationships more than psychiatric drugs.

This coincides with nurses saying how much they value their relationships with their patients. Yet nurses also express frustration and anger as they explain how there is not enough time for them to talk to their patients or to establish meaningful therapeutic relationships with them on acute wards.

Part of this general frustration is compounded, according to the available research, by many nurses' acute *awareness* of the large gap that exists between, on the one hand, the stated values of their profession and personal vocation to be a caring person, and, on the other hand, the harsh reality of poor care experienced by both patients and their relatives [17]. The Department of Health's (1994) mental health nursing review declared:

'The work of mental health nurses rests upon the relationship they have with people who use services. Our recommendations for future action start and finish with this relationship'

But, one could ask, what is the real possibility for developing this kind of partnership between nurse and patient within present acute in-patient settings when nurses do not spend quality time with their patients or talk to them except in summary ways?

According to Cambell (1999), the professional and research consensus is that interactions between service users and nurses have generally improved in the community over the past few decades. The barriers that power imbalances (between those who deliver mental health services and those who use them) used to place along the pathway of therapeutic relations in the past are now generally understood today.

In the more distant past, the role of psychiatric nurse was, according to Sainsbury (1974), clearly defined in terms of a rigid institutional hierarchy in which the patient had the lowest place. Orders were passed down the line. According to Sainsbury (1974)

There was a relationship of authority-submission between nurses and patients, and nurses were expected to direct and manage patients in all their activities. The criterion of the nurse's efficiency was the quietness and tidiness of the ward, rather than the therapeutic atmosphere and the quality of their relationship with their patients.

Cambell reminds us that things have improved considerably since then. Service users are much more powerful today than they were during the high Victorian era and more powerful then they were in the 1960s and 70s. Nevertheless, serious problems and dilemmas still remain within the hospital setting today. According to Cambell (1999)

One of them is why mental health nurses in in-patent settings will not talk to us. Service users clearly expect nurses to talk to them – we may get diagnostic interviews from psychiatrists and group therapy from psychologists, but we expect nurses to talk to us. Ostensibly, that is also what mental health nurses intend to provide. Professor Altschul (1972) has written of the importance of interaction, saying: 'it has meaning, is mutually beneficial and has purpose'*, but*

[17] See Building and nurturing an improvement culture (NHS Modernisation Agency Series 3 (2004).

how much of such interaction do we get and is it becoming more or less common? Unfortunately, patient contact is not a significant priority in the traditional psychiatric hospital.

2.4 The dislocation of appearance and reality on acute wards

Sociological research into the nature of knowledge has demonstrated the many ways in which our knowledge and perception of reality is, in the words of Berger and Luckmann (1966) 'socially constructed'. This has enabled a more self-aware and self-critical appraisal by nurses today of their role within the mental health system of both the past and present and the *historical and ideological factors* which have influenced both the theory and practice of nursing as well as the theory and practice of psychiatric medicine, counselling and psychotherapy. There is, according to Lynch G (1998),

…..an increasing recognition that the cultural and intellectual world that we now inhabit is very different to the one in which therapy originated

The discrepancy between the *stated values* of client-centred care and service user involvement within the nursing profession and the *present reality* of nursing care on acute wards is thus one of the first painful issues that needs to be faced in any serious effort to change nursing practice on acute wards. Contemporary psychiatric nursing in particular is fraught with many dislocations of reality and appearance, which reflect the inner tension between the Victorian and early 20th century origins of psychiatric nursing and its present very different historical context. Contemporary mental health care nursing is thus rife with often unacknowledged philosophical disagreements over the proper focus of mental care, and thus ethical strife.[18]

Ethical strife, according to Lakeman and Curzon (1998) is generated when nurses *strive towards understanding the individual in our care rather than simply relying on psychiatric or diagnostic labels*. Philosophical conflicts (say, over what it means to be a human being) surface where there are sharp disagreements over the proper focus of nursing care. This is especially the case when nurses see their nursing practice compromised or undermined by institutional and administrative practices which they see are clearly disempowering both patients and themselves, practices that are extremely resistive to change or reform. In the literature consulted [19], nurse clinicians and academics as well as service users complain that the gap between nursing theory and practice has never been greater than it is today.

There are complex reasons for this. Peters and Chiverton (2003) observed that where there was focus on a patient's progress this tends to be conceptualised primarily *in medical terms*. In other words, it tends to be constructed in terms of purely medical treatments, new medication or referral to other medical specialities. The result is that doctors tend to dominate decision-making on acute in-patient wards and patients have few opportunities to say how they really feel about things except within formal medical ward rounds lasting about 10 minutes or less. During those few minutes patients must face their psychiatrist, junior medical staff, medical students, the nurse (and often nursing students), the

[18] See Barker and Davidson (ed) (1998
[19] For example, see Nolan P (1999); and Hall B (1996); Horsfall J (1997); and Cambell P (Sept 1999)

social worker, occupational therapist and other helping professionals in a meeting which can involve up to eight to 10 people. Nursing practice, in such a context, tends to subordinate itself to medical interpretations of the patient and the patient's problems. Often the result is the loss of a uniquely nursing perspective.

According to Morrey (1998) Davidson (1998) and Berke (1989), nurses working on hospital acute wards tend to view and talk about the patient as if the person was a passive host of mysterious mental disease processes to be looked after by experts who 'always know best'. They also tend to assume that the patient's own interpretation of his or her experience and symptoms has no or little relevance to their treatment and that 'insight' means agreeing with the doctor or the nurse about the meaning of the patient's symptoms and diagnosis. It is then the job of the nurse to help control or suppress the patient's symptoms of distress, often whilst ignoring the patient's own interpretations or version of events [20].

According to Jourard (1971), much of the professional expertise of psychiatric nurses working in hospitals tends to involve the nurse's

….ability to get patients to conform to the prescribed roles they are supposed to play within the social system of the hospital, so that the system will work as smoothly as possible

Although Jourard was writing over 30 years ago the situation he describes is still current within many hospital settings today, as evidenced by Moorey (1998), Nolan (1999), Hall (1996), Horsfall (1997), Barker et al. (1997) and others. Within a 'containment' or custodial style of care the emphasis falls primarily on the *management of risk* rather than on the recovery of the person in care. Nursing practice in this context tends to value various methods of suppressing symptoms and controlling disturbed behaviour more than learning from the patient about the patient and the nature and meaning of this patient/person's distress from the patient's perspective.

In such an environment, according to both Bray (1998) and Horsfall (1997) the uniqueness of each person receiving care tends to disappear behind diagnostic labels. The person's own voice is easily silenced under such conditions by the authority of professional or bureaucratic language. When that happens, it is more or less inevitable that the relationship between nurse and patient will be a depersonalised one, a relationship which follows a predictable, institutionalised, stereotyped, pattern, not conducive to therapeutic relationships or to genuinely therapeutic conversations.

2.5 Conflicting perspectives on the appropriate focus of nursing care.

Having raised the difficult issue of the 'social construction of reality', it is appropriate for this study to examine briefly those philosophical perspectives which impact on contemporary nursing practice at ward level and on the way in

[20] According to Morrey (1998). - *'Such attitudes are an essential part of the very strategy of professionalism. Professionalism seeks to maximise the amount of social distance between producers and consumers of services and to create conditions of both dependence and uncertainty on the part of consumers, thus being able to control and manipulate them. Laying claim to esoteric knowledge (and the skills which are claimed to follow from this) offers a powerful means of dominating a producer-consumer exchange, and being able to impose what are to be the conditions of exchange.'*

which patients are actually understood and treated. The institutional dislocation between appearance and reality on acute in-patient wards tends, in the view of many clinicians, researchers and academics involved in the mental health field, to recapitulate at the institutional level incompatible conceptions of what it means to be a person as well as conflicting views about the appropriate focus of compassionate care and thus of the nursing task. The literature discussing this issue is extensive [21].

The problem can be expressed in the form of a series of related questions. Should nursing be understood primarily as a reflection of, or an auxiliary to, psychiatric medicine, and work within the parameters of the 'hard sciences'? Or should nursing develop its own methodology and make its own unique contribution to care outside of (but working alongside) the natural sciences? Should mental health nurses be working more (but not exclusively) within the parameters of the social sciences?

Although some nurses still prefer to work within the categories of traditional psychiatric medicine, others are seeking to pioneer a more humanistic and collaborative approach to care which privileges the patient's narrative, concerns and problems (as perceived by the patient) over any professionally constructed 'diagnosis'. According to Barker et al. (1997) nursing care should be located within the context of everyday life and thus be focused on the person's relationship with self and others within the context of their interpersonal world. Nursing practice should be focused on helping people address their human responses to psychiatric disorder, rather than the disorders themselves, which are, by definition, professional constructs.

But, in order for people to do this, nurses must begin to learn to trust the capacity of persons in their care to explore and understand their own troubles, and mental health problems and to resolve these in a climate of warmth, acceptance and understanding. In the absence of such a climate, genuinely therapeutic conversations are, of course, unlikely to happen.

2.6 Contradictions within current mental health nursing theory

Epistemology [22] is that branch of philosophy that deals with the theory of knowledge. In terms of the present debate going on within the theory of nursing, epistemology is the study of our right (or lack of right) to the beliefs we have as nurses about what constitutes good nursing practice. *Ethics,* particularly, the ethics of belief, involves the rules used in evaluating different kinds of beliefs, in this case, beliefs about the nature of human beings and the nature of care.

According to both Horsfall (1997) and the various contributors to *Psychiatric Nursing Ethical Strife* (1998) [23] incoherence in nursing theory arises when the nursing emphasis on care in which the nurse and patient are seen to be

[21] See also Barker, P et al. (2000) and Barker P (1999); Beech I (1999); Beer, Jones and Lipsedge (2000); Bonell C (1999; Drevdahl D (1999); Fabrega, H (2000); Foucault, M (1965); Glaser and Stauss (1967); Grafanaki and McLeod (1999); Hohr, W. K. (1999); Holdsworth N (1995); Horsfall J (1997); *Improvement Leader's Guide to Working in Systems* (NHS Modernisation Agency Series 3 (2004); Keen TM (1999); Kinach, Barbara M. (1995); Kylma J and Vehvilainen-Julkunen K (1997); Leon, Tasman, Lopez-Ibor Jr.,et al (2000); Mohr W (1999); Olthuis, J.H., (2001); Parse RR (1995); and Prior J (2001).
[22] See Honderich, T (ed.) (1995), The Oxford Companion to Philosophy, Oxford University Press.
[23] See Barker P and Davidson B (eds) (1998). *Psychiatric Nursing: Ethical Strife.* Arnold. London

'interdependent' and to be working in collaboration with each other in the context of a personal relationship runs at cross-purposes to materialist epistemologies which see the ideal knowledge situation as depersonalised and entirely objective. When medical understandings of the mind and mental health problems become reductive in this sense (which is not always the case) and are then incorporated uncritically within nursing theory and practice these become riddled with deep epistemological and ethical contradictions, contradictions that have been identified and discussed within the philosophy of mind for over 50 years [24].

In point of fact, Michael Polanyi (1958), the Scottish philosopher John Macmurray (1957 and 1961) and the philosopher of science Thomas Kuhn (1962) have all shown in different ways how the conflict between personal and impersonal forms of knowledge remains counter-productive and is no longer supported within the history of science itself [25]. In its broadest terms it can be seen as a conflict between two irreconcilable life and world-views, that of a basic humanism which is holistically and deeply integrated with basic human ethical values versus a science, which claims complete value and ethical 'neutrality'. This claim can be traced back to the legacy of a particular 19th century philosophical movement called positivism.

Positivism is historically associated with the philosophy of Auguste Comte (1798-1857) [26] who said that the highest form of knowledge is simple description of sensory data and that all that is worth knowing can be reduced to such descriptions [27]. Positivism, in its bio-medical form, seeks a complete account of

[24] The modern conflict between personal and impersonal forms of knowledge is discussed, at depth, by Bernstein, Richard (1983) *Beyond Objectivism And Relativism: Science, Hermeneutics, And Praxis, University of Pennsylvania Press, Philadelphia, USA*; and Nagel, Thomas (1986) *The View From Nowhere*, Oxford University Press, New York; and Searle, J (1999) *Mind, Language and Society: Philosophy in the Real World*, Weidenfeld & Nicolson, London. Searle in particular argues with persuasive examples that most theories of the ideal knowledge situation are beset with a mind/body dualism that entangled in logical contradictions. He identifies the very terminology used in the field (philosophy of mind) as the main source of trouble. He observes that it is a mistake to suppose than an ontology of the mental is objective at all and that the methodology of a science of the mind must concern itself exclusively with directly observable behaviour or a study of neurobiology. He also argues that it is a mistake to suppose that we know of the existence of mental phenomena in other people only or exclusively by observing their physical behaviour. Human behaviour or causal relations to behaviour are not essential, according to Searle, to the existence of mental phenomena. It is inconsistent with what we already know about the universe and our place in it to suppose or to assume that everything is knowable by us or can be known by us. The modern problem of the relationship of a supposedly non-physical 'mind' subject to a law of freedom to a purely physical body subject to a strict cause and effect relations at the bio-chemical level goes back at least to Descartes (1596-1650). According to Bernstein (1983 page 17) *" Few philosophers since Descartes have accepted his sustentative claims, ,but there can be little doubt that the problems, metaphors and questions that he bequeathed to us have been at the very centre of all philosophy since Descartes – problem concerning the foundations of knowledge and the sciences, mind-body dualism, our knowledge of the 'external ' world, how the mind 'represents' this world, the nature of consciousness, thinking, and will, whether physical reality is to be understood as grad mechanism, and how this is compatible with human freedom."*

[25] See Polanyi, Michael (1958). Polanyi in particular has argued that the tendency to make knowledge impersonal in our culture has split fact from value and science from humanity. Polanyi seeks to substitute for the objective, impersonal ideal of scientific detachment an alternative ideal, which gives attention to the personal involvement of the knower in all acts of knowing.

[26] See Urmson, J & Ree, J (eds.) (1991)

[27] Comte had a specific view of positivist science and rationality in mind, which he felt was superior to theology and to philosophy and for this reason, had superseded both in history. Belief in the emancipation of reason from tradition and from religious texts and ecclesial authority made it possible to pioneer a fully modern secularised world with utopian ends in line with the rhetoric of the European Enlightenment. Positivism is thus closely allied with the prestige of scientific empiricism, which denies that there is any knowledge (properly so-called) outside this class of observables. Both positivism and empiricism are inherently reductive in so far as they claim that nothing really worthwhile can be known beyond the senses or beyond that which appears to correlate very highly with observable, measurable data. In other words for positivism *'knowledge' is associated purely with the hypothetical-inductive method of reasoning and denied to other approaches to knowledge.* In our culture the historical connection between positivism, rationalism, empiricism and reductionism is clear at least from the time of the European Enlightenment and this 'tradition' of thought is becoming, as suggested at various points in this paper, increasingly problematic across all academic disciplines since the so-called 'postmodern turn' of the late 20th century.

mental events and human behaviour, including mental health or illness [28], in terms of purely physiological bio-chemical events. However, it is easily shown that a general deterministic theory of the *physiological causation* of human consciousness is philosophically inconsistent as a theory as well as unsuitable as a foundation for an ethical belief system, which could provide a controlling framework for nursing practice as a science of care [29].

Firstly, according to Clouser (1991), who is a philosopher of science, *as a scientific general theory* all such reductionist explanations are self-referentially incoherent. In the specific case of bio-medical reductionism, the inconsistency is due to the fact that purely biomedical explanations of human cognition do not and cannot explain the origins and nature of the theory itself. In other words, those who hold to such a theory are normally unwilling to say that the theory itself is simply the product of the electrical and chemical functioning of their own brains. This would clearly undermine and reduce to absurdity the entire basis of the theory itself, as a credible general scientific theory [30]. And yet logical coherency would require that they say exactly that.

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[28] The arguments against reductive explanations of complex phenomenon are not merely theoretical ,but also practical. Yet the temptation to re-align mental health nursing within a bio-medical paradigm continues to be prevalent within modern psychiatry and has its convinced supporters. ,but as Barker at al (1997) point out-

" Although realignment of nursing within (again) biomedical orthodoxy would simplify the psychiatric service, this simplification might be at the cost of both the development of nursing and, more important, the satisfaction of the human needs of the people defined as the 'mentally ill'. Nurses should treat with caution any attempt to refocus nursing within a biomedical paradigm. The phenomena defined as mental illnesses are two complex to be 'explained away' completely by models of biological causation. Instead, nursing should continue its exploration of what Rosemary Parse (1995) called the 'whole lived experience' of the person in care. This exploration is predicated in the interpersonal process, involving both person-in-care and nurse, and the person and others. Nursing is concerned not to explain, however hypothetically, the origins of the person's mental distress, ,but to assist the many forms of growth and development that are core characteristics of 'being human'. Another perspective on 'the human focus' of psychiatric nursing was recently articulated by Smith (1994) -*' Assumptions that underpin psychiatric nursing [might include]: the nature of humans (the uniqueness of the individual and inalienable rights), society (regarding freedom), health (regarding the right of access to health care) and nursing (i.e. the focus of nursing is human beings). "*

[29] Controversies over the relationship between the mind and the brain (mind/brain dualism) as well as over the nature of consciousness are by their very nature philosophical in nature. Many studies of the 'brain' claim to be studies of the 'mind' without defining how the two are synonymous. According to Barker et al. (1997)-

'If the notion of the 'whole person' is accepted, such distinctions [between mind and brain] become redundant. The use of such distinctions becomes significant, however, when one comes to consider the content of phenomena such as auditory hallucinations. The content of voices saying 'don't act stupid' must surely, in Peplau's view, 'have their origin not in the brain cells ,but in words used by persons in the patient's interpersonal milieu'. All current scanning experiments appear to 'tell us is where the brain does some of the mental stuff'. See Foder, J (1995).

[30] See Clouser R. (1991). According to Clouser, who is a philosopher of science, straightforward logical inconsistency between statements of a scientific theory is not the only type of incoherence. For example, a theory might include a claim, which, while not inconsistent with another statement of the theory, is in some way incompatible with its own truth. In other words a theory must not make any claim that would either cancel out the possibility of its own truth, or cancel out the possibility of KNOWING its truth. If a claim does either of these two things it becomes incoherent when applied to itself. *An example of the first type is the radical sceptical claim that nothing can be known*. Taken without qualification this is self-referentially incoherent statement since to say that 'nothing can be known' is to claim that one knows this statement to be true. The statement thus cancels out its own truth. *An example of the second type of self-referential incoherence is that of biomedical-reductionist theories of human cognition and behaviour*. Another classical example of this type of self-referential incoherence is Freud's famous claim *that every belief is a product of the believer's unconscious emotional needs*. If this claim were to be universally true, it would also have to be true *of itself* since it is the belief of the individual Sigmund Freud. It therefore requires itself to be the product of Freud's own unconscious emotional needs and drives. This would not necessarily make the claim false, ,but it would mean that Freud could not claim to it to be true. The most it would allow him to do would be to admit that he could not help ,but believe it because her was *compelled to believe it because of his own unconscious needs and drives*. And since *the truth of this claim would require that everyone believes whatever they believe for exactly the same reason*, there would be no possible way left for Freud or anyone else to discover whether this particular belief was really true in any meaningful sense or not – including the belief that all beliefs are simply the products unconscious, irrational drives, wish fulfilment, the electrical activity of the brain and so on.

Secondly, *in terms of the ethics of belief*, one cannot posit the physical brain as the exclusive locus and cause (without remainder) [31] of human consciousness, self-awareness and insight and thus of, non-organic mental health problems and *at the same time* advocate genuinely 'humanistic' person centred solutions to care and to the resolution of those functional problems.

Or at least one cannot do so without great inconsistency and without demonstrating a profoundly split and contradictory view of reality, the nature of human being and mental health. Of course this in no way minimises the usefulness of psychiatric medication in the treatment of some conditions or as useful tool to be used in the control or self-management of distressing symptoms of mental disorder (whatever the cause) but that is a different issue.

2.7 Impact of the psychiatric medical model on current nursing practice

According to Clouser (1991) no theory, practice, or institution is neutral with respect to core beliefs. Descending from theory to practice it is clear that what we as individuals believe about human beings will determine to a large extent how we will behave towards ourselves and other people and how, as helping professionals, we will conceptualise the nature of the care we offer to others. Several papers address this issue, especially the need for nursing to establish itself as a form of knowledge (embodying its own values, theory-base and methodology) in its own right alongside other types of knowledge [32] so that nursing practice is informed by its own conception of the meaning of care and is not side-tracked or distracted away from its proper focus within the domain of compassionate care.

In their attempt to formulate standards of good practice psychiatric nurses have often been impeded by the beliefs, assumptions and conceptual parameters of

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[31] Modern materialist biomedical epistemologies hearken back to Democritus and ancient Greek 'atomism' (see Honderich, (1995). in which '*the fortuitous agglomeration of elements or of atoms accounts for the origin of each individual, and the agglomeration disperses totally at death. The breath of life is attri,buted to the phenomenon of the heating and combustion of air, and thought is attri,buted to a spark generated by the 'beating of the heart'. This mechanistic explanation reinforces Gk theories hostile to the reality of the soul, at the same time countering biblical doctrines with its ironic image of the 'breath in the nostrils'* (see also The New Jerusalem Bible, The Book of Wisdom: 2: 2 note c.)

[32] Broad scientific 'general theories', say, the theory of evolution or theories about the relationship between the mind and the body are always philosophically laden; so much so, that they tend to judge in advance what is and what is not to be considered a 'fact'. These theories are, to that extent, examples of circular reasoning, which is more or less unavoidable at that level of abstraction. They are not the same thing as more narrowly defined *specific theories*. And 'in fact' even so-called sensory data is already a theoretical construction, as we have no normal everyday experience of 'sensory data' as such ,but our everyday experience is both integral and pre-theoretical. Contemporary philosophy of science now recognizes that different aspects of the world (i.e. matter and energy, the biological, social, psychological and other aspects) each have their own different epistemologies, different research methods and research criteria. For example, mathematics uses deduction etc., physical sciences use experiment, psychology uses a different type of experiment, using control groups etc., social sciences use surveys, interviews, and the like, to obtain people's interpretations and views. The methods of one science should not be forced on other sciences. To assume that methods of the physical aspect should be applied to all sciences was the mistake the Vienna Circle (positivists) made. Though many academics and researchers have emerged from that misconception today, the general public has not nor have sections of the nursing or medical profession and current 'demands' that nursing practice should be evidence-based is often equivocal and handicapped by this mistake and now outdated misconception. The term '*scientific*' is too often used to mean *'rigorous to the point of being able to prove'*, and all 'science' is seen to be modeled exclusively on the physical sciences. Those methods are suitable for aspects of the world, whose laws are determinative, ,but not for those whose laws are normative, as in the social sciences ,but also within nursing theory and practice ,but also, to a degree, even medicine itself. Finally there is now a well established philosophical argument against materialist, reductionist descriptions of human knowledge and experience which can stand on its own independently of empirical evidence because it is not about empirical evidence at all, one way or the other, ,but about demonstrating (logically) faulty self-contradictory reasoning about empirical evidence. That any theory should be coherent is a prime requirement (amongst several) of good scientific method. If lack of coherency can be demonstrated the theory should be rejected as not meeting the accepted normative standards of sound reasoning.

medical psychiatry in ways that have, until recently, evaded conscious awareness. For example, Hall (1996) argues that nursing still uncritically incorporates assumptions of the psychiatric medical model into its own understanding of the human person and care. The medical model, although appropriate for doctors, is not appropriate for nurses and has not, to date, resulted in any effective *nursing approaches* to the care of people with mental health problems.

Horsfall (1997) also reminds us that modern psychiatric nursing emerged historically under the patronage of Victorian psychiatry in a pre-existing organisational hierarchy in which the medical profession wielded ultimate power and authority over the patient's treatment (Wilson and Kneisl 1992). Thus, a materialist medical epistemology was absorbed uncritically by the nursing profession in its formative stages and became the foundation for much of modern psychiatric training and education. In fact, until recently, psychiatric nursing has, according to Horsfall (1997) more than any other mental health profession, been in thrall to mainstream medical theory. According to Horsfall

As the importance of objectivity, the mind-body split, and a material understanding of the person increased, the values of caring, holism, and self-expertise (of patients and nurses) diminished.

To this day, mainstream bio-medical epistemology proceeds on the philosophical assumption that the psychiatric patient has a disordered *mind* arising from a damaged or diseased *physiology* [33]. The aetiological sites of this malfunction are understood to be lie within aetiological neurotransmitter imbalance, possibly partially genetic in origin, which is to be corrected by means of a specific recourse to chemotherapy. Horsfall draws out several logical and practical consequences of this belief-

Such an orientation ultimately mitigates against the agency of both the psychiatric nurse and the psychiatric service user. What is a consumer to do about his or her terrifying experiences if his or her body is faulty and only medical prescription is offered? What is the nurse to do if mental illness is caused by neurotransmitter excess or depletion and the medication is meant to rectify the uptake at the receptor site? Materialist psychiatric epistemology has profound consequences for psychiatric users and nurses, beyond that of diagnosis and treatment by medication. A focus on the physical indicates a narrow view of patients and of oneself as a person and a nurse. The medical model seriously

[33] Briefly stated, biomedical reductionism in its more extreme or simplistic forms conceptually reduces

- The mind and emotions as well as interpersonal relationships to brain function and
- Disturbed (or disturbing) 'mad' behaviour to chemical or biological or purely genetic factors, and
- Mental health problems to the concept of 'disease' in analogy with physical or organic diseases of the body.

Within this paradigm, a diagnosis of a person's unhappiness and emotional distress is carried out by using standardized published categories, such as found in the latest edition of the DSM-IV which are then correlated with standardized chemical treatments to be found in the British National Formulary. The person's mental health problems then tend to get interpreted purely in terms of malfunctioning neurotransmitters for which groups of psychotropic medications are the designated treatment of choice. The continuing slide towards positivism is reinforced philosophically and under girded financially and institutionally by the vast resources of the multi-national pharmaceutical industry, standardised treatments, political fashion, and alarmist, reporting by the press and media. It is also coherent with the increasing Government demand for effective 'cost effective treatments' within a health care market place. See Barker (1999); Hall (1996); and Nolan 1999b). According to Horsfall (1999). *'Cost effective treatment' in this context equals that treatment which will ensure the most rapid and the cheapest global 'reduction of risk', which will ensure that mentally ill people do not commit crimes or cause a public nuisance. These political and socially reactionary trends continue to encourage the reduction and confinement of in-patient psychiatric nursing to medication administration, assistance with electroconvulsive therapy, observation for medication 'side effects' and giving depot injections to severely mentally ill patients in the community'.*

limits the patient's sense of competence, control, and responsibility. It also excludes or displaces the centrality of the nurse's interpersonal skills in supporting and improving patient resourcefulness and well-being.

Hall (1996) identifies several assumptions underlying the psychiatric medical model and questions these from a more humanistic perspective. She shows how using purely diagnostic medical explanations of the patient's 'problem' is inconsistent with good nursing practice. The author describes the process of her own awakening to how conventional psychiatric thinking was undermining her relationships with patients.

She then offers suggestions for more appropriate nursing practices and strategies as does Evans (2001) who warns that the adoption of chemical therapies should not be employed in place of or at the expense of the holistic approach which is valued so highly by patients, carers and nurses.

The issue raised in different forms by these papers share an over-riding concern with the very real problem of dehumanising treatments and represent what could be called a search for the 'whole person' in care. They are therefore not anti-medical model in tone. As Barker (2003) says, returning to the pioneering work of Hildegard Peplau, medical psychiatric diagnosis represents a useful way of talking about groups of people with similar problems of living, but…

It is largely irrelevant to the consideration of what any individual might need, now, in the name of nursing care. We can answer that only be exploring the widest possible personal context, which will allow us to gain some insight into what is meaningful for this particular person, as opposed to what might be considered 'appropriate; for a group of 'patients'.

Barker (2003) goes on to say that for the past two decades in both the USA and in the UK mental health nurses have started to move away from the strict use of a medical-diagnostic model. Barker continues:

The voice of the nursing process movement urged all nurses to show concern for the person behind the patient label, reminding us to look for 'worth' amid what might seem like insurmountable problems…..

but, he warns:

-There is a grave risk [today] that nursing might drift back into a reductionist approach to care delivery, using medical diagnosis as the primary determinant for the design of care.

On a somewhat different track, Hummelvoll and Steverinson (2001) look at the source of some of the tensions and pressures nurses are experiencing on acute in-patient wards. Their analysis describes in more detail *how* the high-pressure and unpredictable environment of acute wards in combination with short hospital stays is impacting nursing practice. Nursing practice in such contexts tends to be tentative and summary. Nursing care under such circumstances is characterised by great 'therapeutic superficiality'. This constitutes a serious hindrance to nurses encountering the patient as a person. It also prohibits genuinely therapeutic conversations developing between nurses and their patients.

The proper focus of nursing care is distorted, Parse (1999) argues, when the medical specialty of psychiatry is practically and ideologically dominant in relation *to nursing care*. To conceptualise nursing theory and practice in terms of an applied science model, one that combines biology, physiology, and psychiatry but, strangely enough, has no specific knowledge base of its own, is to fail to grasp the true focus and domain of nursing care. Parse is not alone [34] in taking issue with the idea that an applied natural science model should be the template of choice for nursing theory and practice. Although the nurse needs to be informed by medical, biological, pharmacological and other kinds of knowledge these *forms of knowledge* do not and cannot in and of themselves define the heart or unique focus of care.

The preferred alternative is that nursing should be seen as a basic human science with its own unique conceptualisation and contributions to make, one focused on the whole person in relationship to others, to health and to illness. The key concept for Parse is that of 'human becoming' and the fact that people are always in a process of change. The significant structures relevant for nursing are the lived experiences of patents as described by the patients themselves.

Finally, Barker et al. (1997) seek to define the focus of nursing practice in such a way that it is fully outside the perimeters of medical psychiatry. Nurses should acknowledge that the phenomena dealt with by them in the act of care are human responses to various life problems. Nurses do not deal with now, and have never dealt with at any point in history, mental illness per se, as that has always been the psychiatrist's role.

2.8 The starting point of research and the problem of bias.

Although the research methodology of this study will be discussed in **Chapter Three**, the principles and rationale underlying the methodology will be discussed at this point in the literature review.

It has been an essential part of this study to ask the following questions:

- ⇒ How is this study connected to learning, to institutional change, and to nursing theory?
- ⇒ How has the project been effected by on-going operational difficulties within the QEPH acute in-patient service?
- ⇒ How has it been related to present Department of Health guidelines and directives?
- ⇒ How has it been related to the personalities, and experience of nurses in senior management, clinical or teaching positions who have welcomed the initiative?
- ⇒ How does this study relate to the personal bias of the authors of this paper and to their personal beliefs and past experiences of what works and does not work?

Such questions, once asked, according to Mark Fenton (2003), raise critical issues about the very nature of research itself and the evidence base, which should inform good nursing practice. This is especially true for any human science, which seeks to be reflexively self-aware of its commitment to keep its

[34] See also Barker, P. (2001); Barker P and Reynolds B (1997); and Stevenson C (1998).

focus on care. Connected with this is the need for a *kind* of nurse training and education that keeps this focus clear and does not lose it.

One problem that besets conventional research as well as present nursing training and education is their relevance to the real world in which people actually live and work. Thompson and Dowding (2001) found that one of the most influential factors impacting nursing practice is the opinion, recommendations and practices of nursing peers and colleagues, rather than theory or research. In addition to that, nursing practice on acute wards tends to be dictated by what service users are prepared to accept, by the hospital's management and operational policies, by the local 'nursing culture" and by what a hospital is willing to pay for.

Simmons (1995) questions the following three assumptions

1. That decisions about research methods are ever purely objective (in the way usually claimed) or
2. Are ever informed exclusively by the pristine or 'scientific' nature of the research question itself or
3. That research questions ever automatically indicate in and of themselves what approach to use

These three assumptions vastly over-simplify the historical, social, and economic contexts within which all human enquiry and decision-making are embedded. This being the case, Simmons 'grasps the nettle' and recommends that research *bias* is always inevitable, not necessarily a bad thing, and should be harnessed in the cause of doing effective research [35].

One problem that besets nursing research in particular, according to Simmons, is that it usually has no impact at all on actual nursing practice. This is because *most nursing research does not set out to create change in the settings studied*. Researchers usually 'leave the field' unaffected by the research process itself, and this leaves nurses working in the clinical setting seeing little relevance to most research findings, and with little guidance on how to implement the findings even if they wanted to. Therefore Simmons recommends action research as the best way to address this particular problem.

2.9 A commitment to basic principles of action research

This study began as and remains an exercise in action research and grounded theory [36]. According to Newman (2000) and Reason and Bradbury (2001) a basic assumption of action research is that research cannot be divorced from real life. Action research searches for and questions the validity of different types of knowledge, institutional structures and practices, ways of relating and forms of existence. Action research can be applied to establishing and examining why

[35] According to Hans-Georg Gadamer (1975).- '*The self-awareness of the individual is only a flickering in the closed circuits of historical life. That is why the prejudices of the individual, far more than his judgements, constitute the historical reality of his being…What appears to be a limiting prejudice from the point of viewpoint of the absolute self-construction of reason in fact belongs to historical reality itself. If we want to do justice to man's finite, historical mode of being, it is necessary to fundamentally rehabilitate the concept of prejudice and acknowledge the fact that there are legitimate prejudices*'. (pp 276-277).

[36] According to Haig, Biran D, (1995) "*Grounded theory begins by focusing on a specific area of study or concern and then begins gathering data from a wide variety of sources, especially 'interviews and field observations'. Once gathered the data is then 'analysed' and a number of theories are generated with the help of interpretive procedures, before being finally written up and presented. Ideally 'theory' slowly emerges over time from the data rather being made in advance of any data collection*".

when working in the helping professions, people can become so easily trapped in unhelpful and un-therapeutic contexts or 'negative circles' of relating and decision-making.

Action research initiates a focused well-informed course of action into such contexts and begins to reflect on the experience of whatever happens next. This process involves developing a spirit of co-operative inquiry in which all of those involved (nursing staff, managers, patients and service users) become co-researchers whose thinking and experience contribute to the emergence of solutions to the problems, which arise during the project's implementation. *Co-operative inquiry* is thus a form of research as well as a way of working and learning with others in the same organisation who have similar concerns and who, according to Haig (1995):

- Seek to understand what is a shared world in order to make sense of life and to develop new creative ways of looking at things and to learn from experience rather than just recycling all the old problems and explanations
- Want to learn how to act collaboratively with others in order to change things that need changing and to find out how to do things better

2.10 Abductive reasoning

The pragmatic American philosopher Charles Peirce (1839-1914) [37] talks of 'abductive reasoning' [38]. This is a type of reasoning that is prepared to accept a conclusion purely on the grounds that *it appears to satisfactorily explain what evidence is available at the time*. It is the pattern of reasoning most commonly used by ordinary people day by day and is used in both action research and grounded theory [39]. It does not seek to prove that (a) 'causes' (b) in the way typical of the natural sciences and in fact insists that the complexity of some situations prohibits 'proof' of this type.

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[37] See Honderich, T (ed.) (1995)

[38] **Abduction** or "inference to the best explanation "is a form of reasoning based on experience that follows a pattern like this:

D is a collection of data (facts, observations, 'states of affairs' personal testimonies, or 'accepted givens'),
T appears to explain **D** (or would, if true, explain **D**),
No other hypothesis, explains **D** as well as **T** does.

Therefore, **T** is *probably correct*;
or at least it is the best common sense explanation of **D** under the circumstances.

Abduction represents an alternative form of reasoning to the strict canons of RCT's. The strength of an abductive conclusion **T** depends on a number of factors, such as:

- How good **T** is by itself, independently of considering any alternatives,?
- How decisively does **T** surpass alternative explanations?
- How thorough was the search for alternative explanations of 'the problem' and its 'solution', and
- Pragmatic considerations, such
  - The costs of **T** being wrong and the benefits of it being right,
  - How strong is the *need to know, or to come to any conclusion or understanding at all*, especially considering the possibility of seeking further evidence before deciding to take any action on the basis of **T**?
- It is said that the strength of any abductive conclusion **T** depend on the above and other factors, and that it *should* depend on these and similar factors, and that insofar as we are intelligent creatures, our ordinary common sense conclusions based on personal experience will actually depend on factors such as these.

See the Abductive Reasoning Page @ < http://www.cis.ohio-state.edu/lair/Projects/Abduction/abduction.html >

[39] See Glaser and Stauss (1967).

Peirce calls this kind of ordinary reasoning '*inference to the best explanation available at the time'*. This type of reasoning is judged to be *adequate* to most of our purposes in life [40] including, it could be argued those mental health nursing practices, which facilitate good care. But, what would constitute an adequate 'theory' or explanation and justification of these practices? Glaser (1992) gives two basic criteria for judging the adequacy of any theory (or explanation) emerging from such reasoning: firstly that it fits the situation; and that it works –and secondly that it helps the people in the situation to make sense of their experience and to manage the situation better.

One question which arises in such a discussion is: What is adequate evidence and evidence for what purpose? For example, Williams and Garner (2002), two doctors, discuss the host of problems, which are generated when RCT (Random Controlled Trials) becomes the only 'gold standard' for what is considered 'good evidence-based practice' in medicine. Many *medical* practices just do not yield to RCT methodology, but should not, on that basis, be deemed ineffective, irrational or not evidence-based at all. The authors conclude that an exclusive emphasis on narrowly defined evidenced-based criteria drastically oversimplifies and undervalues the complex and interpersonal nature of effective care [41].

Abductive reasoning recognises that a distinction should be made between hypothesis testing (testing some big theory made in advance) and an emergent theory or understanding of a situation involving people in relationship which develops by increments over time. According to Dick (2002) the key to effective research is remaining open to what is actually emerging (in a very global way) once a project such as this gets underway, with a willingness to change course and adapt creatively to whatever does in fact happen within the larger institution as a consequence of undertaking the project.

The danger or temptation is always to move directly to 'premature closure' by forcing some theory on to the evidence generated by the study before any explanation is really warranted or justified at any level of inquiry. In order to remain open to what is actually emerging in the situation one needs, as a researcher, to learn to tolerate:

- A high level of confusion
- Feelings of powerlessness and inadequacy to the job at hand and so on

2.11 Qualitative and quantitative (statistical) evidence

This study seeks to examine *different types of evidence*, generated as part of an action research project undertaken at the QEPH in order to come to a number of conclusions and judgements about those nursing practices which clearly improve the therapeutic experience of patients in contrast with those that do not. So it is important to clarify the nature of this study and the nature of its conclusions and recommendations. According to Stevenson et al. (2002)-

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[40] See Kinach,Barbara M. (1995)

[41] The key point, according to Williams and Garner, is that there are, even in the field of psychiatric medicine many limitations to all RCTs because of variables such as mixed or borderline diagnosis, variations in personality characteristics, social factors and personal history, all of which can and usually are excluded from most RCT studies. Additionally, randomised controlled trials only provide information about groups not about specific individuals. There is also what they call the *'file drawer factor'*. For any given research area one cannot tell how many studies, especially older ones, have already been conducted ,but are not being reported on or referred to or drawn to the attention of the relevant people and thus an excepted part of the discussion.

Research into clinical effectiveness in health care is complicated and cannot mirror the processes of the natural sciences. Consequently, it is important to treat evaluation tentatively…….. Although the Tidal Model has theoretical justification and fits with the recommendations of the National Services framework (DoH 1999), it nevertheless has to be subjected to an evaluation process in order to be classified as evidence-based practice [42].

Bonell (1999) recommends that ideally both qualitative and quantitative methods should be used together in designing any research study. He seeks to dispel the myth that qualitative research methods (such as action research, grounded theory, the use of interviews and focus groups) and quantitative research methods (statistical number crunching) are necessarily opposed.

Whether or not they are in conflict depends entirely on the assumptions and philosophies of the researchers [43]. Therefore the evidence base for this study includes of a mixture of quantitative and qualitative data such as QEPH nursing interviews, audits of nursing documentation of the Tidal Model following its implementation, and the personal testimonies of key people, including service users involved in the project as the process of implementing the Tidal Model on Tolkien unfolded. This evidence has then been examined in the light of the known literature and other studies, which addresses the same or similar issues [44].

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[42] According to Phil Barker, (personal correspondence December 5th 2003) "*Speaking as a researcher with 30 years experience, I do not believe that it is possible to 'prove' in any absolute sense that 'systems' have direct effects on phenomena like 'length of stay' or 'untoward incidents'. All we can say is that there appears to be weak or strong correlations between certain systems and measures of such phenomena. A well-organized and careful evaluation will not be 'rocket science'. Such 'science' is impossible in the social sciences. However, such a careful evaluation will yield some information on what appears to be happening, and 'why' that might be happening. This will help management make decisions as to whether or not this is a good/bad/or indifferent thing. It is worth saying that services have been changed, adapted and modified (often massively) with recourse to nothing other than anecdotal commentary from HAS visitors or CHI inspectors. A careful evaluation may not be wonderful science, ,but (in the absence of major funding - say £300K) is probably the best that can be done in the circumstances* "

[43] According to Bonell, *Quantitative (experimental) research* is not necessarily positivist or reductionist so long as it is made clear that the epistemological assumptions are not absolutized or privileged over other forms of competing knowledge claims. *Qualitative research* needs the support of more experimental approaches if it is to establish 'what is the case' under certain circumstances and in certain contexts. Bonell gives an example of a recent study, which concludes on the basis of a range of specific quantitative outcome measures that care had significantly improved ,but that "*the measures used in the evaluation were informed by prior qualitative work and were properly piloted so that they reflected patients own conceptions and meanings.* 'Also, see Barker P and Davidson B (eds) (1998); Barker P, Reynolds W, Stevenson C (1997); and Simmons S (1995) .

[44] The bringing together of both qualitative and quantitative evidence as part of an action research project and looking at this in relation to other studies of the subject is an example of triangulation. According to Thurmond V (2001) *The point of triangulation*, Journal of Advanced Nursing 33(3) pp -253 – 258: "*Triangulation involves the combination of at least two or more theoretical perspectives, methodological approaches, data sources, investigators, or data analysis methods and so on. The intent of using triangulation is to decrease, negate, or counterbalance the deficiency of a single strategy, theory or approach thus increasing the ability to interpret situations and findings usefully* ". Thurmond outlines various types of triangulation, its advantages and disadvantages. The basic disadvantages of triangulation are primarily practical including:

- *The increased amount of time needed in comparison to single strategies,*
- *The difficulty of dealing with vast amounts of data,*
- *Potential disharmony based on investigator biases and perspectives,*
- *Conflicts between theoretical frameworks or philosophical convictions, and*
- *Lack of understanding about why triangulation strategies are used.*

On the positive side,

- *The use of triangulation will never strengthen a flawed study; rather, it will expose it.*
- *Triangulation can also enhance the completeness and confirmation of findings in qualitative research.*
- *Specifically, the use of BOTH quantitative and qualitative strategies in the same study will strengthen research results and is therefore to be recommended.*

Significantly, for Thurmond: *"If different philosophic and research traditions will help to answer a research question more completely, then research should use triangulation."*

2.12 Conclusion: In search of a non-reductive science of care

According to a number of authors, especially Barker (1999), Sullivan (1998) and Nolan (1999), alternative more humanistic approaches to mental health nursing need to be pioneered in the 21st Century or the problems currently facing NHS Mental Health acute in-patient services will continue to get worse. An essential feature of a balanced model of care is that it will be genuinely holistic, non-reductive, truly collaborative and respectful of the whole person in care and of that person's voice in the context of that person's life-narrative.

The meaning of the stories different people tell about themselves cannot be reduced to the way in which they are functioning (well or poorly) within the different aspects of their lives. The focus of nursing, it is argued, should thus be *upon these stories and upon caring interpersonal relationships located uniquely within the context of everyday life* [45]. But, as all the above authors point out, to re-focus nursing care in this kind of way will require a redefinition of what it means to be a mental health nurse. Such a change will also require major redefinitions of what it means to provide good care within the context of acute in-patient services. Thus, more rigorous attention will need to be given, argues Barker (1999), to nurse training and education for the development of –

a 'critical and informed' self knowledge with more sensitivity and compassionate awareness of the nurse being a fellow human traveller with her or his patients on life's sometimes strenuous, dangerous, but exciting journey into the unknown.

But, in order for this to happen, according to May (1990), nursing, as a profession, will need to make a more robust commitment to the reformation of the institutional context within which nurses are educated and trained and seek to practice if they are to provide a therapeutic environment of nursing care. This is not an easy task.[46] Root and branch reform is necessary to bring present institutional and professional practices in line with basic human values, human rights, and human duties/responsibilities.

One theme that stands out clearly in the papers reviewed above is that the nursing profession is seeking to extricate itself from the medical model not by being 'anti-medical model', but by insisting that nursing is not medicine and should be concerned with fundamentally different issues and practices than medicine. Nursing, in its central focus, is not concerned with 'cure' or medical

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[45] Barker P, Reynolds W, Stevenson C (1997) argue that nursing needs to acknowledge more openly and clearly that fact that the phenomena dealt with by nurses are human responses to various life problems. Psychiatric nurses do not deal with now, and have never dealt with, mental illness per se. *" Concepts such as schizophrenia in particular, and what has 'down the ages' been called 'madness' in general, are no more than ideas about some people, their behaviour and their reported experience, formed through generalisations about the behaviour and reported experience of other people. Even if such ideas had validity, nurses have no responsibility to explain people by use of diagnostic concepts such as schizophrenia. Nursing's task is 'and has always been' to help people deal with the human problems they experience: their responses to what other people call various forms of mental illness. Given this focus, nursing needs to be promoted as a form of human inquiry, (in Paplau's words) ' to help patients [who] are embarked on a search for truth about themselves and their life experiences.* The author's interest in such human inquiry in nursing is linked to the work begun half a century ago with Peplau's theory of interpersonal relations applied to nursing. Nursing's exploration of the human context of being and caring is predicated in the potential for growth and development witch is inherent within each person-called-patient. In the author's view, being with and caring with people-in-care is the process which distinguishes nurses from all other health and social care disciplines, and needs to be recognized also as the process that underpins all psychiatric nursing*"*

[46] As May points out-*" patient difficulties and nurse responses are often mediated and impeded by health systems, hospital procedures, and ritualised professional interactions."* Horsfall (1997) is even more gloomy, saying- *"...a positive, caring, and egalitarian orientation towards others is not likely to emerge easily when both parties [patients and nurses] who should benefit from such changes are comparatively powerless in the face of medical dominance within psychiatric services"*

treatments per se (as these are the concern of the medical profession) but with the person's relationship to health and illness.

According to Olthuis (2001) to dwell exclusively on 'cure' can focus the nurse so much on solutions, answers, and performance that there is little room for the listening, attending, and caring that is required for inner healing, which lies at the heart of therapy. Success in implementing real change in acute in-patient care, according to Griffiths (2002) as well as Rix and Shepherd (2003) requires working in a genuinely collaborative way with commitment at all levels of the organisation including clinical leadership, management support and a wide range of stakeholder input. According to Griffiths:

The problems facing many acute wards may seem utterly daunting, but there does seem to be something in a systematic collaborative approach that can lead to rapid and significant improvements. It requires planning, enthusiasm and commitments. I know the solutions are out there because I have seen them.

Horsfall (1997), however, is not so upbeat:

Humanistic nursing care cannot apply revolutionary leverage to an ossified system. But, it can assist with changing nursing ideas, practices, and workplace cultures at the grassroots level for the benefit of psychiatric service users and nurses. Before humanistic nursing practice can be implemented, contradictory theoretical assumptions need to be uncovered.

Humanistic nursing remains committed to holistic conceptions of nursing care, which, in turn, are based historically on non-reductive views of the human person where the emphasis is on the importance of personal relationships, personal growth and development as well as spirituality and ordinary everyday life as the appropriate context of care [47]

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[47] **Non-reductive views of the human person as the foundation of a nursing science of compassionate care.**

The concept of a non-reductive view of the human person is ancient in origin with roots in the Judeo-Christian revelation of mankind being made 'in the image of God'. The specifically biblical origins of the science of compassionate care can be heard within the biblical commandment that we should love God and our neighbour as ourselves and that doing the will of God is the meaning of temporal, earthly life. ,but this concept also has parallels within the other world religions such as Islam, Hinduism and Buddhism, where, according to the theologian Hans Kung (1990) human being are seen to be dependent in some essential way on what is ultimately divine, that is, we as human beings are dependant on '*That which all else depends, yet which does not depend on anything else for its own existence*" (Clouser 1991).

……

The ideas of the non-reductive view of the person need not be a 'religious' conception at all, and can also be found in the secular tradition of the European Enlightenment in the moral maxim that human beings are to be treated, 'as ends in themselves' from which the entire secular liberal tradition of human rights as well as the concept of client-cantered care have their origin. Non-reductive conceptions of the human person usually rely on some idea of different levels of being. The classical statement of this can be found in E.F Schumacher's A Guide For the Perplexed (1977). Schumacher points out that the universe consists of different levels of being moving from what is 'lower' in the scale of being to what is 'higher'. Thus what is unique to the mineral kingdom (= m), what is unique to the sensitive vegetative life of the plant kingdom (=x), and what is unique to animal life and instinctual awareness (= y) and what is unique to beings as persons (= z) form four separate kingdoms. The higher levels cannot be 'reduced' to the lower. Each 'kingdom' higher on the scale is rooted within the kingdom below it and yet fully transcends it. Thus plants are higher on the scale than stones, animals from plants and human beings from animals. The four great Levels of being can be summed up as follows:

Humanity can be written (m+x+y+z)
Animal can be written (m+x+y)
Plant can be written (m+x)
Mineral can be written (m)

However, according to Schumacher (1977). A Guide For the Perplexed. Chapter Two:

"If, instead of taking "minerals" as our base line and reaching the higher Levels of Being by the addition of powers, we start with the highest level directly known to us--man--we can reach the lower Levels of Being by the progressive subtraction of powers [using the minus sign]. We can thus say:

Man can be written (M)
Animal can be written (M-z)
Plant can be written (M-z-y)
Mineral can be written (M-z-y-x)

Such a downward scheme is easier for us to understand than the upward one, simply because it is closer to our practical experience. We know that all three factors-(x), (y), and (z)--can weaken and die away; we can in fact deliberately destroy them. Self-awareness can disappear while consciousness continues; consciousness can disappear while life continues; and life can disappear leaving an inanimate body behind. We can observe, and in a sense feel, the process of diminution to the point of the apparently total disappearance of self-awareness, consciousness, and life. ,but it is outside our power to give life to inanimate matter, to give consciousness to living matter, and finally to add the power of self-awareness to conscious beings.

What we can do ourselves, we can, in a sense, understand; what we cannot do at all, we cannot understand--not even "in a sense." Evolution as a process of the spontaneous, accidental emergence of the powers of life, consciousness, and self-awareness, out of inanimate matter, is totally incomprehensible. For our purposes, however, there is no need to enter into such speculations at this stage. We hold fast to what we can see and experience: the Universe is as a great hierarchic structure of four markedly different Levels of Being. Each level is obviously a broad band, allowing for higher and lower beings within each band, and the precise determination of where a lower band ends and a higher band begins may sometimes be a matter of difficulty and dispute. The existence of the four kingdoms, however, is not put into question by the fact that some of the frontiers are occasionally disputed. Physics and chemistry deal with the lowest level, "minerals." At this level, (x), (y), and (z)--life, consciousness, and self-awareness--do not exist (or, in any case, are totally inoperative and therefore cannot be noticed). Physics and chemistry can tell us nothing, absolutely nothing, about them. These sciences posses no concepts relating to such powers and are incapable of describing their effects. Where there is life, there is form, Gestalt, which reproduces itself over and over again from seed or similar beginnings, which do not posses this Gestalt ,but develop it in the process of growth. Nothing comparable is to be found in physics or chemistry.

To say that life is nothing ,but a property of certain peculiar combinations of atoms is like saying that Shakespeare's Hamlet is nothing ,but a property of a peculiar combination of letters. The truth is that the peculiar combination of letters is nothing ,but a property of Shakespeare's Hamlet. The French or German versions of the play "own" different combinations of letters.

The extraordinary thing about the modern "life sciences" is that they hardly ever deal with life as such, the factor (x), ,but devote infinite attention to the study and analysis of that physicochemical body that is life's carrier. It may well be that modern science has no method for coming to grips with life as such. If this is so, let it be frankly admitted; there is no excuse for the pretence that life is nothing ,but physics and chemistry.

Nor is there any excuse for the pretence that consciousness is nothing ,but a property of life. To describe an animal as a physiochemical system of extreme complexity is no doubt perfectly correct, except that it misses out on the "animalness" of the animal. Some zoologists, at least, have advanced beyond this level of erudite absurdity and have developed and ability to see in animals more than complex machines. Their influence, however, is as yet deplorably small, and with the increasing "rationalization" of the modern life-style, more and more animals are being treated as if they really were nothing ,but "animal machines." (This is a very telling example of how philosophical theories, no matter how absurd and offensive to common sense, tend to become, after a while, "normal practice" in everyday life.)

All the "humanities," as distinct from the natural sciences, deal in one way or another with factor y--consciousness. ,but a distinction between consciousness (= y) and self-awareness (= z) is seldom drawn. As a result, modern thinking has become increasingly uncertain whether or not there is any "real" difference between animal and man. A great deal of study of the behaviour of animals is being undertaken for the purpose of understanding the nature of man.

This is analogous to studying physics with the hope of learning something about life (= x). Naturally, since man, as it were, contains the three lower Levels of Being, certain things about him can be elucidated by studying minerals, plants, and animals--in fact, everything can be learned about him except that which makes him human All the four constituent elements of the human person (= m+x+y+z) deserve study, ,but there can be little doubt about their relative importance in terms of knowledge for the conduct of our lives."

CHAPTER THREE: METHODOLOGY

3.1 Study design

There have been eight distinct, but complimentary dimensions to this study:

1. A multi-disciplinary literature review was undertaken to determine the state of psychiatric acute admission wards today, the difficulties mental health nurses are facing in this context in their attempt to provide good care, and current nursing opinion on the best way to overcome these problems so that the therapeutic experience of patients on acute wards can be substantially improved.
2. The *aims and objectives* of acute admission wards as understood by nurses at the QEPH was then ascertained and examined.
3. Nurses' perceptions *of the quality of their relationship with patients* on acute wards at the QEPH was then established and examined.
4. *Current nursing practices* on QEPH acute admission wards as discerned by nurses was elicited and examined.
5. *Specific problems and difficulties* that nursing staff were experiencing in their day-to-day work on acute wards has been identified and examined.
6. The Tidal Model has been implemented on Tolkien Ward in an attempt to address some of the problems and difficulties that have been identified.
7. The Tidal Model has been evaluated by way of interviews with service users, staff evaluations and by means of statistical data obtained with the help of the Trust's Research Department.
8. On the basis of the information and learning generated by the above process, a report has been written with specific recommendations to Birmingham and Solihull Mental Health NHS Trust (BSMHT) as to how the therapeutic environment and the running of acute wards at the QEPH can be substantially improved, thus leading to an improvement in patient care and to a substantial improvement in the therapeutic experience of service users.

3.2 Qualitative and quantitative methods of enquiry used in this study

The qualitative methods used by this study have included:

- QEPH recorded interviews of nurses' perception of the quality of care they are providing on the acute wards
- Tolkien Ward nursing staff and MDT evaluations of the Tidal Model
- Tolkien Ward 'away day' nursing staff reflections on the changes in nursing practice on Tolkien Ward which had taken place through use of the Tidal Model
- A Documentation Audit of Tolkien Ward nursing notes.
- Tolkien Ward service user evaluations of the Tidal Model
- Tolkien Ward Manager's testimonial narrative of the process of change management required for successful implementation of the Tidal Model
- Testimonies of senior nurse managers

The quantitative methods used by this study have included:

- Analysis of data from the Risk Management Department
- Analysis of data from the Information Management and Technology (IMT) Department
- Analysis of data from the Complaints Department

3.3 Five questions which have needed an answer

This two-year study has sought to answer five basic questions:

1. What is the nature of the work currently taking place on acute admission wards at the QEPH according to the testimony of the nurses who actually work there?
2. How can the services that nurses provide to patients and their carers within the acute in-patient setting be substantially improved?
3. What kinds of nursing-practices generate a therapeutic (or healthy) as opposed to an anti-therapeutic (or toxic) ward environment?
4. What kinds of continuing education and training/re-training do nurses actually need to ensure that their practices are evidenced-based, client-centred, outcome-effective, and in-line with current protocols of good practice?
5. What kind of policy and management changes need to take place at the QEPH and within the Trust in order to facilitate appropriate changes in nursing practice as well as that of the nursing culture so as to substantially improve the quality of in-patient care?

3.4 Six stages of action research implementation

The carrying out of this project has therefore involved six distinct stages:

1. Undertaking the literature review (**Chapter Two**)
2. Carrying out individual recorded interviews with nurses (Grades A-G) who are normally working as part of a duty rota on acute in-patient admission wards at the Queen Elizabeth Psychiatric Hospital (**Chapter Four**)
3. Introducing a new therapeutic nursing model called the Tidal Model on Tolkien Ward (**Chapters Five & Six**)
4. Assessing and evaluating the implementation of the Tidal Model on Tolkien Ward (**Chapters Seven & Eight**)
5. Writing a report, based on that evaluation, which includes specific recommendations to BSMHT on how best to reform current nursing practice (**Chapter Nine**) in the light of the evidence provided by this study
6. Disseminating the report with its recommendations widely within the Birmingham and Solihull Mental Health NHS Trust and beyond

CHAPTER FOUR:
THE QEPH NURSING STAFF INTERVIEWS

During May and June of 2002, nurses employed within the acute admission wards at the Queen Elizabeth Psychiatric Hospital (QEPH) were approached to participate in recorded interviews regarding their views of their current role and the care they provide. A total of ten qualified nurses participated (Grades D-F). All four acute in-patient wards (Tennyson, Bronte, Owen and Tolkien) were represented. The interview schedule (see Appendix 10.10), was designed to elicit:

- Nurses' understanding of the aims of acute in-patient admission wards
- Their perception of the type and quality of nursing practice on the wards
- Specific problems and difficulties experienced in their day-to-day work

4.1 Thematic analysis of QEPH nursing staff interviews

Following is a thematic analysis of the recorded nurse interviews. The interview schedule and a complete verbatim summary of the transcripts to these interviews may be found in **Appendix 10:10 and 10:11**.

4.1.1 Nurses' perceptions of their role on acute in-patient wards

The nurses were asked what it was like for them working on an acute in-patient ward at the present time. The consensus view was that the wards were extremely hectic and busy with little therapeutic focus. What made them feel most frustrated was that there just was "not enough time to do the job properly":

"I spend most of my time just running around a lot, but at the end of the day what have I actually done?"

There was thus not enough time spent with patients. One reason given for this was the amount of administrative work nurses are required to undertake:

"The paper work I have to do takes me away from the patients. I don't like that."

Only one person said that they enjoyed working within this hectic environment, whilst three felt it was "very stressful". High staff turnover, resulting in "only a few experienced nurses to carry the ward" contributed to the nurses' general feelings of dissatisfaction.

When asked to describe what their actual work entailed, most responses were task-orientated bearing little relation to therapeutic engagement with patients, such as:

- giving out medication
- counting the benzodiazepines
- doing administration
- ward rounds
- doing observations

- checking the staff alarms
- order the meals
- getting information from the Ward Clerk
- most of the time I spend in the office dealing with the doctors and staff issues
- admissions
- dealing with doctors

Only one nurse mentioned patient care plans. Some nurses said a large proportion of their time was taken up with "checking up on bank and agency staff to make sure they are doing their job" and allocating staff to specific duties such as undertaking patient observations. An F grade also said their role was to give support to the nursing team.

It was clear, however, that the nurses, despite this, felt that their primary role should be to "care for patients":

"To listen to them, to be a go-between the patient and the medical staff. To speak for the patient."

"The most important aspect of my job is patient care. But, this means having a well-run ward which is not in chaos so much of the time with only fire-fighting and crisis management the main way of working."

"All the other things I have to do defeats the purpose for why I am here, which is to spend time with and to help patients. That's very frustrating."

Indeed, it was a lack of quality patient contact that most of the nurses said was the part of the job they liked least. The majority cited spending time with patients as the part they liked the most. It was particularly satisfying "*watching patients get better*" when that happened. Some also saw the variety and unique challenges posed on the ward in a positive light: as one nurse said, "*no two days are the same*".

4.1.2 Perceptions of the purpose of acute wards

The nurses were asked what they saw as the purpose of the acute admission ward on which they worked. Many felt the ward should be providing a safe environment for people in crisis, to help them get better. This was seen to involve service users having "someone to talk to" and "getting their medications sorted out". One person additionally commented that the purpose of the ward appeared to be "dealing with anything that comes through the door".

However, in the opinion of the nurses interviewed, not everyone who 'comes through the door' has a serious mental health problem. Although most appear to come in the midst of some kind of "psychiatric breakdown", or, for example, to have their medication reviewed, a large number are seen to be admitted for other reasons:

"In reality it seems like the real reason many are admitted is that they are just not coping with their personal circumstances and relationships."

"We get a lot of patients who are basically in crisis for one reason or another who are not really mentally ill."

Such crises were cited as including drug and alcohol problems, or "even just accommodation problems".

Concern was expressed that some people are admitted to the ward at the expense of others:

"We get a lot of personality disorders. These are the ones who tend to keep being readmitted over and over again, not the people who are genuinely mentally ill."

4.1.3 Perceptions of patients' expectations of care

The nurses shared the opinion that patients' main expectation of in-patient care was to be discharged as soon as possible, "get back out there", but "in a state where they can look after themselves". It was noted that some patients do not appear to know what to expect, especially if it is their first admission. Others, on the other hand, described as the "revolving door" patients, know what to expect and tend to "settle right in" quickly. Two nurses expressed the view that most "patients feel they should be having more contact time with nurses", and yet "often time is not available to them when they need it the most". However, one nurse also commented that:

"Sometimes they expect staff to do everything and sometimes they get resentful and get angry at the idea that they need to take a few steps themselves."

It was noted that there was often very little for the patients to do to occupy themselves on the ward, and it was felt that the restrictions placed on patients, including "being confined to the ward", was an aspect of in-patient care the patients liked least. Despite this, the nurses thought the social aspect of the ward was what patients liked most about their in-patient stay:

"They tend to like socialising with other patients and tend to spend most of their time sitting in the smoking room socialising with other patients."

It was also felt that patients liked "being helped by nurses", and that they sometimes complained when they did not have enough contact with staff. Indeed, as one nurse pointed out, lack of staff contact left patients feeling "angry and neglected":

"One patient said to me that she had been on our ward for a month and not a single nurse had spoken with her about her problems. She said that this had happened on her previous admission as well."

Despite the lack of nurse-patient contact, and the negative feelings that appear to arise from this, all the nurses described their relationships with patients as good or very good.

"I get to like them over a period of time and I would hope they would get to like me."

One nurse defined the roles that they adopted in building relationships with patients:

"Sometimes I take on a parental role because of the state they are in. I like to act as a distant friend or encourager."

4.1.4 Perceptions of the quality of nursing care planning

The nursing staff were asked how well they thought individual care plans worked on their ward. The consensus was that they didn't work very well at all. One nurse commented, "Staff on our ward are too busy to do proper care plans on a regular basis". However, nurses on other wards said that care plans were written, but rarely consulted "except in the case of very difficult patients". Care plans tended to be "more or less the same for each patient", "not really individualised". When they were individualised they tended to be "so long and complicated that nobody bothers to reads them". It was further suggested that:

"Not everyone on the team will agree with the plan a nurse has made because people have different opinions on how to manage things like self-harm and so on. So what's the point?"

It was said that disagreements about the content of individual care plans was often not confined to the clinical team:

"There tends to be a real mismatch between the patients' views of things and the nursing and medical views. So it would not be a good idea to show patients their care plans."

"I know that if I showed patients the care plan I had written for them, many would get angry and upset, so you don't want to upset the applecart."

It appeared that these conflicts were not the only reason why patients were not involved in the development and review of their own care plans. Some nurses felt that "most patients are just not interested", whilst others "are not well enough to set their own goals so we have to step in and do that for them". Once again, lack of time was raised as a key issue justifying the lack of client-centred care planning on the wards.

"We struggle just to do basic nursing care and written care plans just do not feature in that kind of basic nursing at all. There is just not enough time to sit down with patients for 20 minutes or so to do a care plan or review a care plan with them."

The time factor not only hindered patient involvement: it was felt that the wards were too "hectic" or "chaotic" for staff to ensure that the planned care was implemented at all. Care plans were therefore generally seen as merely a paper exercise with little benefit to either staff or patients.

4.1.5 Perceptions of the amount of time spent talking to patients

All of the nurses interviewed commented on how difficult it was for them to organise any regular or structured time with patients on their wards. This was another reason given for not doing regular care plans:

"There is no point in making an appointment to meet up with a patient because often when the time comes you are busy elsewhere doing other things, so what's the point? You just let the patient down."

They did, however, try to find time to spend with individual patients on an ad-hoc basis, for general encouragement or to sort out a crisis, but this tended to be just 15 minutes per shift.

"The longest time I spend with patients is during the ward round in a group setting led by the doctor. That's a shame, but that is the truth."

Unsurprisingly, therefore, none of the nurses spent time with patients in planned structured group settings:

"Groups do start up now and again on our ward through the initiative of one or more nurses, but is soon discontinued because there is not enough time or staff and other activities and duties tend to make running groups impossible."

4.1.6 Nurses' knowledge of models of nursing care

None of the wards appeared to implement any specific model of nursing care:

"Everyone works in his or her own way".

"We joke and say 'eclectic', but in reality we do not have one."

"We are dictated to by the medical model. This is because of the way the hospital is actually run and the way decisions affecting the patient are actually made on the ward by the consultants."

"We do not operate any specific nursing model. There are too many consultants on the ward. Sometimes the ward feels like a busy Accident and Emergency ward."

The nurses were not forthcoming with their knowledge of different models of nursing care, and none could suggest any model that might help improve patient care.

4.1.7 Teamwork issues

Teamwork was considered to be very important, and the nurses felt that the members of their nursing teams worked well together, especially when under pressure which was most of the time. They also recognised situations that caused a breakdown in teamwork:

"*When we don't work well it is usually because of poor communications and everyone being under such stress all the time."*

4.1.8 How, in your opinion, can nursing care be improved?

Many suggestions were made about how the wards could be improved in order to provide better patient care:

- less bank and agency staff
- more qualified staff
- less patients (so more time can be spent with each)
- a better physical environment
- more interview rooms
- time for more one-to-one patient care
- more organised activities
- less 'fire-fighting'
- less paper work
- reduce the number of tasks that do not directly relate to patient care (e.g. answering the telephone, dealing with doctors)

4.2 Concluding remarks

A thematic analysis above has established that in the opinion of the nurses interviewed the nursing care on acute in-patient wards where they work does not reflect, on the whole, principles of good nursing practice. They realise this, but feel there is little or nothing they can do about it because of the busy and often chaotic nature of the ward, lack of time, the way in which in-patient treatment is dominated by medics, and because of nursing administrative activities which keep them away from meaningful patient contact. The predominant feeling is one of frustration and powerlessness to change things. All of these factors, when brought together, appear to preclude genuinely therapeutic conversations developing between nurses and their patients on any kind of regular or structured basis.

On the other hand, nurses agreed that the main way of making improvements for both patients and staff was to free up the nurses' time to allow them to work more closely and collaboratively with patients in a structured manner. It was also suggested that training, for example in counselling skills, would facilitate better engagement with patients further still. But, all were pessimistic about any of this ever happening.

Increased patient contact would have the additional benefit of allowing the nurses to spend less time on the tasks that currently cause frustration: administrative work, "constantly answering the telephone", "being available on demand to doctors" and to other members of the multidisciplinary team and constantly "checking up on bank and agency staff". The nurses also believed that this would result in less tension and aggression on the ward, leading to a more therapeutic environment generally.

Throughout the interviews, there was also a very strong sense of the nurses wanting to reduce the chaotic nature of the wards, which left them feeling so stressed that at times they felt unable to do their jobs properly. But, there

seemed to be no way of doing this. This affected their morale negatively. As one nurse suggested, the first thing that would need to take place before the ward could be improved would be “a morale boost” for the nursing team.

CHAPTER FIVE: WHY THE TIDAL MODEL?

5.1 Recent developments in nursing science

The relatively recent development of involving mental health clients in their own care, especially those in in-patients settings, has become, not without controversy [48], a central tenet of DoH recommendations and directives [49] as well as a central tenet within the contemporary mental health nursing profession itself.

There is a growing body of evidence [50] that the therapeutic experience of patients is enhanced greatly when nurses spend quality time with their patients and where genuinely collaborative client-centred care is adopted as the fundamental principle underlying nursing practice and nursing interventions.

Goodwin et al. (1999) concluded that it is the users of the services themselves who are the best judges of the effectiveness of mental health services. They are the people who are in the best position to identify those factors that promote or block recovery from mental health problems. They recommended that *service providers* pay much closer attention to the experience of *service users* and to use the experiences of service users and 'survivors' of the mental health system as the bedrock for future developments.

Recent studies have shown that in-patient clients who do well are those who relate well to nursing staff, are engaged with, kept informed about their condition, have their therapies explained to them and sense a hopeful attitude on the part of the nursing staff. Clients describe the significance of the ward environment during their stay in hospital and its impact not only on their progress in recovery, but also on the nursing staff who work within it.

Primai et al. (1998) found that it is *the attitudes of the nursing staff* that have the greatest impact on the ward atmosphere and this impact is what influences the extent to which nurses engage with clients [51]. These researchers also found that the quality of the nursing involvement with clients was what clients considered most helpful. High levels of engagement were also influenced by the composition of the care team, but more importantly, according to Mohr (1999) by the characteristics of the dominant nursing culture that prevails within the hospital itself and on the ward. Eklund and Hallberg (2000) report that in an environment where interpersonal skills and engagement with clients is highly valued, job satisfaction tends to be high, as does the level of communication and co-operation between team members and managerial feedback. In such therapeutic environments, all staff regularly have clinical supervision, to which they attribute the success of their ward.

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[48] See Barker P and Davidson B (eds) (1998); Horsfall J (1997); and Hall B (1996)

[49] Clinical Governance: Quality in the New NHS DOH (1999); Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments DOH 2003

[50] See Barker P (1998),(1999), (2001) and Barker P and Reynolds B (1997); also, Goodwin et al (1999); Stevenson (1997); Eklund and Hallberg (2000); Cambell P (Sept 1999) and Acute Problems: A Survey of the Quality of Care in Acute Psychiatric Wards, The Sainsbury Centre for Mental Health (1998), London, The Sainsbury Centre for Mental Health;

[51] This is consistent with both Davenport (2002) and Menzies Lyth (1988) where it is suggested that when nurses complain that 'there is not enough time' to talk with patients what really may be in operation is not an absolute lack of time ,but, rather, unconscious defences against anxiety which reinforce depersonalised ways of relating to patients and ways of avoiding patients through 'excessive business' unwarranted by the actual clinical situation.

5.2 Time as a commodity

Available evidence according to Jackson & Stevenson (1998) also suggests that *nursing perceptions of time*, especially 'lack of time to speak to patients' depends mostly on the attitudes of the staff team and the nursing culture in terms of what is considered to be the highest priority. The amount of time spent talking to patients is also closely related to the degree to which nurses actually value interpersonal helping skills and to whether or not there is regular clinical or non-managerial supervision of the staff team.

It is these factors more than any other types of constraints that determine nursing perceptions about *how much time* is available to engage with patients therapeutically. According to Jackson & Stevenson (1998)

'Time is not absolute and perceptions [of how much time there is to give] are constructed on the basis of many information sources.'

The initial findings of a large study into the 'need for nursing' by Barker et al. concur with a number of other studies [52]. According to Jackson & Stevenson (1998):

"*What makes nursing different from any other discipline of the health care team is the time spent with clients both in social, ordinary relationships, as well as with more therapeutic agendas. What users of mental health services most need from psychiatric and mental health nurses is time to form relationships and to talk."*

5.3 Use of the Tidal Model as a means to reforming nursing practice

A decision was made to introduce the Tidal Model on Tolkien Ward in an attempt to significantly increase the frequency and quality of therapeutic nurse-patient contact on the ward, to ensure that care plans were being done on a more consistent basis according to genuinely client-centred principles in the hope of reducing the often chaotic atmosphere of the ward. It was felt that the use of the Tidal Model nursing manual [53] in conjunction with appropriate re-training would supply the necessary tools and structure for this to begin to happen, even though a number of staff were pessimistic about the possibility of any significant changes taking place.

It was clear that the following changes were necessary if nursing practice was going to improve on Tolkien Ward.

- Nurses on Tolkien Ward needed to spend more quality time with their patients in order to engage therapeutically with them
- Appropriate nursing holistic assessment and care planning tools needed to be in place to facilitate this
- Nurses needed to be properly educated and trained to work in a truly collaborative spirit with their patients and in an appropriate client-centred

[52] See Strang J (1982); McIntyre, K., Farrell., & David, A.S. (1989); Davidson, B (1992); and DiSisto M et al. (1995)
[53] Barker P (2000) The Tidal Model: Theory and Practice, unpublished manual reproduced under licence agreement by the Birmingham and Solihull Mental Health NSA Trust

way. Some nurses working on the ward appeared to lack basic counselling and interviewing skills [54]

- ❖ All of these changes, it was agreed, were inter-related and thus required the kind of integrated evidenced-based holistic approach to nursing care and practice exemplified by the Tidal Model

5.4 Origins of the Tidal Model

The Tidal Model was originally developed from a Newcastle University 5-year study of the 'need for nursing' by Barker, Jackson and Stevenson (1999). Using grounded theory methodology, a substantive theory of nursing practice emerged based on the perceived need for mental health nursing care. This study involved six sites from England, Eire and Northern Ireland and discovered a consensus across both the receivers and providers of mental health care that the essential feature of mental health nursing (the core category) involved a complex set of personal relationships: "*knowing you, knowing me*". The emergent theory confirmed present understandings of the centrality of good interpersonal relationships in the healing of persons with mental health problems and confirmed that this understanding should inform nursing care and practice.

As a theory-based approach to psychiatric and mental health nursing the Tidal Model emphasises the central importance of:

- ❑ Developing an understanding of the person's nursing needs through collaborative, client-centred nursing practices
- ❑ Developing therapeutic relationships through discrete methods of active empowerment
- ❑ Establishing nursing as an educative element at the very heart of interdisciplinary intervention

A key mental health nursing task, according to the Tidal Model, is to focus on the personal experience of the patient in the current moment of time. By maintaining that focus, according to Barker and Reynolds (1997) the nurse gains an appreciation of '*Who this person is'* as well as that person's *human needs* and what needs to be done to address them.

To first find and then keep this focus involves listening carefully and respectfully to patient's unique story, which then becomes the context of care planning. The patient's needs and wishes are the heart of the caring process. This means nursing assessments and care planning with the patient avoid professional jargon or medical constructions of the person's problem preferring, instead, the use of ordinary everyday language.

One purpose of nursing care planning is to help patients to identify their own problems and needs. This is undertaken by way of an initial formal holistic nursing assessment which is completed with the nurse, but written in the patient's own words.

[54] Although some nurses had attended various courses on subjects like BCT the skills acquired were not normally transferable to the unique context of acute admission work with its relatively high level of clinical activity.

5.5 The theoretical basis of the Tidal Model – a thumb-nail sketch

Briefly stated, the Tidal Model draws on five overlapping theoretical frameworks.

1. The theory of psychiatric and mental health nursing developed by Barker, Jackson and Stevenson from the 'Need for Psychiatric Nursing Study' (1998)
2. The interpersonal paradigm of nursing developed by Hildegard Peplau (1952/1988)
3. The various theories of empowerment within interpersonal relationships and educational environments
4. An empowering-interactions model of mental health nursing developed by Barker et al. (2000) in the context of community mental health work
5. Chaos theory, where the unpredictable – yet bounded – nature of human behaviour and experience can be compared to the flow and power of water provides the core metaphor of the Tidal Model. See Barker (2000)

5.6 Introducing the holistic nursing assessment of patients' needs

The holistic assessment, according to Barker (2003:74) involves:

….dipping into a complex bag of tools in search of the one tool (or combination of tools) that will unlock our understanding of the person's problems – or shared understanding with the person of 'what is really going on, and what might be done in response to this'. We might assess people:

- *To find out who they are – as in the life profile*
- *To describe and measure specific 'problems of living' – as in the problem-oriented interview; or*
- *To describe their assets and personal and social resources – as in the strengths assessment*

5.6.1 Holistic assessments and other types of professional assessments

Traditional professional assessments (medical, psychological, or social work) are designed to break down the 'whole' person into different aspects of functioning, and into constituent 'sub-problems' in terms of psychiatric diagnosis, psychological functioning, social functioning and so on. The assessment is usually written in the professional terminology of the discipline to which the assessor belongs and within which she or he has been trained. In addition to this, traditional assessments tend to be based on a highly professional relationship in which the assessor, not the client, is seen to be 'the expert' and the authority on the patient's problem. The Tidal Model nursing holistic assessment differs from these in the following important ways:

- The nursing holistic assessment is focused on the person's experience of their problems and needs, health or distress right here and now [55].

[55] See Barker *The Tidal Model: Theory and Practice* (2000)

- The nursing assessment of need seeks to draw together, as far as possible, the person's whole experience and seeks to produce a representation of the person's problems in ways that seem real to the person and reflect accurately the person's understanding of 'the problem'.
- The results of the nursing holistic assessment are thus presented in the person's own words or 'voice' and not in a professional language.
- The nursing assessment emphasises collaboration and dialogue, and recognises that the person in care is the 'expert' on their own problems and needs. To this extent the nursing assessment does not seek to be a 'professional construction' of the problem (in the same way that a psychiatrist or psychologist would seek to do that) but seeks an understanding of the patient's world in terms of the lived experience of the patient and seeks to expresses this in ordinary language that makes room for both mutual learning with the client and collaborative problem resolution.

5.7 Daily care plans

The task is then for nurses to sit down with patients on a daily basis to review and to construct with them practical plans which accurately reflect the person's own understanding of their present, medium or long-term goals. The purpose of good care planning is to work on problems, which are of concern to the patient especially in those areas where the person's mental health and human functioning are at issue.

The holistic assessment and daily care plans, with supporting documentation, are just two of a number of practical tools provided in the Tidal Model nursing manual. Key to implementing the Tidal Model is ensuring that every nurse has a copy of the manual, which by teaching and example is specifically designed to empower nurses to foster:

- *Engagement* with the client vs. distanced and merely custodial 'observation'
- *Collaboration* with the client vs. a dictative or authoritarian approach
- *Empowerment* of the client through privileging the client's self-narrative and self-description as the primary locus of engagement within which solutions to problems are discovered and worked through
- *A way of working with clients* that avoids and resists the imposition of professional constructions and interpretations of the clients' problems

5.8 Evidence of clinical effectiveness of the Tidal Model from other pilot sites.

Fletcher & Stevenson (2001) give the results of a pilot study on the introduction of the Tidal Model on two wards in the acute health services in Newcastle City Health Trust. This was followed by introduction of the model into all nine adult acute wards in the service. One ward was evaluated for six months before and after introducing the model. Nurses' perceptions of the model were then assessed using questionnaires. Initial results indicate that after implementing the Tidal Model:

- There was an increase in the number of people admitted on an informal basis
- A reduction in the number of people subject to sections of the MHA
- The number of admission for the post-test period doubled
- The length of stay decreased by 24%
- The number of violent incidents decreased by 40%
- Episodes of self-harm decreased by 6%
- The use of restraint decreased by 67%
- The interval between admission and full initial assessment was reduced to an average of 1.3 days (from 3 days)

Staff questionnaires elicited the following responses:

- *I enjoy working within the Tidal Model. It gives me as a nurse a unique way of working – it gives nurses more power*
- *I think the Tidal Model has improved standards of care because it makes nurses listen and talk with the patients. Some people used to shy away from this*
- *It gives the empowerment to the patient by planning their own care with support from staff. It appears to work with all types of mental health problems*
- *The model allows truly patient-centred care, rather than just rhetoric about it*
- *The model helps us formally access the suicide risk. Before, it was just nurses' and doctors' intuition*

Stevenson et al. (2002) report in even more detail on this project and ends by saying:

After a two-year pilot phase the Tidal Model was introduced in May 2000 across the whole Adult Mental Health Programme in Newcastle and North Tyneside, comprising eight admission wards, a 'step down' sub-acute unit based in the community, and all associated community support teams. A number of supplementary pilot sites have been established in several countries – Australia, Ireland, Japan, New Zealand, Scotland and Wales – across a wide range of clinical settings; from a rural mental health service in Adelaide, Australia, and a Maori forensic mental health service in Porirua, New Zealand, to a rehabilitation service in Glamorgan, Wales. These additional pilot sites (numbering 15 at the time of writing) will allow a degree of cross-national as well as cross-cultural evaluations of the model in action.

Finally, Cook at al. (2003) report on an evaluation of the Tidal Model within a Maori forensic unit based in Rangupapa, New Zealand. The outcomes of this study suggest that the implementation of the Tidal Model has resulted in positive experiences for both nurses and patients, as well as other identifiable beneficial outcomes. The Tidal model, according to this report:

….supported the nurse's ability to provide nursing that was directed from the patient's narrative as well as other factors for the person concerned. The themes that arose from this research project show that the impact of the model was empowering for the patients, their families and thus nurses.

The participant patients were supported and encouraged to take an active part in the direction and implementation of their nursing care. The patient's experience was realised through mutual discussion. Their ability to identify their own needs and co-create their care goals with the nurse supporting them is consistent with a recovery approach. This enabled the nurse to focus on the kind of care the patient needed as they took steps on their own recovery processes. The researchers intend to undertake further analysis in relation to a recovery approach and report their findings separately"

CHAPTER SIX: NARRATIVES OF CHANGE

6.1 How the Tidal Model was implemented on Tolkien Ward By Graham Brooks – Ward Manager

This narrative section has been written by the Ward Manager of Tolkien Ward who describes how the Tidal Model was implemented on Tolkien Ward, what decisions were made, why they were made and the effects on the care delivered on the ward. In addition to this, he gives an analysis of what worked and what didn't, the successes and the mistakes, the hurdles that had to be overcome, the mountains the staff team had to go round and how they slayed a few 'dragons' on the way.

6.1.1 Implementation strategy

The choice of Tolkien Ward as the pilot project site for implementation of the Tidal Model at the QEPH was made prior to my coming to the ward as Deputy Ward Manager in May 2002. When I arrived on the ward the plan was for the Ward Manger, myself and the other Deputy Ward Manager to receive training in the basic Tidal Model principles of nursing practice. From there, decisions would be made about how the Model would be implemented.

In order to do this, there was an away day for the three of us with the Lead Project Nurse to provide this training and make decisions on how best to begin and then carry through implementation. We agreed on a number of things that would have to be in place if the model was to be implemented successfully on the ward.

6.1.2 Tidal Model Induction Day

Various aspects of how the model would be implemented were discussed, but it was agreed that for the model to be implemented successfully on the ward then Nursing Assistants would have to be much more involved in the nursing process than they had traditionally been. This included engaging with patients in a structured manner, being involved in and able to contribute to aspects of care planning and regularly writing in the nursing notes. We did not want the Tidal Model to be seen purely as yet another domain of the Qualified Nurses, but something that could be 'owned' by all the staff on the ward. Therefore, we felt it was vital that Nursing Assistants would carry out some of the daily care plan assessments. Secondly, all clinical grades of staff working regularly on the ward would be involved in a full training day. The purpose of these 'Tidal Model Induction Days', which were facilitated by the Project Nurse, was to provide a basic introduction to both the theory and the practice of the Tidal Model for all staff.

The day involved a PowerPoint presentation on the historical background and theory of the Tidal Model, with opportunities for staff to ask questions and a video presentation of a nursing holistic assessment. Participants were then given an opportunity to construct a core care plan based on the video example of the holistic assessment and to reflect on their present practice. This was followed in

the afternoon by a role-play session where participants had the opportunity to use the holistic assessment form by experiencing interviewing, being interviewed by other participants and observing the process.

It was recognised that this one-day training did not cover all of the training needs of the nursing staff, but it would be sufficient to start implementing the model and it remains a basic feature of the training of new staff who come to work on the ward. It was also felt that it was necessary for Nursing Assistants to receive the same basic training in the Tidal Model as Qualified Nurses.

6.1.3 Preparing the ground

The training of the whole staff team was carried out over a six-week period (one day per week) from July 2002 through to September 2002 by way of allowing a study day for staff to attend and sending approximately six staff per day. A mix of graded staff were sent on each day to ensure that there was not a problem with staffing the ward. This also included Student Nurses who were on placement on the ward at that time.

6.1.4 Nursing attitudes to training

This was not an easy or straightforward task. A number of staff on the ward at that time had a record of not attending training days when nominated to go and expressed negative views about such days. Non-attendance was usually due to sickness or to avoidance, such as claiming they had forgotten that they had to attend on that day, attending on the wrong day etc. Training courses were seen as an inconvenience, an interruption to the normal routine and not held in very high regard. The situation was compounded by the systems in place at the time, which made it difficult to monitor attendance of training courses, such as little or no feedback about attendance.

To combat this negativity and to avoid 'confusion' all staff were informed in writing when they were expected to attend. This was verbally confirmed when they were given the letter and it was made clear on the off-duty what staff were meant to be doing on that day. In addition, I requested feedback on attendance from the Project Nurse. These steps proved to be successful. Out of a total of 29 staff and students, 24 attended as nominated, three had to attend a later session due to non-attendance (various reasons) and two, who had been on long term sickness, attended the next training day after the launch of the model on the ward. Also included in these training days was the Ward Clerk to help facilitate the administration of the project.

6.1.5 Redesigning the nursing documentation

The next part of the project was to redesign the nursing process and its documentation. It had been some while since the existing process and documentation had been formally reviewed. Forms had changed over a period of years. There was no cohesion to the documentation and the presentation looked shabby.

It was immediately obvious that the forms used on the ward were not suitable for the assessments and care planning aspects of the Tidal Model. In addition to this, it was felt that there were deficiencies in the existing admission

documentation. For example, there was no place for recording necessary relevant information or contact details of others involved in a patient's care, which was therefore very time consuming to find when needed. This contributed to inefficiency. So the opportunity was taken to revamp the entire nursing process documentation.

We felt it important to make the new forms, based on Tidal Model principles, as adaptable as possible so that it would be easy to make changes based on observations whilst it was being used. As a starting point, the examples of the documentation included in the Tidal Model book were used as a template. However, there were no copies of the forms on computer disc and scanning them proved problematic so they had to be re-designed from scratch. Other forms, examples of which are included in the **Appendix** to this report, were created in a similar style. It was also decided to use different colour paper for different categories of forms to make them easier to locate.

This was completed and circulated to all interested parties for approval, which was granted with a few minor alterations for legal reasons.

6.1.6 Changes in management

It was at about this time that the Ward Manager decided to take one year's sabbatical leave. I applied for the temporary Ward Manager's post and was successful in obtaining the position. From the perspective of continuity for the project this was beneficial, as I had been at the centre of the decision process with Bill Gordon and the Project's Steering Committee from when I first arrived on the ward. I was also aware of the many difficult changes in working practice that would be needed to create the time for the nursing assessments and care planning to take place and I had ideas of how they could be made.

6.1.7 "T DAY"

The next step was to agree on a day when the ward would officially 'convert' to the Tidal Model. By now all the paperwork was ready, the majority of the staff had been trained and the patients on the ward at the time had been made aware of what was happening and how it would affect them. This was done by way of the weekly Community Meeting, which had been set up on the ward. We agreed that there would always be a reason not to implement it, such as staff on holiday or high clinical activity, so we set a date and stuck to it. The date we chose was 5th October 2002 and this became known as 'T Day'. We decided to make 'T Day' a Saturday as the weekend tended to be quieter than weekdays and would make it easier to change over to the new nursing process documentation.

Initially, we put all new admissions from the community onto the Tidal Model when they came in. We also put patients who had been admitted to different wards, but came within our catchment area onto the Tidal Model when they were transferred to Tolkien Ward.

6.1.8 Bed management issues

Implementing the Tidal Modal on Tolkien Ward has been an uphill struggle because, at times, the needs of the project have been in conflict with the hospital's administrative and bed management policies. The bed management

policy for the QEPH at the time was to admit to the 'host' ward and to transfer out a patient was deemed more settled in order to free up a bed.

As the only ward operating the Tidal Model we all had some concerns about this. This policy meant that patients who had been initially admitted and started on the Tidal Model and benefiting from that were suddenly transferred to another ward when their bed was needed for a new admission, possibly losing the benefit they had gained.

Our bed occupancy ran at about 110-120% so this happened very frequently. It took a lot of negotiating with the Duty Nurse (who all admissions came through) to keep the problem to a minimum. However, this was one of the 'dragons' we came across where hospital policies had priority over the needs of the pilot project.

This led to a constant 'watering down' of what we were trying to do. It also led to increasing patient dissatisfaction, as they did not get the same level of structured nursing intervention on the other acute wards. The policy was eventually changed, about six months after 'T Day', although not due to the problems we had identified. There was a consensus between medical and nursing staff that the policy was creating a poor experience for patients throughout the hospital. From then on the policy was to admit to where the bed was and to repatriate when possible in a controlled way. This has helped maintain the consistency of the project, but the staff on the ward have had to be watchful that the new policy is upheld.

We discussed, as a team, what we should do when patients who come under the catchment area of other wards are admitted to Tolkien Ward, as this happens regularly. The concept of nursing them under the 'old' system was rejected as unworkable. It is not felt to be possible to run the old and the new nursing process together side by side on the same ward. Generally, patients from other catchment areas who have been admitted to Tolkien Ward tend to stay on Tolkien Ward rather than being transferred to their host ward.

We also explored the possibility of patients from our own catchment area who were being nursed on the Intensive Care Unit (ICU) being nursed under the Tidal Model. However, this was soon discounted as impractical due to the different systems being operated on the two wards and to the limitations of the staffing establishment.

6.1.9 The Tidal Nurse

To help the project get fully underway and to reinforce and consolidate the training that the staff had already received, we decided that every member of staff, including A Graders, should have the experience of working one week as the lead 'Tidal Nurse' on a rotational basis. During that week the member designated 'Tidal Nurse' would be supernumerary and responsible for ensuring that the initial Tidal holistic nursing assessments and daily care plans were being carried out on a daily basis. The plan was not for them to do all the assessments and care planning, but to facilitate that process.

In practice, the Tidal Nurse would, on occasion, go back into the official numbers to free up another member of staff to come out so that other staff could carry out

the care plans, engage with patients in-line with the new nursing process and gain valuable experience. This was never planned to be a permanent feature, but as a key aspect of staff training that would last about six months whilst the Tidal Model became embedded into the culture of the ward. On the whole, this system worked very well for a while and gave everyone increasing confidence in carrying out the assessments and care planning.

Unfortunately, this process became diluted on occasion due to staffing shortfalls when it was necessary to include the Tidal Nurse in the numbers when it was not possible to provide additional staff to cover. It was further complicated by budgetary constraints.

6.1.10 Budgetary constraints

The acute wards at the QEPH are perceived to be constantly running over their budgets. This had a negative impact on the work we were trying to do as a pilot project. We did all we could to operate in as cost effective way as possible. On the other hand we had no extra budget or resources over and beyond the input of the Project Nurse to implement the changes. We were running at a comparative level to the other acute wards who were not undertaking a major reform of nursing practice. Consequently, a lot of questions were asked about the viability of the 'Tidal Nurse' concept and despite explaining what we were trying to achieve by doing this, after negotiation with Senior Management, we reluctantly agreed that we would stop the practice of having a supernumerary nurse.

6.1.11 A temporary reprieve for the Tidal Nurse

Shortly afterwards there was an unexpected need within the hospital to temporarily re-deploy a senior nurse from another area. Senior Management decided to place her on Tolkien Ward to assist us with Tidal Model implementation. The original plan was that she would be supernumerary and would not be included in the numbers. This was possible because her salary was not linked to Tolkien Ward's budget. It was also felt that because of her experience she could act as the 'Tidal Nurse' whilst she was based on the ward.

We all had misgivings about this as we felt that our regular staff would not be gaining the experience they needed from adopting that role themselves. But, I decided to proceed on this basis. Fortunately, our concerns proved to be unfounded and this proved to be a very beneficial thing. The staff team learnt a lot about engagement and working with patients from the new nurse and after a while she spent more time coming into the numbers than being supernumerary. This 'Tidal Nurse' process therefore continued until a permanent post was found elsewhere for the nurse. By this time Tidal had become firmly embedded into the fabric of the ward.

On reflection, we all feel that using the original 'Tidal Nurse' concept (all staff having the experience on a rotational basis) was a very helpful and effective approach to staff training and development and I would recommend that this approach be used should the Tidal Model be implemented elsewhere within the Trust. Obviously it does have temporary cost implications, but the benefit to the staff and to the task of initial Tidal implementation far outweighs this.

6.1.12 Challenging the previous nursing culture

The Tidal Model has not been popular with all staff. However, as highlighted elsewhere in the report, the general reaction has been very positive. This is reflected in the staff interviews and was the consensus of the staff away day (see **Chapter 7.1.2 –7.1.3**). Nevertheless, for various reasons, some staff have not been in favour of it. During the first year of the project, there has continued to be a high turnover of staff on the ward. In most cases they have gone on to 'more responsible' posts.

From talking to staff on other wards and in different Trusts it appears that there is often a misconception of what the Tidal Model is actually about. Apart from the expected resistance to change, some staff are worried that the Tidal Model asks them to work harder than they already do at present at a time when they feel they are already working too hard in a very stressed environment. There are also those staff who like the status quo, who don't want to do the job in a more professional way or in a way that is different from the way they have always worked in the past. There is also the issue of lack of confidence in carrying out the assessments and care plans. And there are also those who seem to thrive in the chaos that used to be, and on occasion still is, prevalent on the ward.

6.1.13 Accountability and work delegation

One of the biggest problems that I encountered when I first began to work on the ward as a Deputy Ward Manager was a lack of accountability within the staff team. Tasks were delegated to staff, but these were often not done and there appeared to be little in the way of monitoring performance. I felt strongly that this needed addressing so that the Tidal Model could be successfully launched.

The main way this was dealt with was to get organised at the beginning of each shift. This meant properly and officially nominating who would be responsible for various tasks, when work-breaks would be taken, designating who would carry out observations and when. The issue was making sure this was obvious to everyone. This was generally adhered to, but was not popular with some staff who were used to a more ad-hoc approach. We also introduced a Tidal Diary which was an up-to-date record of which patients had had their daily care plans completed, when they were done and who did it. This kind of approach soon made it obvious who was shirking their responsibilities. I believe that this was a factor in why some staff asked for a transfer to other wards and why others moved on.

Over time, the effect of this has been that most of the staff on the ward now want to be there and are happy to be working with the Tidal Model. The last four months have seen a period of stability in the staffing on the ward. However, I feel that this pattern and the issues it raises will be repeated anywhere the Tidal Model and a structured way of working is implemented. It is thus imperative that all staff should be involved with the decision of when and how to roll it out.

6.1.14 The use of Bank Nursing Staff

The other main issue of concern is the use of Bank staff. During periods of staffing instability and also at times of high observation levels, it has been necessary to use Bank Nurses. We worked hard to ensure our skill mix was as robust as possible with the resources available and that wherever possible we minimised the use of bank staff. However, the Project Nurse and myself anticipated that this would be an issue and we agreed that we should do our best to train the Bank Nurses we used on a regular basis.

This was arranged and carried out at the ward's expense. However, we soon discovered that the Bank staff we had trained were working on other wards at the same time that we were being sent Bank staff who had not been trained in the Tidal Model. When I spoke to the staff concerned they reassured me that they had wanted to work on Tolkien Ward, but that the Resource Department had arranged this.

I brought this up with the Resource Department and it was explained to me that vacancies were filled by allocating the staff who declared themselves available for work on a 'first come, first served basis'. I explained the rationale behind what we had done and tried to negotiate for us to have first use of those Bank nurses we had trained and who had indicated that, if given the choice, they would prefer to work on Tolkien Ward, ,but without success. Again, it appeared that the needs of the hospital had priority over the needs of the pilot project. We eventually did solve this problem by anticipating and predicting when our staffing shortfalls would be and by block booking the Bank staff we used, thereby minimising the problem.

However, I feel that it is not cost effective to train people in a particular skill and then not utilise them when staff are needed to carry out that task. I also feel that this has seriously delayed the process of implementing the Tidal Model on Tolkien Ward. The situation went on for many months and put unnecessary strain on the regular staff team and on the ward by making them have to 'carry' untrained staff every shift. This meant the care planning and patient contact suffered. On reflection, we should have considered building in some safeguards to ensure that bank staff who were 'Tidal Trained' were obliged to work on the ward and that Resource had no option to send them here, thereby solving the problem ourselves. Whether this will be a problem in the future will depend on how the Tidal Model is expanded to other areas of the Trust. If that happens, the training of Bank Nurses should be a high priority once all regular staff are trained.

6.1.15 Observation versus "Engagement"?

Tolkien Ward has 22 beds. The establishment staffing levels for the ward are as follows.

EARLY	LATE	NIGHT
5	5	4

When there are Level 3-4 (1:1) observations on the ward the establishment changes to:

	EARLY	LATE	NIGHT
1st LEVEL 3-4	5	5	4
2nd LEVEL 3-4	6	6	5
3rd LEVEL 3-4	7	7	6

The Observation Policy states that each ward should have no more than three Level 3/4 observations. However, high clinical activity can sometimes dictate that we go above that level.

Over the period of running the Tidal Model we have had fluctuating observation levels. It is noticeable that the number of daily care plans completed drops dramatically when we have three Level 3 observations. We have tried to analyse why this happens and have come to the following conclusion.

6.1.16 Care planning and observations

We operate the Shift Co-ordinator system where one Nurse operates as the focus of all that is happening on the ward. This seems to work best in terms of communication amongst the team and disseminating information. This means that when we have three Level 3 observations there are 6 staff to carry out the three observations and the Level 1 (General or hourly observations) and Level 2 (Timed) observations.

In practice staff have an hour carrying out Level 3 observations and then an hour doing other tasks, such as Level 1/2 observations, assisting in-patient care, escorting etc. When you factor in work-breaks you have a situation where for most of the shift there is only 1 Nurse each hour not carrying out observations.

With up to two Level 3 observations you can have between four and two staff available as staff do not usually have the 'hour on, hour off' schedule, therefore they can more easily fit in the normal routine of the ward and are left free to carry out other tasks, such as the Tidal assessments and daily care plans. We have tried various ways of managing the situation, but with minimal success. I do not feel that having more staff would necessarily be the solution to the problem as this brings up issues such as managing them and the cost.

However, I feel serious consideration should be given to limiting the number of Level 3 observations to two per ward should the Tidal Model be implemented throughout the hospital. We have already done a lot of work on the ward with the medical staff to make the observation levels realistic and to keep them under more regular review, but there is still scope for more to be done. If this work is carried forward in the right kind of way then it is feasible.

I feel a lot of this is due to the growing 'engagement' ethos of the ward rather than the 'observation' mentality of the old system. Experience has taught us as a team that for many Nurses, 'observation' still means just that, sitting looking at someone, rather than an opportunity to spend time with someone, getting to know them. To help combat this we are now promoting the use of the term 'engagement' instead of 'observation' and our nursing process documentation now reflects this.

6.1.17 Hitting rock bottom: June, 2003

In June 2003, there were four separate serious clinical incidents on Tolkien Ward in the space of about 10 days [56]. As staff came to terms with one, then another one happened. Investigations showed that they were all unrelated, involved different staff and patients and that they would have been difficult to predict. This had a profound effect on the staff team and consequently the Tidal Model took a back seat.

As the month wore on the ward became more like it was before the introduction of the Tidal Model. Holistic assessments and daily care plans were being completed very infrequently, the 'Those Who Shout the Loudest Getting the Most Nurse Attention' syndrome had set in once again. We discussed how to stop the stream of serious incidents as a team. I also spoke to my peers and to Senior Nurse Management asking for advice.

However, it was only when I discussed the situation in clinical supervision that it became obvious to me that it was the Tidal Model that had originally solved the problems for the ward and it was likely to do the same again. So the team started to do the holistic assessments and the daily care plans regularly again and the ward soon returned to what it had become since the launch of the Tidal Model.

On reflection it is now obvious that this is what was needed, but it has been a very useful lesson to learn.

6.1.18 Future developments on Tolkien ward

The Project Nurse and myself have discussed how we would like to take things forward from here and feel the following would be appropriate and necessary.

6.1.18.1 Group Supervision - We have been running a weekly supervision session for staff on the ward in conjunction with the Psychology Department. It has been a tremendous success and is popular with staff. However, clinical activity initially impacted on this and meant that the sessions did not happen. They were also not seen as a priority by staff who were unfamiliar with what they could potentially gain from it. Over time it has become a regular occurrence and is well attended. However, it is difficult to free up staff from their normal working day and we have had to be innovative with how we organise it. In addition, as it is staff who are on duty when it happens who attend there is no organised approach to ensure that all staff receive supervision. We plan to keep a register of who attends and ensure that the off duty offers all staff the opportunity to attend.

6.1.18.2 Staff training – We feel that there are further training needs that staff require to supplement the experience they have gained since working with the

[56] The incidents consisted of:

- A patient setting fire to their bedroom and barricading themselves in.
- A patient being sectioned on the ward and the staff carrying this out being physically assaulted by the patient's relatives during this.
- A patient being restrained on the ward and two other patients attacking the staff with pool cues whilst they were carrying out the restraint.
- Pool balls being thrown at staff.

Tidal Model. Firstly, they need training in engagement and how to get the most from the time they spend working collaboratively with the patients. Secondly, they require additional training in working with diverse cultures. They also require guidance in how to work with groups so that the remaining part of the Tidal Model can be launched. The intention is to provide this in conjunction with the Psychotherapy Department who are keen to provide input into the Adult in-patient service. A pilot course has been devised and will shortly be up and running. We also feel that it is necessary to provide training in the new Nursing documentation. Staff have adapted well without much in the way of formal training, but to enable them to make full use of the potential that the documentation offers they need to build on their experiences.

6.1.18.3 Group Work – Once sufficient staff have been through the training in Group Work then groups will start to be run on a regular basis, taking into account what is recommended by the Tidal Model manual and also by what the patients on the ward would like.

6.1.18.4 Environment – Unfortunately, Tolkien Ward only has two rooms where the patient interviews can be carried out. In lieu of more available space, we have created two areas that can be used for therapeutic interaction. One of these was created by virtue of a kind and sizeable donation from the WRVS who purchased a large fish tank for the ward. This has now become the main area for patients to congregate on the ward. In addition, as previously mentioned, there was a pool table on the ward, which due to incidents has now been removed. We now use this area as a quiet space and it is used for a variety of things including daily care planning.

6.1.18.5 User Voice – We have forged strong links with User Voice and they now hold a fortnightly closed (to Nursing Staff) meeting on the ward alongside the regular Community Meeting. This initiative has been very productive and is appreciated by both service users and staff. A lot of the recommendations from these meetings have been implemented and have had a positive effect on the Ward environment.

With these changes I feel certain that we will have an environment that is therapeutic and of benefit to the patients that spend time there. It will also be somewhere where the staff can be proud to work.

6.2 The Perceptions of Nurse Managers

6.2.1 Testimony of previous Ward Manager of Tolkien Ward

"I was Tolkien Ward Manager when this project was first initiated and I gave it my full support because I felt the Tidal Model offered a way forward for us on the Ward.

When Bill first joined the nursing team on Ward 5 it was at a time when there was a new interest being shown in the acute in-patient service from government and at different organisation levels at the QEPH. This included Clinical In-patient Specialist, and our Operational Manager who was the Deputy Head of Nursing, as well as the Resource Manager.

It felt like the services were being supported economically and developmentally and we were being supported and encouraged to take the time to explore nursing initiatives.

What I hoped we would get out of the Tidal Model was a positive way of re-engaging with our patients, a way that empowered both the patients and the nursing staff.

I felt the Tidal Model could be the vehicle to get nurses back to what out training had taught us, to learn from our experiences of interacting and communicating with patients and to develop new skills and positive experiences for both nursing staff and for patients."

6.2.2 Testimony of the Clinical Nurse Specialist Adult In-patient Services QEPH

"…Bump bump, bump, on the back of his head, behind Christopher Robin. It is as far as he knows the only way of coming downstairs, ,but sometimes he feels there really is another way, if only he could stop bumping for a moment and think of it."

Bump, Bump, Bump

During my three-year period working as a Clinical Nurse Specialist on the four busy acute in-patient wards at the QEPH, I often thought of the above intelligent words of a very wise bear. Words, which rang so true for the situation both staff and patients found themselves in on those wards.

The situation of always being too busy to think, too busy to do anything different or to change things was part of a continual negative circle we found ourselves in. Words like "we have tried that before, we are too busy, we do not have the staff" were all too familiar. The questions we kept asking ourselves were:

What are the experiences of patients/service users on the acute wards?
What do they get from the service we are providing?
What is it they get from being an in-patient on our wards?

We could not always answer these questions. It sometimes felt that people got better despite what we did! The staff wanted to make a difference. They did care, but they felt frustrated by things that were out of their control and influence, but affected their working practise. There was a constant pressure on beds, complaints, unsatisfactory ward environments, on-going staffing problems, untoward incidents and a general lack of recognition for what was really positive and good work going on under those conditions.

From a personal point of view I returned to the adult acute environment after a considerable period of time working in the forensic service. What was obvious to me, but difficult for me to understand was how busy everyone was on the acute wards! Staff were governed by tasks rather than interventions. They often talked of wanting to spend more time with patients, but the tasks always took over. We needed to find a way of moving out of this negative circle of events. What we had to help us was the fact that the staff wanted to do things differently and wanted to work smarter, not harder.

So we took time away from the ward to reflect together on ways in which to move forward in a positive manner and support and encourage the teams on the ward. We tried to capture the motivation and commitment of staff and utilize this as a key tool in making a difference on the acute wards. We had very positive support from the service user groups as well.

The Tidal Model

We were in the fortunate position that where staff were reflecting on their practice and when Bill was looking at the Tidal Model we all felt we had the makings of a structure that would enable us to take things forward. On reflection now, the old problems still exist. However, the important point is that they are now less overwhelming for those working on Tolkien Ward since the introduction of the Tidal Model. The staff feel that they now have a clear plan and a structure to work to. Having that structure has enabled staff to engage more often with patients and to implement better nursing interventions as well as doing the fire-fighting.

I was personally involved from the start of this project and feel fortunate to have taken part in it. Within a short period of time change began to happen on Tolkien Ward, and with other important developments within the service I believe that we have made good progress.

Looking Ahead

Having moved on from the adult acute service, I am extremely proud that the developments have continued. Now, through the research and reflection on how the Tidal Model has improved the service, I am keen that we role out the model onto the other acute wards and within BSMHT. I am aware that there are already plans to involve the forensic directorate in implementing the model.

There is clear evidence that the model is making a difference. It has enabled the work on Tolkien Ward to improve. In my opinion it is the staff and service users within the service which are the main reasons why it has been successful.

We have been able to stop bumping for a while and to think of other ways of doing things. Problems still remain and the outside influences beyond our control are still there, including bed pressures. So it is important that the progress achieved on Tolkien be built upon and extended. We must persevere to continue to improve engagement with our patients within the in-patient service. We should be offering service users a positive experience of care and an acute in-patient service, which makes a positive difference to their lives and enables their recovery."

6.2.3 Testimony of the Modern Matron for Adult In-Patient Services QEPH

"I have to admit to some initial scepticism about the Tidal Model; - I wasn't convinced that the time and resources needed to implement it would be a worthwhile investment when there were so many pressures on the QEPH acute wards and their environments often seemed chaotic.

15 months on I feel thoroughly converted. The Tidal Model has provided Tolkien ward with a robust framework both to improve patient care and to give staff a

sense of order and purpose. In addition, the atmosphere on the ward is generally calmer, as the statistics for untoward demonstrate.

Valuable lessons have been learnt for the Adult In-patient Service; (for example, staff training needs in the area of therapeutic engagement and group work skills have been highlighted) and Tolkien ward has often been at the forefront of developing and piloting new documentation and working practices which have then been adopted by the other acute wards.

In the light of these positive changes, I feel we should work towards implementing the Tidal model on the rest of the Adult In-patient wards. I would like to thank Bill, Graham, and the staff team for all their hard work."

CHAPTER SEVEN:
EVALUATION OF THE TIDAL MODEL

This evaluation of Tidal Model brings together both qualitative and quantitative evidence and interprets these within an action-research paradigm.

7.1 Qualitative evidence

Central to this evaluation has been the personal testimonies and opinions of in-patient service users, which have been assessed by means of a questionnaire. One assumption of this evaluation is that service users are the best judges of the quality of the care they have been receiving. Another key source of evaluation has been the opinions and testimonies of nurses and psychiatrists. These were assessed by questionnaires as well as by a nursing staff away day in which the model was discussed and evaluated by all grades of nursing staff working on Tolkien Ward. This section concludes with a documentation audit of the nursing processes associated with Tidal Model implementation.

7.1.1 Service user (in-patient) evaluation

Four in-patient service users were interviewed on Tolkien Ward and asked about their view of the Tidal Model. The interview schedule (see **Appendix 10.16**) was designed to reflect the principles of the nursing holistic assessment. In other words, the answers given to the questions where written down verbatim and the wording checked with the patient to ensure that it accurately expressed their view and opinion. All four persons had been in-patients on at least one occasion in the past.

7.1.1.1 Overall service user evaluation of the Tidal Model

All four persons interviewed said that:

- Their own story was given full attention by the nursing staff
- Their own views were respected by the nursing staff
- Their words were recorded (in both the holistic assessment and care plans) verbatim
- The care plans were focused on their actual needs/wishes
- The nurses helped them to be more clear about their personal goals
- All found the 'daily activity programme' adequate
- The nurses helped them to move towards discharge from hospital.

However, one patient said that there was often a lack of consistency and regularity doing care plans, especially during a two-month period around Christmas, which had an adverse effect on her and some of the other patients because:

"For some reason the nurses just did not talk to us very much anymore. But, things seem to have improved a bit since then." [57]

Three of those interviewed claimed that their experience with the Tidal Model was dramatically different and much better than the way they had been treated in hospital before as psychiatric in-patients.

7.1.1.2 Comparison with previous in-patient experience

All four patients interviewed said they greatly appreciated the Tidal Model emphasis on collaborative care planning and said that this was very different from the kind of nursing they had received previously at the QEPH or elsewhere. One patient said:

"When I was here before the nurses never talked to me, but only the doctor. I think (the Tidal Model) is a lot better. The communication is a lot better."

Another said:

"I was here five years ago. Nothing was in place then. It was all just a fog for me. This time the fog cleared up quickly by meeting up with the nurses and talking about specific things."

Another said:

"I think the Tidal Model is more organised and focused than what I had before. I feel better treated this time around (it's my 5th admission)."

7.1.1.3 Holistic assessment and care plan aspect of the Tidal Model

Three of those interviewed said they found these aspects very helpful and attributed much of their recovery to the process of therapeutic engagement with the nursing staff. The one person who found it less helpful said:

"I am not sure how helpful anything was. I was just glad I have gotten through this. I found the holistic assessment dreadful because I did not like the person I saw myself to be when I was saying the things I was saying. It made me feel all mixed up inside. For two months I was 'numb', but I am now a lot better. I don't know why I am better. But, the nurse did respect my views which I appreciated. I am not sure how much the care plans helped, but I am really glad that discharge from hospital is in sight."

The positive comments from the other three were as follows:

"The care plans helped to pinpoint the areas that need to be discussed, as opposed to just rambling on. They provide the skeleton to put the meat on. They help to bring up areas of concern so you've objectives to work towards and you know how to achieve them because you have talked about it."

[57] To put this statement into context it should be noted that the ward management team was absent during this period of time (about 5 weeks in duration) due to sickness and holidays. Upon their return within 2-3 weeks the daily care plans were being carried out regularly again and the ward settled down again.

"The nurses have more time for you and MAKE more time. It was really helpful to be able to talk out my problems and the nurses really listened to me. That didn't happen before."

"They helped me to see when I was ready to get out of here. The nurses heard MY version of things. I feel the nurses really understand me (I am difficult to understand)."

"The nurses really helped me with my goals so I knew what to do in order to get out of here. We went step by step. Talking to the nurses and having them listen to me was the best support."

7.1.1.4 Most helpful aspects of the Model

The most helpful aspect was seen to be the opportunity to meet up with nurses on a regular basis in order to construct relevant, practical care plans that were recovery-focused. This process sometimes resulted in the bringing up of personal issues for the patient, which, although painful, were seen to help facilitate recovery.

"I feel I have been helped properly this time. What I have requested I know will be done. I was able to see for myself the problem areas. I broke down and cried because I could see where I have been going wrong, being so selfish towards my wife."

"I feel very supported by the nurses. It (the care plans) gives me the opportunity to go back and to look at the previous agreement and to see if things happened or not. If they have not happened I can then make sure it does happen."

"We are able to make a personal plan together."

"This time I was picked up from the depths of despair…but in stages, step by step. I think that was due to the regular care plans. I think the whole thing is really excellent."

"What was most helpful was just the nurses talking to me and having a laugh and a joke sometimes. I now realise how the miscarriage I had when I was 15 made me ill. I never told anybody about that not even the doctors. When I told them (the nurses) about my past they just listened to me. I found that a lot of help."

7.1.1.5 Least helpful aspects of the Model

One criticism made about the Tidal Model was lack of nursing consistency in doing it. One person said:

"It seems logical to me and I like it in principle. But, the main problems with the Tidal Model are that it is sometimes not done or done consistently."

"One of my problems is that I am distrusting and disbelieving about most things. I think being clear about things and my own goals is down to me and not the nurses or the doctors."

7.1.2 Tolkien Ward staff evaluation questionnaires

The Tidal Model was launched on Tolkien Ward on the 5th of October 2002. Questionnaires were sent to all clinicians on Tolkien Ward in order to obtain their views of the Tidal Model, 6 months after Tidal Model implementation

7.1.2.1 Qualified Nursing Staff

Questionnaires were sent to the eleven qualified nurses. Seven were returned, a high response rate of 64%. Of the seven who completed them, one was an F Grade (Deputy Ward Manager) four were E Grade staff nurses and two were D Grades.

7.1.2.1.1 Satisfaction with the Tidal Model

This section consisted of seven questions, and the nurses were asked to give a rating in response to each using a scale where 1 = much worse, 2 = worse, 3 = about the same, 4 = better and 5 = much better. The following table shows the average rating of the seven nurses for each of the questions.

Table 5: average rating of the Tidal Model by Tolkien nursing staff in terms of 'satisfaction with the Model of care'

QUESTION:	Average rating
To what extent does the Tidal Model enhance your professional practice? My sense of professional nursing competence is now…	3.86
To what extent does the Tidal Model help you to focus more clearly on the patient's need for nursing care? My sense of focus is now…	4.14
To what extent does the Tidal Model help you develop a helping relationship with the person in your care? My ability is now …	4
To what extent does the Tidal Model help you to develop an understanding of the person in your care? My understanding is now…	4.57
To what extent does the Tidal Model help you to construct collaborative nursing care plans, which express the views of the patient? My opportunity and ability to do this is now…	4.14
To what extent does the care plan element of the Tidal Model enhance your sense of job satisfaction? My job satisfaction in this area is now…	4.14
To what extent does the Nursing Holistic Assessment element of the Tidal Model enhance your assessment skills? My skills in this area are now…	4
Using the rating scale above rate the overall quality of the nursing care on Tolkien Ward, as you perceive that, in comparison to the way you worked before using the Tidal Model. In your opinion the care is now…	4.8

According to the above, the qualified nursing staff rated the Tidal Model as Better (4) >> Much Better (5) than their previous way of working in terms of professional satisfaction.

Additional comments made concerning the overall quality of nursing care on Tolkien Ward were:

"Patients say they are listened to. They feel they can approach staff to talk to when they are feeling low or anxious etc. They also feel that their care is better over all because the nurse sits down with them on a daily basis to listen to their problems."

"The number of violent incidents has decreased. Patients feel usually more involved in their care. Referrals to OT and Dentists are completed more readily."

The nurses were asked how they thought the Tidal Model could be improved and their nursing practice brought more in harmony with the therapeutic principles of engagement, collaboration and empowerment. The wide range of suggestions fell broadly into five categories:

- Nursing team working

- To pull together more as a team
- Regular clinical meetings for nursing teams
- "When an admission comes in it is important to fully complete the admission process even if the patient is not allocated to the team you are working with and hand the client over"
- "Working with Bank/Agency staff is not good enough – too much pressure is then put on regular staff to do TM"
- "More support from Bank Agency Mangers to ensure that those who have completed the TD Training are booked on Tolkien Ward to ensure consistency of care"

- Multidisciplinary team working

- Doctors should visit the ward at appropriate times during the day
- "Tolkien Ward can be very busy. This does not necessarily have to do with the amount of patients, but the amount of Consultants. Less Consultants means less SHO means fewer ward rounds and fewer Doctors on the ward wanting nurses' time"
- Multi-disciplinary notes

- Service user activity

- Re-design of the ward to give the client a pro-active role
- Specific ward-based groups and more co-ordination in this area
- More staff to escort patients off the ward

- Time pressures

- Inability to complete Tidal Care Plans due to time constraints
- "Not to feel pressured to spend so much time with paper work"

- The ward environment

- "More interview rooms available"

7.1.2.1.2 Training, supervision and staff handovers between shifts

Five nurses (71%) felt that further training; support or supervision would be valuable in using and developing the model fully.

"For the TM to work effectively all staff need to be trained before implementation."

One respondent suggested that any type of further training would be helpful as shift patterns had prevented them from attending any training other than the away day. Others felt that further training would enhance the staff's confidence in facilitating group sessions and implementing care plans and that unqualified staff would benefit from training in counselling skills. Two nurses also wanted to explore the Tidal Model further as they felt that that the model had not yet been fully implemented:

"The Tidal Model needs to be deepened as it becomes more of a philosophy not just another model of nursing."

All of the staff stated that there were, normally, no a) staff clinical supervision sessions or b) care support groups outside daily handovers. There was no appropriate context within which to discuss, at depth, current nursing care and staff team issues. This was, it was felt, detrimental to the quality of the nursing care on the ward.

The majority (71%) also felt that the daily staff handovers were inadequate to deal effectively with the often difficult, personal, managerial and care issues that arose during the course of each shift. The main reason given for this was lack of time due to ward activity. There was a consensus that regular structured care team meetings would be beneficial.

7.1.2.1.3 Comparison with other nursing models

There appeared to be a lack of clarity concerning what, if any, nursing models staff had used prior to using the Tidal Model on Tolkien Ward. Models given were: Roper, Logan and Tierney; Orem's self-care deficiency model; the medical model and an eclectic approach. It was also stated that "there appeared to be no obvious nursing model employed" on other acute in-patient wards at the QEPH. The nurses were again asked to give a rating in response six questions comparing the Tidal Model with other models using the scale between 1 (much worse) and 5 (much better):

Table 6: Average rating of the Tidal Model in comparison with other models or 'no nursing model'.

QUESTION:	Average Rating
In general, how does the Tidal Model compare with the nursing model you were using before?	4.29
In terms of the initial nursing assessment of the patient on admission, how does the Tidal Model Holistic Assessment compare with the kind of assessment you were using before?	4.57
How does the Tidal Model care planning element compare with the way in which you did care plans before?	4.29
In terms of time, to what extent is the Tidal Model more or less efficient that the one it has replaced, or the one you have used before?	4.5
In terms of communication with nursing colleagues, how does the Tidal Model compare with the one you used before?	4.17
In terms of communicating with the MDT (Multi-disciplinary team) how does the Tidal Model compare with the one you have used before	4.29

The Tidal Model was generally viewed as far superior, that is, rated Better (4) >>> Much Better (5) to the nursing models or lack of any nursing model they had been involved with previously at the QEPH or elsewhere.

"One of the main strengths of the Tidal Model seems to be its simplicity, and I think that this helps facilitate its implementation in different areas with suitable adjustments."

The main reason for the popularity of the model was that it facilitated engagement with individual patients and the entire patient group and that all members of the nursing team had a role in this. As one nurse stated:

"With the Tidal Model people are aware of issues in regard to all clients."

One respondent, who felt that the environment on Tolkien Ward was "chaotic", as a result of a low staff-patient ratio, saw this as particularly important. There was agreement that the increased knowledge of all the patients also facilitated communication with the rest of the multi-disciplinary team.

The care planning element of the Tidal Model was viewed extremely positively, resulting in care plans that were generally more relevant and up to date. Its particular strength was seen to be its emphasis on collaboration with patients and the fact that it encourages engagement with individual patients every shift. It was felt that this increased satisfaction for both service users and staff.

"I think the Tidal Model is good with patients who are withdrawn as it engages them. Patients have often commented that they like having an opportunity to discuss their care plan more frequently and it gets them more involved in their own care."

"I think it is great and satisfying to work in collaboration with clients instead of the old system fighting to access the computer to print off a prepared care plan

off a template. Which means care was not individualised and with the Tidal it is now."

"It looks at the clients in collaboration with their care and this feels like what I came into nursing for."

The Tidal Model was seen to be more efficient than previously used models, and not having to spend so much time at the computer was also seen as beneficial. One nurse added that it improved assessments, as "*the questions [in the initial assessment] are different from those asked by the doctor*". It was also felt that the model provided a more structured approach to patient care. It was noted, however, that "*It can be time consuming, but that depends on organisational skills of staff to get the job done*."

7.1.2.2 Nursing Assistants

Questionnaires were sent to the 10 Nursing Assistants attached to the ward. This time the response rate was very low (10%) with only one questionnaire being returned. This one evaluation was, however, very positive. The Model was rated 'better' than the previous way of working and the respondent rated the overall quality of care as 'better' than before, concluding:

"Having the Tidal Model has helped the ward extremely. Patients feel more comfortable with staff, & staff feel they are now aware of patients' problems more. The ward could be better, but it has definitely improved."

7.1.2.3 Medical Staff

All 10 medical staff attached to the ward were asked to complete questionnaires. Three were returned, a low response rate of only 30%.

The medical staff were asked to compare the nursing care being provided following the introduction of the Tidal Model with the nursing care previously provided on Tolkien Ward or on other wards. Two of the doctors stated that this question was not applicable, and one said they felt the nursing care was "about the same":

"When it works, it is excellent. But, my experience is that it does not work enough of the time so I do not think it has a massive effect yet."

When asked how satisfied they were with the information they had received regarding the Tidal Model and its implementation on Tolkien Ward, the three respondents' replies ranged from satisfied to not satisfied.

One doctor said that they thought they understood the principles underlying the Tidal Model well, although a second doctor said they did not understand the principles very well. When asked what they believed the principles to be, the responses were:

"Every patient offered time each day to discuss their concerns and come up with some goals and management plan as desired by the patient."

"Engaging with patients. Exploring patient's symptoms/consensus/wishes."

"Concentrating on the patient's narrative."

"Getting nursing staff to talk to patient's more."

None of the medical staff felt that a half-day's training in the Tidal Model would be of interest or of use to them. However, one did perceive the need for information provision:

"I think as doctors we do need information given formally, but perhaps not as much as a 1/2 day."

7.1.2.3.1 Communications

The doctors were asked to rate the communications and contributions of the nursing team within the MDT on a scale from 1 to 5, where 1 was very poor and 5 was excellent. The average score was 2.7, indicating an overall view of poor-OK. Rationale for this low rating was the lack of consistency, with communication varying greatly depending on which nurses were on duty. One respondent further suggested that:

"Nurses know what has been going on with patients, but do not tell us. Nurses need to take more initiative as they do have an important role in the MDT."

Despite the very low response rate from the medical team, the comments that were received were generally very encouraging and supportive of the Tidal Model. The medical staff also appeared to recognise some of the difficulties faced by the nursing team in implementing the Tidal Model:

"Unfortunately, nurses seem to have to spend most of their time on administration and paper work or patient observations and spend very little time in building relationships with patients. The Tidal Model goes some way towards ensuring that nurses spend time with patients in a therapeutic setting."

"I really like and agree with the Tidal Model. It needs commitment and money from the Trust to make it work in the interest of patients."

7.1.2.4 Concluding remarks

Although the response rate for the medical team and the nursing assistants was disappointing, the response rate for the qualified nursing staff was high. The important point is that the responses that were obtained by all grades of staff showed overwhelming support for the Tidal Model, mainly because it was felt to empower both service users and the nursing team. There were also many useful suggestions for improving the use of the Tidal Model in the future, including further training, improved staffing and the introduction of structured team meetings.

7.1.3 Nursing staff away day: applying the EFQM Excellence model

Sue Phillips facilitated the day in the context of the EFQM Excellence Model, which seeks to provide a self-assessment tool that can empower continuous improvement. Staff were encouraged to

- Identify their strengths
- Identify areas needing improvement
- Identify an adequate benchmark to assist the measurement of progress
- Assess improvement in the clarification of priorities
- Identify a framework for sharing best practice

A consensus emerged during the day that the Tidal Model provided a good framework for shared practice. During the day participants broke down into groups for sharing and discussion over specific issues, and comments were written down on a flip chart for further discussion. The following comments were taken verbatim from the flip-chart and notes of the day. According to the staff team, benefits of the Tidal Model included:

7.1.3.1 Benefits for the staff team

- *The Tidal Model is more a philosophy of care than it is a 'model'*
- *The TM patient/nurse relationship fostered by the Tidal Model improves communication*
- *The TM increases staff and patient rapport*
- *Improves quality of information*
- *Makes you feel like your part of something bigger than just Tolkien Ward practising worldwide*
- *Makes staff MORE pro-active*
- *A-Graders (Care Assistants) now do more one-to-one work with patients*
- *Helps us do the job we are paid and trained to do*
- *The whole approach*

7.1.3.2 Perceived benefits for service users

- *It is patient-led rather than nurse-led*
- *It allows patients to set their own goals that are real and achievable by them*
- *It enables staff to be constantly updated with information from patients*
- *It facilitates engagement with 'quieter' patients*
- *The quieter patient doesn't get neglected because of the more vocal patients*
- *Talking to and involving patients – getting to know them as individuals*
- *To make the patient's feel valued and respected*
- *Improves communication*
- *Benefits for the wider organisation*
- *Increases continuity of care and consistency*
- *Reduces frustration, violence or risk*
- *Reduces the 'revolving door'*
- *Staff coming from different Trusts are interested in working on Tolkien Ward*
- *Allows more time for patients to express their feelings*
- *Helps prevent violent incidents occurring on the ward*

The Tidal Model also presented a number of challenges and difficulties for the staff team, which were openly discussed. These were identified as:

7.1.3.3 Staff training and education

- *There is a lack of staff training for Bank staff*
- *Time constraints make doing the TM difficult*
- *Lack of experienced staff*
- *Unfamiliarity with staff and patients due to bank/agency staff supplying cover*
- *Staff who do not know the ward (Bank and Agency) are not Tidal trained*

7.1.3.4 Documentation of the nursing process

- *Extra cost and paper wasted (organisational)*
- *An awful lot of paper work*
- *Administration documentation can be wordy and difficult to understand*
- *Other non-Tidal jobs omitted (organisational)*
- *Storage problems due to continual paperwork*

7.1.3.5 Leadership

- *Other tasks (not directly related to patient care) take priority (medics, problems on ward high level of clinical activity)*

7.1.3.6 Resources

- *Can put strain on staffing levels*
- *Low staffing levels affect your time with patients*
- *Not enough private space on the ward*
- *Doing holistic assessment and daily care plans is time consuming (for staff)*
- *Can be repetitive*
- *Pressure to do it everyday, but staff do it only and when or as it is required*

7.1.3.7 Nursing policy issues

- *Daily care plans can be repetitive (patient)*
- *Language barriers and cultural awareness*
- *Problems engaging with some patients i.e. lack of insight, paranoia etc*
- *Needs to be done over 24 hours*
- *Lack of patient motivation*
- *Patients sometimes refuse to engage on a daily basis stating that everything is the same as yesterday*
- *Problems with delegation – primary named nurses aren't always given their patients to do*

At the conclusion of the day the feedback concerning "where are we, right now, concerning Tidal Model implementation?" was as follows:

7.1.3.8 Where are we, right now, concerning Tidal Model implementation?

- *We still need a deeper understanding of the model to build a more thorough relationship with patients*
- *I am new to the Tidal Model, but have reviewed the theory and am glad to be involved with it. Pleased with what I've seen*
- *We need to establish the need…for this*
- *I think we are doing well and have implemented the model well. Sometimes there is a lack of communication*
- *Things are going well. Feel that some patients do not need daily care plans*
- *Sometimes a patient has had a Tidal done on the night shift and then has it redone first thing on the early shift. I feel this is sometimes too much*
- *Positive approach, more time spent with patients*
- *Some improvement, but not 100%*
- *Feel Tidal is going well, but need more feedback from Bill*
- *All staff should be Tidal trained, not just left up to a few people to do*
- *I think there are problems with all the Tidal paperwork*
- *Proceeding, but we need more practice*
- *The team has made tremendous steeps and their hard work has made it a success in the short term*
- *I don't know much about it, but hope to learn and apply it throughout my placement*
- *Encourages staff to spend time with patients, is a positive thing*
- *Care plans are improving the additional elements need more work and understanding*
- *Can't comment*
- *Needs some tweaking, fine-tuning, particularly with regard to admission assessments*
- *It definitively ensures that more time is spent with patients. You can get to their main issues more effectively*
- *I feel we're getting to grips with the Tidal Model more, spending more time with patients*

7.1.4 Four-Month Tolkien Ward Documentation Audit

The Tidal Model was launched on Tolkien Ward on the 5th of October 2002.

On January 14th 2003, four months after Tidal Model implementation, using the following format, 22 patient files were audited from Tolkien Ward:

NAME			
	Date	Complete/Incomplete?	Poor/OK/Good
Admission Form			
Admission Checklist			
72 Hour Care Plan			
Holistic Assessment			
Risk Assessment			
Daily Care Plan (last completed)			
Today's Date			

Gap between PRESENT CARE PLAN and LAST CARE PLAN?	Number of days:

Reason for Gap?
General comments on Tidal Documentation:

7.1.4.1 Daily Care Plans

With a few exceptions, all Tolkien Ward patients are now being seen daily, or almost daily by members of the nursing staff team for a period of interpersonal engagement, care plan review and care planning. Where this is not happening there are identifiable reasons why not, such as serious 'engagement' difficulties because of the nature of the patient's mental health problem or because the patient has issues about being in hospital and/or resentment about being detained under a section of the Mental Health Act.

7.1.4.1.1 Audit results

On the day of the audit of those 18 patients not on leave:

9	Patients had been seen either that day and/or the day before.
6	Patients, had gaps ranging from 2-6 days.
1	Patient had not been seen (or constructively engaged with) for 11 days
1	Patient had not been seen (or constructively engaged with) for 12 days
1	Patient had not been seen (or constructively engaged with) for 20 days.

Two of these had returned from leave on the day of the audit (which was done in the morning) or the day before and one (not seen for 12 days) had serious engagement difficulties because of severe chronic mental health problems. The remaining three patients: with two week, three week and two week gaps respectfully were on leave.

It was not possible to determine from one patient's documentation when the admission had taken place, as the information was not available. A home phone number was attached to the front sheet, but there were no other details

Overall, daily care plans, with a few exceptions, are now being done daily or almost daily with, on occasion, no more than two-three days gap appearing between plans.

Anecdotal testimony from nurses on Tolkien Ward suggests that patients are responding positively to these changes and value the increased nurse/patient contact, feel their needs are being 'heard' and acted upon and that their views are being more respected. Patients are thus more willing to co-operate with and value their care plan.

7.1.4.1.2 Quality of nurse-patient engagement

It is difficult to determine the quality of the patient/nurse engagement or improvements in meeting patients real needs from the paper documentation alone, although this documentation is an improvement on the system it has

replaced because it makes clear what is not clear in the other system, namely, the frequency of nurse-patient engagement in a collaborative care planning process.

By their nature, the descriptive powers of nursing notes are very 'thin' and an entire one-to-one session with a patient may well be summarised by way of a few "bullet points" and not as a coherent case-history This, however, is entirely appropriate and recording one-to-one sessions in detail would not be practical within an acute in-patient setting. So, it is difficult to discern to what extent and depth Tidal principles of holistic, collaborative, empowering client-centred care have been understood by nurses working on the ward or penetrated into the ward culture as a whole.

With the above observations in mind, I now turn to some specific problem areas this audit has highlighted along with some recommendations on how these problems might be resolved.

7.1.4.1.3 Daily care plan implementation

Documentation indicates (even by its absence) as well as anecdotal evidence indicates from both nurses and patients that there remain difficulties with care plan implementation. Care plans are sometimes not completed or the nurse does not carry out his or her part of the agreed plan. This, understandably, creates tension and resentment on the part of patients, especially when they trust the nurse to 'sort something out' or to do something for them as part of an agreed care plan and nothing happens. This failure may be connected with staffing problems and, on occasion, lack of qualified OR regular staff that know the ward and patients well enough to do these tasks.

The solution to this problem is threefold:

- Staffing levels and skill mix need to be brought up to an adequate standard
- There should be proper delegation of work at the beginning of each shift and
- The primary or named nurse should be the person to both plan and carry out care with the help of the associate nurse or a care assistant by way of clear delegation of the tasks required

7.1.4.1.4 Cultural issues

One reason care plans do get followed through is that care plans have not been delegated properly to another nurse at the beginning of each shift or, if it has been delegated, it is not carried out. This appears not to be a problem of 'lack of time', but a problem within the ward and hospital nursing culture itself. Some nurses appear to resent being told what to do by other nurses and there is a lack of accountability and consequences for failure to carry through work, which has been delegated. Some nurses appear to be reluctant to take responsibility for their actions within the context of a staff team. Others clearly resent 'the added work' which client-centred care seems to 'add' to an already busy ward.

In addition to this, high levels of clinical activity on the ward, high staff turnover, lack of regular qualified staff and over dependency on the Nurse Bank and on

Agency nurses (not trained in Tidal principles) continue to frustrate progress in implementation and place added pressure on the staff team. However, the staff seem to be rising to this challenge rather than getting discouraged and appear to be well motivated to get the Tidal Model to work

7.1.4.1.5 Identifying staff training/education deficits

Implementing the Tidal is revealing a serious lack of the most basic "interviewing/listening/counselling" skills within much of the nursing team, many of whom have little experience in engaging at depth with people in emotional or mental distress in a structured therapeutic way. This makes the undertaking of proper nursing holistic assessments as well as genuinely collaborative care planning difficult. The provision of regular, on-going courses in basic helping, interviewing, counselling, problem solving and listening skills are not considered to be a priority by the Trust as it is simply assumed that nursing staff working on acute wards already possess these skills, when, in fact, many do not.

7.1.4.1.6 Staffing levels and skill mix

On Tolkien Ward chronic staff shortages and/or inadequate 'skill mix' also continue to create serious logistic problems for ward management and to a large extent have been doing so for several years now. This includes areas of chronic staff sickness, staff suspensions, and a steady stream of newly qualified ,but relatively inexperienced staff nurses who tend to 'move on' after six months as well as over-reliance on Bank and Agency staff who know little or nothing about the Tidal Model or of the pilot project underway.

Despite this regular Tolkien staff that have undertaken Tidal Model training have been coping very well under difficult circumstances and have achieved a much higher standard of care nonetheless.

7.1.4.1.7 Initial 72-hour assessment and care plan

This is the 'holding' care plan we have designed on Tolkien Ward to bridge the period from admission until the holistic assessment has been completed. It is accepted that this 'Initial 72 Hour Assessment and Care Plan (72CP)" will often be initially constructed on the basis of incomplete information and on first impressions of the patient. The 72CP has been designed so that an initial assessment can be undertaken non-collaboratively (if so required) to ensure a safe environment and other basic issues, especially for patients who are very emotionally or cognitively disturbed or who are hostile or uncooperative. But, ideally, it should be undertaken collaboratively with the patient on admission. It should be completed at the same time as the admission and seen as part of the admission procedure.

7.1.4.1.8 Audit results

Of 22 patients, 13 had a completed 72CP for the day of their admission, four patients had a completed 72CP within three days of their admission. Of the five who had no 72CP, clearly in three of these, the patient had been admitted elsewhere OR before the Tidal implementation. This left only two patients with no 72CP and with no reason being given or evident from the notes why not

7.1.4.2 Nursing holistic assessment

According to this audit only nine (out of 22 patients) on the day of the audit had received a Nursing Holistic Assessment, even though daily care plans were in operation for the remaining 13.

The question needs to be asked: "What is the basis of these care plans if no documented nursing assessment has taken place?"

Of the nine who had been assessed, the gap between the days of admission ranged from 'the same day' to three weeks, with an average of just over four and half days.
Of the 13 who did not have a Holistic Assessment, one long-term in-patient (with serious chronic mental health problems) was clearly not yet capable of usefully benefiting from a collaborative assessment. Yet, perhaps one could be undertaken with her mother and brother? A creative use of the Tidal tools should be considered in difficult cases. Of the 12 remaining, for two patients admission information was very 'thin' and incomplete (see below) and no admission date was given although many weeks had gone by. Of the 10 remaining, two had been admitted within the previous week. Of the eight remaining patients who had not received a Holistic Assessment, the admission dates are as follows:

Date of this audit: 14/1/03

10/12/02
29/12/02
12/10/02
31/12/02
24/12/02
18/12/02
28/10/02
18/12/02

7.1.4.3 Discussion and concluding remarks

In the light of this initial audit of Tidal Model implementation three observations are in order:

First of all, patients who may be highly distressed or mentally disturbed on admission, or initially hostile and uncooperative about being admitted against their will to hospital on a Section of the MHA, may be initially unwilling or unable to engage with a nurse sufficiently for a collaborative holistic interview to be done within the first three days following admission. Ideally, the holistic assessment should be undertaken *within* the first three days, or as soon as possible after that. On occasion this may take a number of weeks or longer.

Secondly, when engagement with the patient is proving to be very difficult so that both the holistic assessment and collaborative care planning are not taking place the three nursing goals

- To therapeutically engage with the patient, and
- To do holistic assessment
- To do the risk assessment (*)

should be the primary on-going nursing goals until such time as the holistic assessment has been completed. Only after a therapeutic alliance between nurse and patient has been established is it realistic and practical for genuinely collaborative care planning to begin.

(*) *The new full Risk Assessment procedure and documentation is not yet in place on Tolkien Ward. It is anticipated that it will be within a few months time*

It is understood that in rare circumstances genuinely collaborative care planning may never take place at any depth with some patients, especially in the case of inappropriate admissions where the person is not mentally ill. The attempt to make such an assessment, and the refusal of the patient to take it seriously, and other factors may help identify more quickly inappropriate admissions.

Failure to undertake a genuinely collaborative holistic assessment within the first three days of admission is therefore not a serious issue if good reasons can be given why, for this patient, an assessment of this type has not been possible or even desirable. Nevertheless, degrees of collaborative care planning can still take place.

On the other hand, with patient transfers to and from other wards it is sometimes possible to have a patient occupying a bed on the ward who is on permanent leave from another ward, a patient one has never met and for whom both the relevant notes and documentation are sometimes temporarily missing or very incomplete etc.

However, if the patient is known, and has been resident on the ward for many weeks, but is still refusing or 'unable' to engage, and a holistic assessment has still not been completed and there is no recurring daily care plan for a) engagement or b) to do the holistic assessment, *a potentially dangerous situation is being generated which could erupt into a serious untoward incident*.

This is especially the case if the patient is deluded, isolated, hostile and prone to violence or unpredictable behaviour. At the very least it should be documented, as part of the daily care plan that "*patient is not engaging with the nurses*" with a clear daily plan for that engagement to happen, as above.

Thirdly, there are several aspects of the Tidal Model we are not doing which we need to develop to a good standard over the next year. These include

- Weekly Group Work. The Tidal Model Manuel suggests three main types of Tidal focused groups, A *Solutions Group*, *A Recovery Group*, and *An Information Group*. These would be in addition to the present Patient Meeting Group
- Use of the patient security plan
- Use of the BSMHT Risk Assessment Tool
- Regular clinical supervision of all staff using TM

In conclusion, considering that we are in the early stages of Tidal Model implementation the results of this audit are very encouraging although, predictably, the implementation of the Tidal Modal has exposed a number of problems, which will need to be addressed as part of the implementation process.

- *On the positive side:*

  - All 'regular staff' have undertaken a day's training in the basic principles and practice of the Tidal Model
  - Each new admission is, in principle, receiving a Nursing Holistic Assessment
  - Daily care plans, with regular reviews, are being implemented for all patients
  - New Documentation forms have been devised to facilitate accurate recording of the Tidal Nursing Process. These are under regular review
  - A new admission front sheet and checklist has been designed so that all Tolkien Ward nursing documentation is now consistent in basic design and typographical appearance
  - A 'Tidal Nurse' with a clear job description has been introduced to work on a 9-5 basis to help implement the process and to keep nursing care 'focused' and its documentation accurate and up to date. The Tidal Nurse is drawn from all existing regular staff, including A-Graders who work 'on rotation' to fulfil this role
  - All 22 patients are now officially on the Tidal Model
  - New nursing notes folders have been introduced

- *On the negative side:*

The introduction of the Tidal Model and this audit has highlighted various problem areas related to staffing levels, management issues as well as educational and training deficits within the staff team. For example**,** problems related to the old pre-Tidal Model nursing culture include:

  - A nursing culture in which work does not tend to get properly delegated or, if delegated properly, it is not carried through
  - The absence of any explanation or consequences for this
  - The lack of regular opportunities for staff to meet together, to discuss staff team issues in an environment suitable for open and honest sharing of issues
  - Handovers 'between shifts' on a busy ward do not normally provide this opportunity
  - In addition to this, high numbers of agency staff, transient bank staff not trained to a ward's therapeutic ethos and a high regular staff turnover are clearly detrimental to the delivery of any quality service

These are difficulties that, I hope, will be resolved over time, as there seems to be a positive attitude and a will to overcome these problems at both the clinical and management levels.

It is hoped that continued, effective implementation of the Tidal Model will help to both recruit and 'keep' a well-motivated, highly trained and good quality staff to work in this demanding specialist work within the acute in-patient facilities of the Birmingham and Solihull Mental Health NHS Trust.

7.2 Quantitative evidence

7.2.1 Untoward Incidents

7.2.1.1 The concept of milieu toxicity

The metaphor of *relational toxicity*, as described in section **2.2** can be used to describe those ways of relating which do not promote trust, mutual respect, openness, honesty and learning from experience, but are typified by defensiveness, manipulation, scapegoating, blame, insecurity, and resistance to change. Such relational contexts are, it has been suggested, non-therapeutic to the degree that they cause insecurity and anxiety, and put people at risk. Such environments cannot, when these features predominate, promote the recovery of clients or the personal growth and professional development of staff.

With these issues in mind it is essential to look at acute in-patient wards where care has become compromised or is under constant threat because of institutional and administrative practices that tend to disempower both patients and nursing staff and unnecessarily limit choice (See Barker and Davidson 1998). Of special concern are the rates of patient self-harm, patient's absconding, 'acting out' behaviour and the need for physical restraint as well as other indicators of toxicity such as low staff morale, the number of staff suspensions, a high staff turnover, and a constant 'crisis management' style of operations on acute wards and within the hospital.

Therefore an analysis of untoward incidents was undertaken for the year prior to the introduction of the Tidal Model on Tolkien Ward and these compared with the untoward incidents for the year following Tidal Model implementation. It was also decided to determine how the number and nature of such incidents compared with those on the other three acute admission wards at the QEPH, Tennyson, Bronte and Owen Wards for the same two periods. Data for this purpose was obtained from the Trust's Safecode database of untoward incidents.

7.2.1.2 Serious versus minor incidents on Tolkien Ward.

For the sake of this evaluation some untoward incidents reported on the IRIS forms have been deemed more significant than others as indicators of the relative 'toxicity' of the ward environment as defined above. On the whole, most serious incidents come under the category of Violence/Abuse/Harassment, but others, such as patient self-harm, reported physical restraint and absconding/AWOL come under the Clinical Incidents and Security Incident categories.

Categories such as staff ill health, fire incidents and personal incidents have been excluded. Clinical incidents such as minor medication errors (those with no adverse outcome) or things like "needle-stick injury" or "Box found in doctor's office open" or administration errors like "papers not receipted on admission" have also been excluded from the more detailed Tolkien Ward evaluation. On more than one occasion an Incident Report has included two incidents i.e. Patient attempts to abscond AND is restrained. This has been taken into account.

The serious incident types for measuring the level of toxicity were considered to be the frequency and type reported

- Serious Clinical Incidents (such as patient self-harm or suicide)
- Serious Security Incidents (absconding/AWOL)
- Violence/Abuse/Harassment

For the purpose of the Tolkien Ward evaluation the following categories of untoward incidents have been used:

- Intended or actual self-harm
- Abscond/AWOL
- Physical Restraint
- Threat of physical violence
- Actual physical assault
- Sexual assault
- Verbal abuse
- Disorder/Intimidation
- Sexual harassment
- Racial harassment
- Other

7.2.1.3 Untoward incidents on all four QEPH acute admission wards

In the year prior to the launch of the Tidal Model (1st October 2001 – 30th September 2002), a total of 308 untoward incidents were reported to have taken place on Tolkien Ward. This compared with 258 on Owen Ward, 215 on Tennyson Ward and 180 on Bronte Ward.

Tolkien Ward therefore accounted for 32% of the 961 incidents that were recorded on the four QEPH acute admission wards, the highest percentage.

Of the 961 incidents across the four acute admission wards, 403 were categorised on the Safecode database as clinical incidents, 145 as security incidents and 413 as violence/abuse/harassment. **Figure 1** below shows the number of incidents within each category that occurred on the four wards, and **Table 7** shows the percentage of the total number of incidents within these categories that occurred on each of the four wards.

Figure 1: Number of incidents that were reported within each category on all QEPH acute admission wards, October 2001 – September 2002

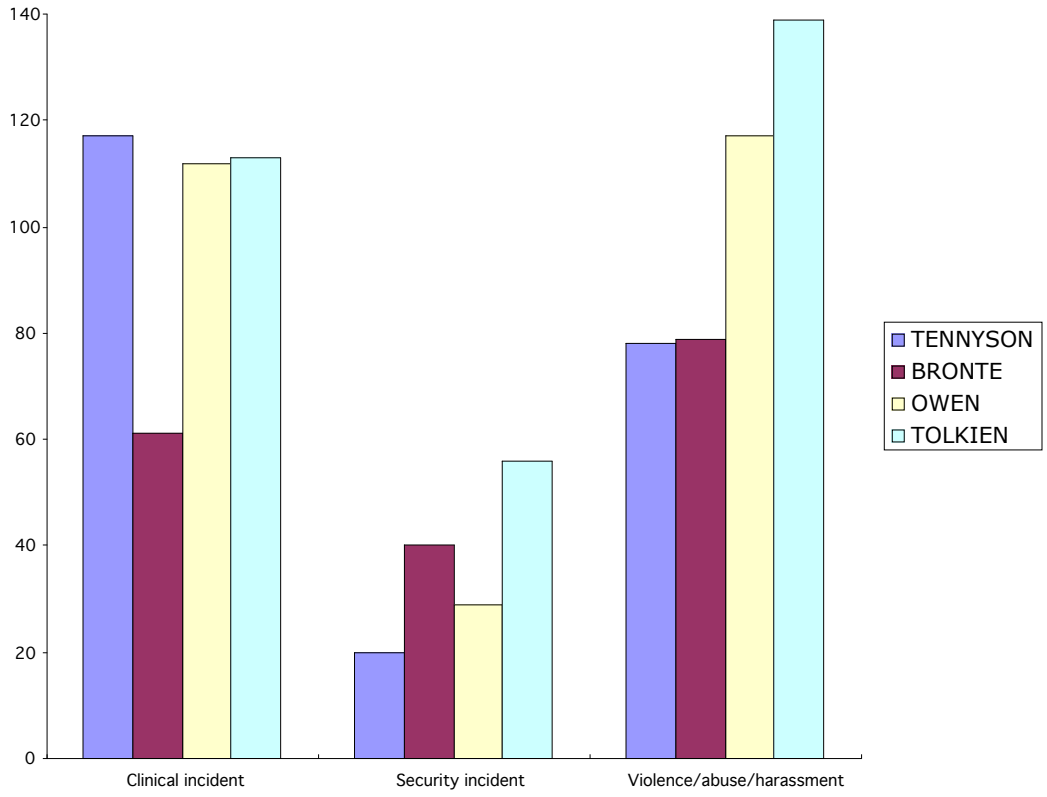


Table 7: Percentage of untoward incidents occurring on each of the QEPH admission wards, October 2001 – September 2002

Category of incidents	Percentage (%) of the total number of incidents in each category				Total
	Tennyson	Bronte	Owen	Tolkien	
Clinical Incident	29	15	28	28	100%
Security Incident	14	27	20	39	100%
Violence/Abuse/Harassment	19	19	28	34	100%

In the twelve months following the introduction of the Tidal Model (1st October 2002-30th September 2003) the total number of untoward incidents reported for Tolkien Ward reduced from 308 to 140, a decrease of 55%.

This decrease in untoward incidents on Tolkien Ward, when compared with the rise in untoward incidents on both Tennyson and Bronte Wards (and a slight decrease on Owen Ward), is significant. Tolkien Ward, in the year 2002-2003 accounted for only 14% of the 990 untoward incidents reported across all the acute admission wards, now significantly the lowest percentage. This means

Tolkien Ward, which had the highest number of untoward incidents in the hospital in the first year, had the lowest number in the second year.

When the two years (pre and post-Tidal Model implementation) are compared, this amounts to a decrease from 32% to 14% of the total number of untoward incidents reported on all acute wards. **Table 8** below gives the figures for this and **Figure 2** gives a bar graph representation. **Figure 3** then gives a bar graph representation of the total number of incidents that were reported *within each category of incident* for all acute wards during that second year from October 2002 – September 2003.

Table 8: Number of untoward incidents recorded for each admission ward during the two time periods

Ward	Total Number of incidents	
	2001-2002	2002-2003
Tennyson	215	423
Bronte	180	191
Owen	258	236
Tolkien	308	140
Total	961	990

Figure 2: Number of untoward incidents recorded for each admission ward during the two time periods

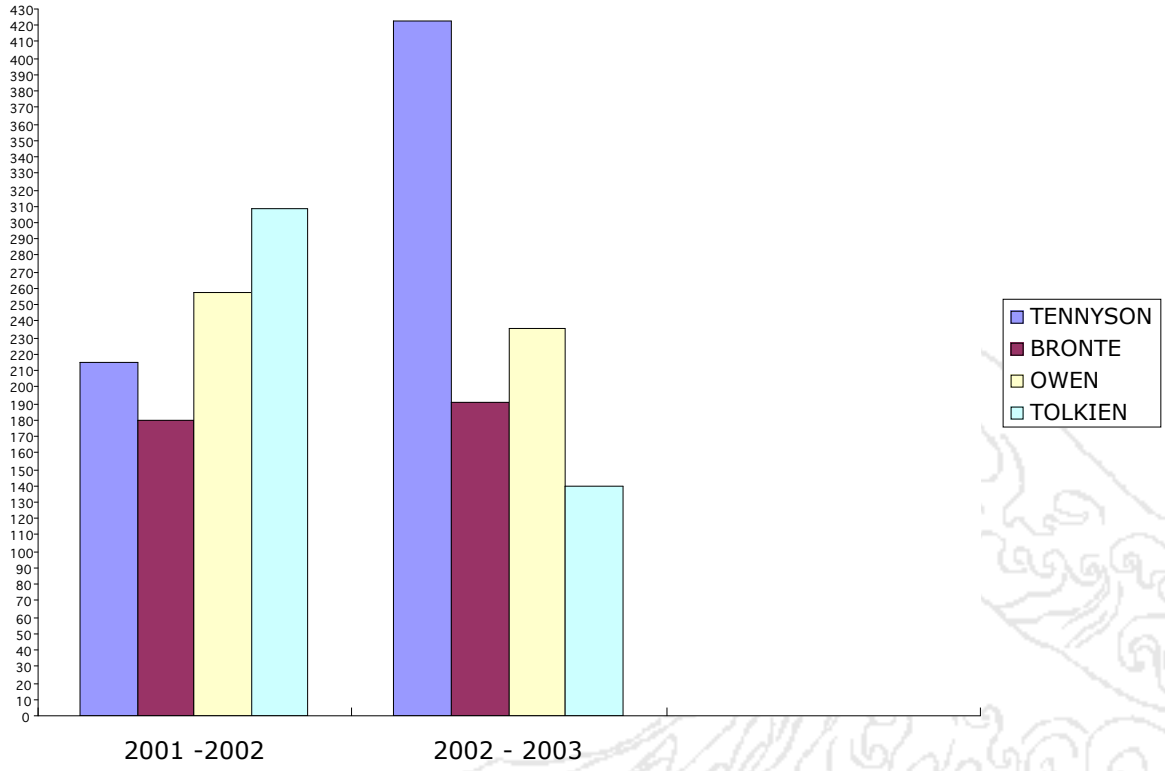
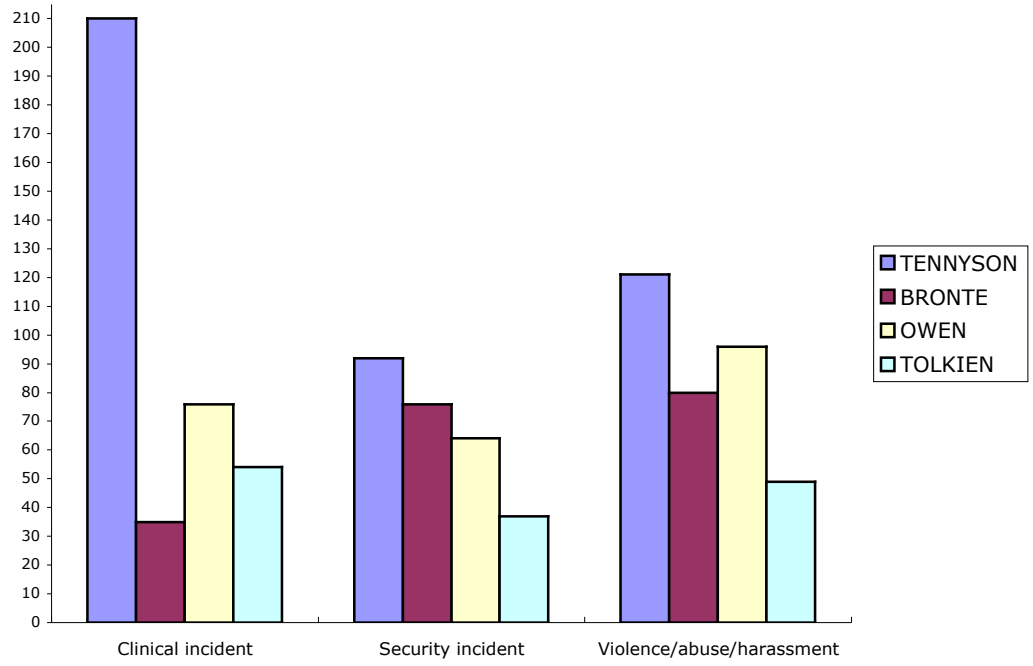


Figure 3: Number of incidents that were reported within each category of incident for all the acute wards October 2002 – September 2003



Of the 990 incidents recorded for the year 1st October 2002 - 30th September 2003, 375 were categorised as clinical incidents, 269 as security incidents and 346 as violence/abuse/harassment. The *percentage of incidents* within these categories that occurred on each of the four wards is shown in **Table 9.**

Table 9: Percentage of untoward incidents occurring on each of the admission wards, October 2002 – September 2003

Category of incidents	Percentage (%) of the total number of incidents in each category				Total
	Tennyson	Bronte	Owen	Tolkien	
Clinical Incident	56	9	20	15	100%
Security Incident	34	28	24	14	100%
Violence/Abuse/Harassment	35	23	28	14	100%

7.2.1.4 Untoward incidents on Tolkien Ward

An essential aspect of this evaluation has been to look at Tolkien Ward not in comparison with the other acute wards at the QEPH, but in relation to itself prior to and following the introduction of the Tidal Model to see if there were any significant changes between the two periods. The data obtained from the Safecode database was therefore analysed in more detail to determine the exact nature of these incidents. For example, the 'clinical incident' category was

subdivided into what was considered to be 'serious' in contrast with minor incidents. This allowed the incidents to be placed in more specific and meaningful categories (see **Table 10**, below).

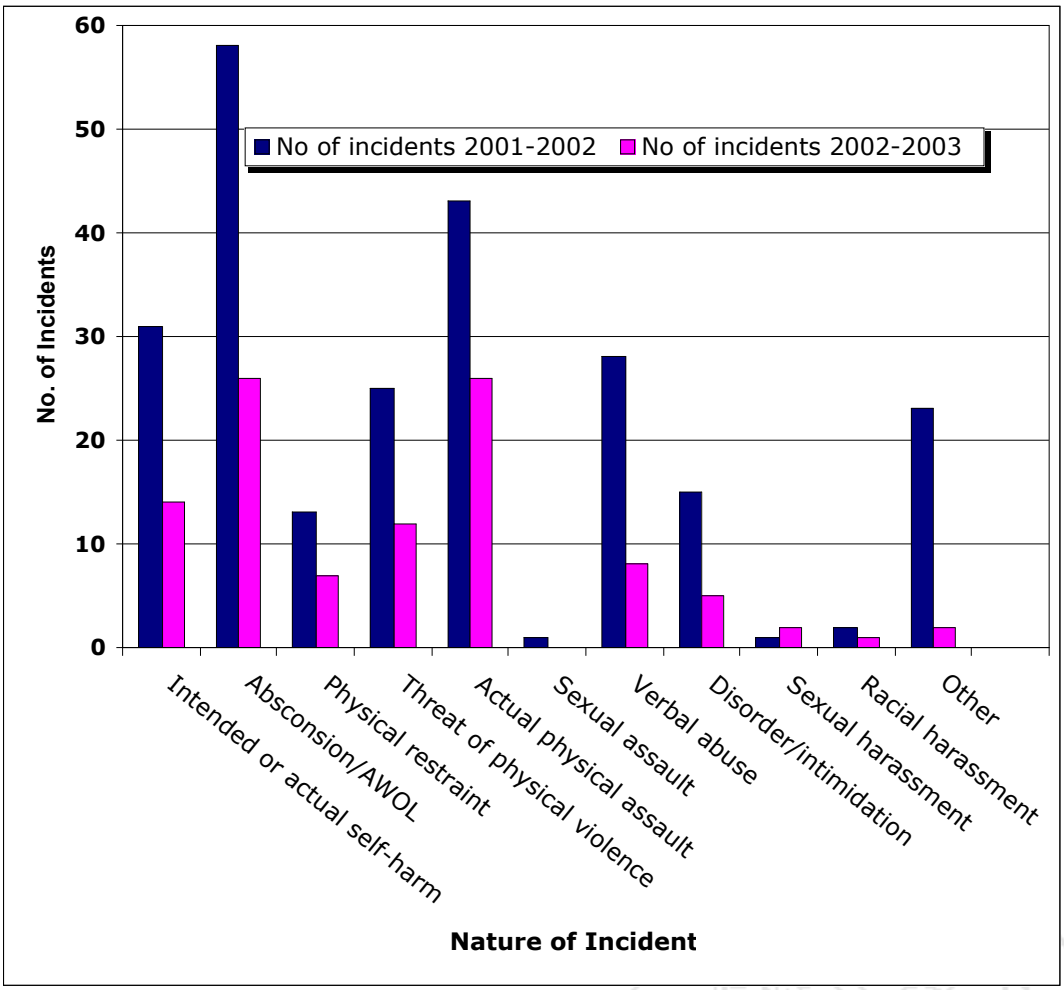
It was found that some incidents were not relevant to the issue of 'milieu toxicity' as defined above and they have therefore been excluded. Thus, the total number of incidents for both years shown in **Table 10** is lower than the totals given above.

Table 10: Number of incidents of each type before and after the introduction of the Tidal Model on Tolkien Ward

Nature of incident	Number of incidents	
	2001-2002	2002-2003
Intended or actual self-harm	31	14
Absconsion/AWOL	58	26
Physical restraint	13	7
Threat of physical violence	25	12
Actual physical assault	43	26
Sexual assault	1	0
Verbal abuse	28	8
Disorder/intimidation	15	5
Sexual harassment	1	2
Racial harassment	2	1
Other	23	2
Total	240	103

As both **Table 10** above and **Figure 4** (following page) indicate, the numbers of incidents of all types were reduced dramatically following the introduction of the Tidal Model, with the exception of sexual harassment where the increase was minimal.

Figure 4: Comparison of the number of each type of incident on Tolkien Ward in the twelve months before and after the introduction of the Tidal Model.



7.2.2 Characteristics of Patients Admitted to Tolkien Ward

Data was then obtained from the Trust's electronic patient information system (ePEX) in order to obtain an overview of the admissions, discharges and characteristics of patients admitted to Tolkien Ward before and after the implementation of the Tidal Model.

7.2.2.1 Number of Admissions

In the year prior to the introduction of the Tidal Model (1st October 2001 - 30th September 2002) there were a total of 308 admissions to Tolkien Ward, including transfers from other wards. This comprised 267 individual patients. As **Table 11** below indicates, 27 patients were admitted twice during that period, four patients were admitted on three occasions and two patients were admitted four times. Patients who were admitted to Tolkien, transferred to another ward, and then subsequently transferred back to Tolkien are counted as a single admission.

The number of admissions to Tolkien Ward after the introduction of the Tidal Model (1st October 2002 - 30th September 2003) was slightly lower than during the previous year. The 277 admissions comprised 252 individual patients, of which 23 were admitted twice and one patient was admitted on three occasions.

Table 11: Number of admissions and repeated admissions to Tolkien Ward before and after the introduction of the Tidal Model

	Number of Service Users	
Number of Admissions	Oct 01 - Sept 02	Oct 02 - Sept 03
1	234	228
2	27	23
3	4	1
4	2	0
Total Number of Admissions	308	277

The mean length of in-patient stay for patients admitted during the period 1st October 2001- 30th September 2002 was 33 days. This ranged from a single day to 482 days. Following the introduction of the Tidal Model the mean stay was 35 days. However the range was lower: from a single day to 314 days.

7.2.2.2 Source of Admissions

Table 12: Percentage of patients admitted to Tolkien Ward via different sources before and after the introduction of the Tidal Model

	Percentage (%) of Service Users	
Source of Admission	Oct 01 - Sept 02	Oct 02 - Sept 03
QEPH Ward Transfer	23.7	28.2
Emergency Domiciliary Visit	18.8	15.2
Emergency GP	14.6	7.2
NHS Accident & Emergency Department	9.0	15.6
Out Patients Clinic	8.4	8.3
Police Station	6.8	7.2
NHS General Hospital	5.8	1.8

Emergency CPN	3.6	5.4
Self-Referral	2.9	2.9
Planned Admission	2.6	1.1
Emergency Social Worker	2.3	4.3
Court	0.9	0
Usual Place of Residence	0.4	0.7
Other NHS Psychiatric Hospital	0.3	1.1
NHS Maternity Hospital	0	0.4
Day Hospital	0	0.4
Not Known (No Fixed Abode)	0	0.4
Total	100	100

7.2.2.3 Patient Age

The age ranges of patients admitted to Tolkien Ward during the time periods were very similar. In October 2001 – September 2002, the range was 16-67 years, and in October 2002 – September 2003 the range was 17-73 years. The mean age for both time periods was 39 years.

Table 13: Age of patients admitted to Tolkien Ward before and after the introduction of the Tidal Model

Age Group	Percentage (%) of Service Users	
	Oct 01 - Sept 02	Oct 02 - Sept 03
<18	1.1	0.4
18-24	15.7	14.3
25-34	24.3	24.6
35-44	26.2	27.0
45-54	18.7	21.4
55-64	12.0	9.9
65+	1.9	2.4
Total	100	100

7.2.2.4 Medical diagnosis

Figures 5 and 6 following show the diagnoses for patients admitted to Tolkien Ward during the two time periods under study. There is no significant difference in the medical diagnosis of patients over the two year period indicating that changes in the number of untoward incidents was not related to any significant changes in the patient population in terms of diagnosis.

Figure 5: Medical diagnoses of patients admitted to Tolkien Ward prior to the introduction of the Tidal Model

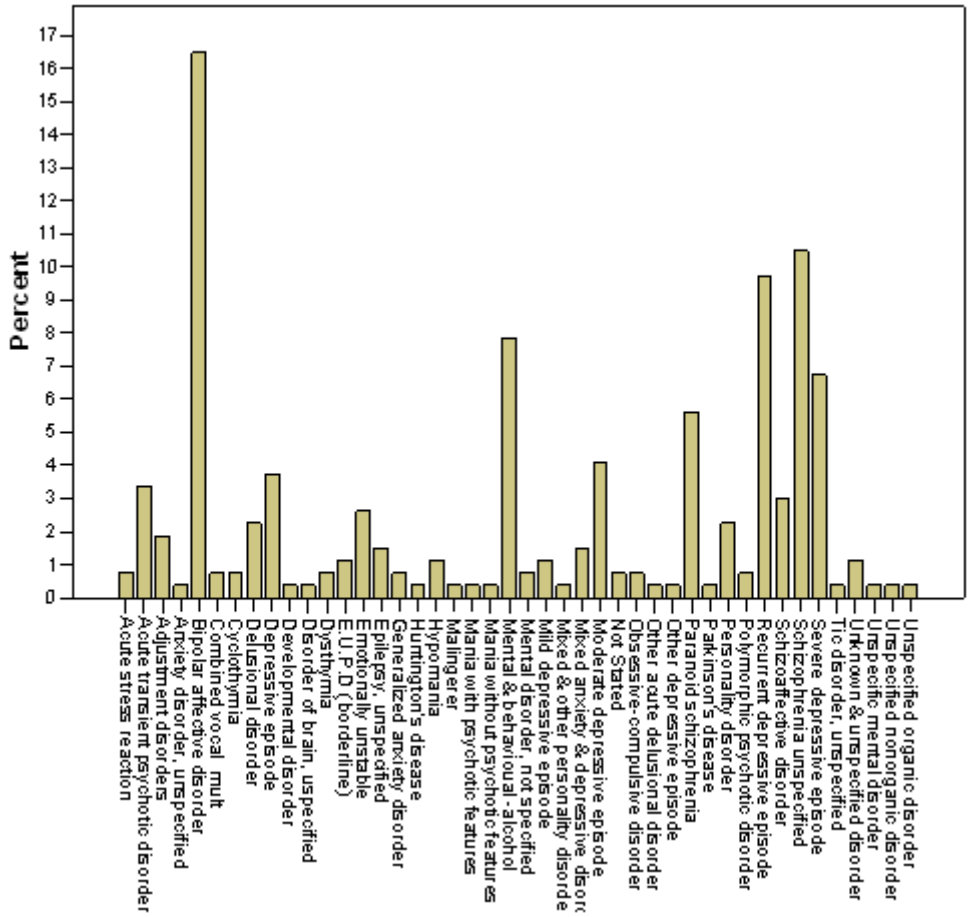
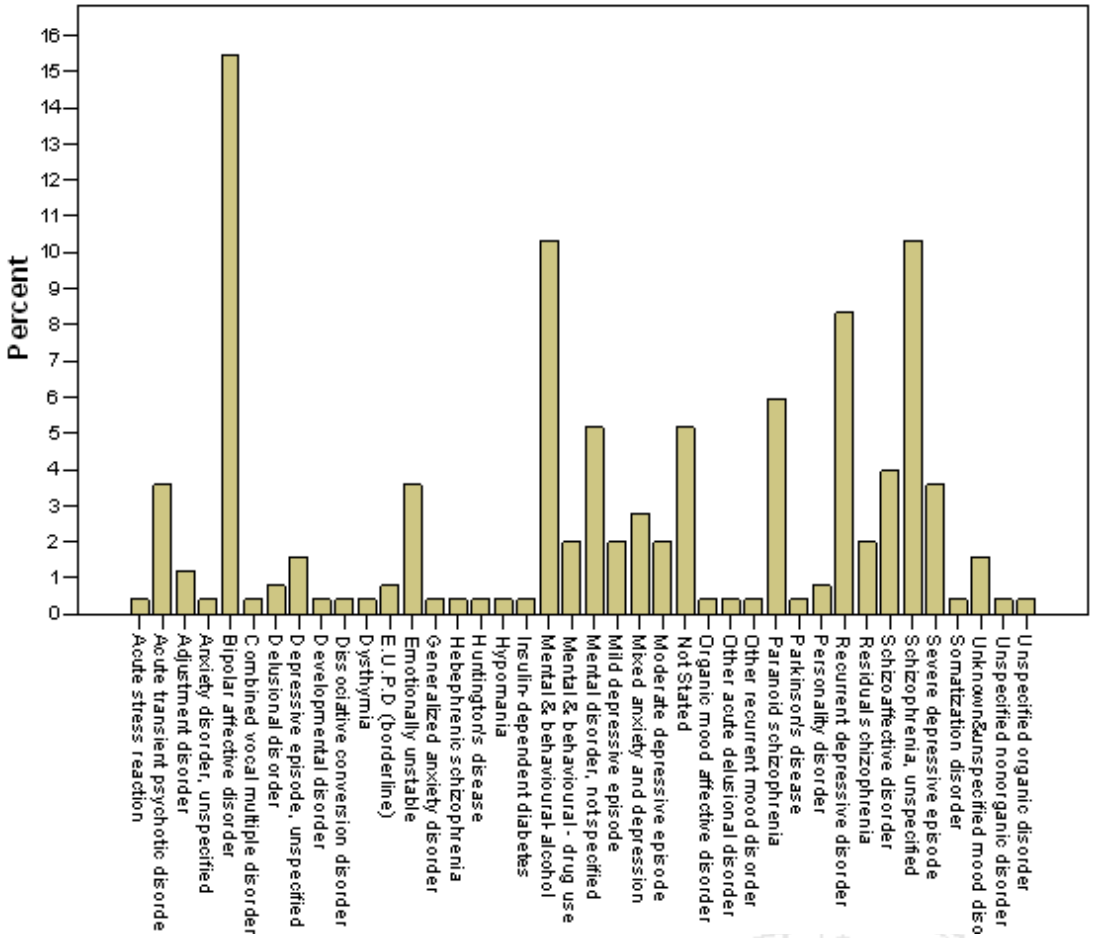


Figure 6: Medical Diagnoses of patients admitted to Tolkien Ward following the introduction of the Tidal Model



7.2.2.5 Patient Ethnicity

Table 14: Ethnic groups of patients admitted to Tolkien Ward

Ethnic Group	Percentage (%) of Service Users	
	Oct 01 - Sept 02	Oct 02 - Sept 03
Asian/Asian British Bangladeshi	5.5	1.4
Asian/Asian British Indian	0.7	2.4
Asian/Asian British Pakistani	0.7	2.4
Asian British Other	0.4	0
Black/Black British African	0.7	0.4
Black/ Black British Caribbean	2.6	6.0
Black/Black British Other	0.4	0
Chinese	0	0.4
Mixed White & Black Caribbean	0.4	1.2
Mixed Other	0.4	0.4
White - British	59.2	65.1
White - Irish	3.4	2.4
White - Other	1.9	1.6
White	8.2	4.8
Other Ethnic Group	1.5	1.6
Not Stated	14.2	11.1
Total	100	100

7.2.2.6 Methods of Discharge

Table 15: Methods of discharge from Tolkien Ward before and after the introduction of the Tidal Model

Method of Discharge	Percentage (%) of Service Users	
	Oct 01 - Sept 02	Oct 02 - Sept 03
On Medical Advice:		
Usual Place of Residence	58.4	45.1
Local Authority Residence	0.3	0
Temporary Residence	0.9	0
NHS General Hospital	0.3	0.3
NHS Psychiatric Hospital	0.9	0.9
Non-NHS Hospital	0.3	0
Police Station	0.6	0.3
Not Specified	10.0	15.9
Against Medical Advice	4.9	2.5
Self Discharge	1.9	1.4
MHRT	0	0.4
Transferred within the Trust	20.8	30.0
Died	0.3	0
Not Specified	0	2.5
Not discharged at time of data collection	0	2.5
Total	100	100

7.2.3 Complaints

7.2.3.1 Number of complaints relating to nursing care

Both before and after the introduction of the Tidal Model, Tolkien Ward has had a slightly higher number of complaints concerning nursing care in comparison to the other three acute admission wards at the QEPH. In the first year it had the second highest and after the introduction of the Tidal Model, the highest. But, as both the sample and the differences are relatively small it is not possible to draw any conclusions from this

Table 16: Number of complaints relating to nursing issues by Ward at the QEPH 01/10/01 – 30/09/02 and 01/10/02 – 30/09/03

Ward	01/10/01 – 30/09/02	01/10/02 – 30/09/03	Total
Bronte	13	17	30
Owen	28	17	45
Tennyson	9	16	25
Tolkien	22	23	45

7.2.3.2 Analysis of complaints on Tolkien Ward

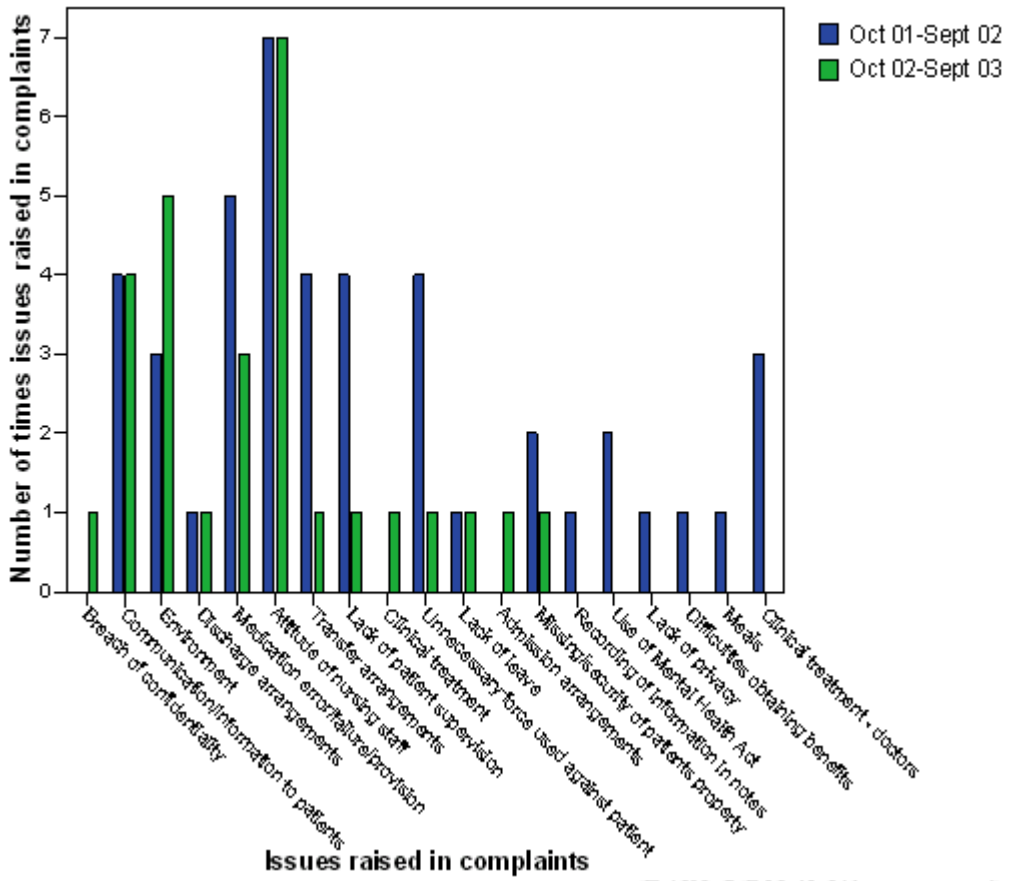
There were 22 individual complaints concerning staff, including medical and nursing staff as well as environmental issues on Tolkien Ward during the year prior to the introduction of the Tidal Model. A number of these involved more than one issue, and therefore each issue is represented in the graph below (**Figure 7**). The total number of issues raised in complaints for the year 1st October 2001 – 30th September 2002 is 45.

In the year following the implementation of the Tidal Model, 27 complaints were made in total. One complaint raised two concerns, and therefore the total number of *issues raised* totals 28. This is substantially lower than the previous 12 month period.

The issues raised during the two time periods were very similar ,but the following differences are worthy of note. There were significantly fewer complaints about lack of patient supervision and unnecessary force being used against a patient.

Interestingly, one of the complaints made following the introduction of the Tidal Model concerned a patient feeling they were not involved enough in decisions regarding their nursing care plan. This indicates that patients may be becoming more aware of their collaborative role in their care as a result of the Tidal Model.

Figure 7: Issues raised in complaints against all professions: on Tolkien Ward - A comparison of the year prior to and following Tidal Model implementation



7.2.4 Concluding remarks

In the 12 months following the introduction of the Tidal Model on Tolkien Ward the total number of untoward incidents decreased by 55% (or by 57%, depending upon which figures are used). Significantly, the data presented indicates that the patients admitted to Tolkien Ward in the year prior to the implementation of the Tidal Model had similar characteristics in terms of age, diagnosis, ethnicity, and methods of admission and discharge to those admitted after the Tidal Model was introduced.

This suggests that the reduction in untoward incidents was not related to any significant changes in the characteristics of patients admitted to Tolkien Ward during the two periods. The only slight difference was the overall number of patients admitted following the implementation of the Tidal Model. This was lower than in the previous 12 months and there were slightly less repeated admissions.

With respect to complaints, the total number of complaints remained about the same, but the nature of complaints against nursing staff changed somewhat. Following the introduction of the Tidal Model there were far fewer complaints with respect to patient supervision and less complaints against nurses using unnecessary force against patients. However the data is just not robust enough to draw any significant or firm conclusions one way or the other.

CHAPTER EIGHT: DISCUSSION AND CONCLUSION

8.1 Discussion

8.1.1 Interpreting the results of untoward incidents

Both current and past research indicates that it is the quality of the personal relationship between the person in need and the person providing help or care that will impact most significantly how the person in need will *respond* to the care being given. The key factor is how that person is treated. This will also be the most important factor determining whether or not the care, counselling or therapy will be experienced by the client as helpful or not (See Rogers, CR 1951).

When transposed over into the field of mental health nursing, this most basic and foundational therapeutic principle would indicate that where the relationship between mental health service users and the nursing staff on acute wards is summary, with little opportunity for nurses and patients to talk meaningfully about what most concerns them, the therapeutic experience of patients will be corresponding poor and anti-therapeutic. In such environments low staff morale and high staff turnover would also be likely because nurses would also find their relationship to patients equally unsatisfactory. The evidence of this study suggests that a poor, non-therapeutic environment is created on acute wards:

- ⇒ When service users do not feel that their needs are being heard, respected or understood by the nursing staff
- ⇒ When nursing assessments are not undertaken in a truly client-centred way that fully respects the patient's own views and version of events
- ⇒ When nurses do not engage with patients therapeutically on a regular basis and provide time to talk through problems and issues
- ⇒ When patients are not involved daily or almost daily with the nurse in a genuinely collaborative construction and review of their own care plans
- ⇒ Where the nursing culture is custodial, dictative and controlling in style and atmosphere rather than empowering, client-centred, collaborative and recovery oriented

Under such conditions it would not be surprising to find that some patients 'act out' and vent their frustration, sense of powerlessness and anger in different kinds of destructive ways against a) themselves, b) other patients, c) the nursing and medical staff, and d) the 'mental health institution' which has curtailed their freedom, not listened to their needs, and appears not to care very much.

It would also not be surprising to find that, when service users feel that their views are being heard and respected and discover through personal experience that their care plans are being done in a positive spirit of collaboration with the nursing staff and thus taken seriously, some of the most 'difficult of patients' stop 'acting out' as before and became much more willing to co-operate with their treatment programme and begin to get better and to recover from their mental health problems.

All of this is perfectly reasonable to suppose at the level of common sense. This common sense supposition is confirmed not only by research, but also by the testimony of service users and experienced nurses.

Common sense would also seem to indicate that the number and frequency of serious untoward incidents on an acute in-patient ward should provide one indicator (amongst others) of 'how how well people are getting on' and would reflect, in some way, *the quality of the nurse-patient relationship.* If this were not the case, the rationale for obtaining information about such incidents for analysis could be called into question.

It is therefore also reasonable to suppose that clear evidence of a substantial decrease in untoward incidents over a period of time, (other factors, such as the nature of the in-patient population, being constant) would suggest that there had also been a corresponding decrease in relational toxicity and an improvement in the ward's therapeutic milieu.

If, concomitant with this, nursing practices on that ward during that same period could be shown to have substantially changed for the better (other factors such as medical practices remaining basically the same) it would then also be reasonable to suppose that *the decrease in serious untoward incidents was functionally related in some way to the documented improvements in nursing practice*. This appears to be the case for Tolkien Ward in the year following the introduction of the Tidal Model.

When set out in terms of **Table 17** below, the significant reduction in untoward incidents on Tolkien Ward is evident in all serious categories of incident.

Table 17: Percentage of decrease in serious untoward incidents on Tolkien in the year following Tidal Model implementation.

Nature or type of reported incidents	Decrease in incidents from previous year
Intended or actual patient self-harm	A decrease of 55%
Absconsion/AWOL	A decrease of 51%
Physical restraint	A decrease of 46%
Threats of physical violence	A decrease of 52%
Actual physical assault	A decrease of 40%
Verbal abuse	A decrease of 71%
Disorder/intimidation	A decrease of 67%

8.1.1.1 Other plausible reasons for the reduction in incidents

Nevertheless, caution should be used before jumping to the conclusion that the reduction in serious incidents has been due exclusively to the Tidal Model. Other explanations of the evidence should first be considered. It could be argued, for example, that there may have been significant changes in reporting behaviour, rather than any real reduction in the number of incidents per se. However, this is unlikely as during the year of Tidal Model implementation there was a general 'tightening up' of nursing professionalism within the nursing team as a whole in all areas as evidenced in **Chapter Six: Narratives of Change**.

In addition to this, staff were not aware that their reporting of incidents was going to be part of any evaluation. Therefore it is possible that the reduction of incidents could be greater, not less, than the data suggests. But, there is no way to prove this one way or the other.

It is also theoretically possible that just one or two difficult patients were causing all the disturbances in the year prior to Tidal Model implementation and that this was the reason the number of incidents was so high. On analysis of the Safecode database, however, it has been determined that four patients were responsible for a high proportion of the incidents reported in the pre-Tidal Model year. During the year following Tidal Model implementation, two of these patients were readmitted, but without incident. In addition to this, those patients, which were responsible for untoward incidents in the second year 'acted out' less frequently.

It would also be strange to claim that the frequency and seriousness of untoward incidents on acute wards bore *no relationship at all* to the quality of the nursing care being provided as that would call into question all current research and undermine the rationale of all current DoH recommendations [58] for improving acute in-patient services.

Most of the evidence of this study suggests that serious untoward incidents do not normally occur purely as a function of some mysterious disease process going on inside individual patients arising independently of and bearing no relationship at all to the context of care. On rare occasions this might be the case for people suffering from an organic illness, toxic confusional state or brain injury. However the majority of the patients admitted to the four acute wards at the QEPH during the two years of this study did not fit into that category.

In other words, the evidence of this study strongly suggests that the frequency and seriousness of untoward incidents is related to the nature of the care being given and to how therapeutic (or non-therapeutic) that environment is for people going through whatever crisis has led to their admission to hospital.

Finally, there were no additional resources made available to Tolkien Ward during the Tidal year (financial, extra interview rooms, staff etc.) to which any change in data could be ascribed [59]. What did change was the introduction of the structure and therapeutic ethos of the Tidal Model in conjunction with adequate preparation at the beginning of each shift, the adoption of the shift co-ordinator system and staff education in time management and self-discipline which enabled the implementation of the Tidal model to be successful. It is all of these factors working together which have led to substantial changes in nursing practice in the midst of less than ideal circumstances.

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[58] DoH 1999). Mental Health Nursing: 'Addressing Acute Concerns': Department of Health. Report by the Standing Nursing and Midwifery Advisory Committee, (DoH 2002). Mental Health Policy Implementation Guide: Adult Acute In-patient Care Provision. London and DOH (2003). Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments

[59] Central to the success of this project has been the difficult task of 'making time' for nurses to sit down and talk to patients despite periods of high clinical activity on a 22 bedded ward with five Consultant Psychiatrists with their attendant SHO's and Medical Students, each asking for precious nursing time on an ad hock basis to discuss their patients. In addition to this, there are only two rooms available on Tolkien Ward suitable for interviewing and doing care plans with patients in a confidential atmosphere with minimal interruptions.

8.1.1.2 Rigorous 'proof' or inference to the best explanation? [60]

It is just not possible to prove with the rigor of the natural sciences that a specific intervention into a complex social system will have a direct impact on only one aspect of that system or that other factors are not also impacting that aspect at the same time. Action research methodology is very different from the procedures of Random Control Trials (RCTs). For example, in relation to this study, other changes, such as changes within the staff team (a change in Ward Manager) and within the hospital and the National Health Service were occurring concomitantly with the Tidal Model implementation. Finally, there is also the recognized factor of what has been termed the Hawthorne Effect, whereby initial improvements in any process may be stimulated simply by the obtrusive observation of that process.

However, despite these caveats, it is still possible to reasonably infer a strong connection between the introduction of the Tidal Model in conjunction with the changes in ward management outlined above and the significant reduction of untoward incidents. These interventions have facilitated in a real improvement in the therapeutic culture of the ward. This is reflected in a substantial improvement in staff morale, in an increasing sense of professional competence, and a renewal of the staff team's motivation to deliver a high quality service in a very difficult and often dangerous clinical setting. See **(7.1.2 and 7.1.3)**

Additionally, this evidence does not stand on its own ,but should be correlated with the service user testimonies and evaluation **(7.1.1)**, interpreted in the light of the other studies referenced in the literature review (See **2.1-2.7**) and in the context of data emerging from other Tidal Model pilot sites in the UK and in other countries. For example, compared with another study undertaken at the Newcastle City Health Trust by Fletcher & Stevenson (2001) the following similarities should be mentioned.

- **Legal Status**. It has was not possible in this study to determine if there was any difference between the two years in terms of the percentage of people admitted on an informal basis in comparison with those admitted under a section of the MHA. This was due to difficulties with the database.
- **Mean Length of In-patient Stay**. In the Newcastle study the length of in-patient stay was reported to have decreased by 24% following Tidal Model implementation. On Tolkien Ward the mean length of in-patient stay remained basically the same, although the range was lower (from 1 day to 314 days) following Tidal Model implementation than in the previous year (1 day to 482 days).
- **Untoward Incidents**. In the Newcastle study there was a decrease in reported violent incidents of 40%. For Tolkien Ward the reduction was the same. In Newcastle there was a decrease in episodes of self-harm of 6%. On Tolkien Ward the decrease was 55%. In Newcastle there was a 67% reduction of the use of restraint. On Tolkien Ward the reduction was 46%

[60] See **(2:10) Abduction**. This is reasoning that is prepared to accept a conclusion purely on the grounds that it appears to satisfactorily explain what evidence is available at the time; it is the pattern of reasoning most commonly used by ordinary people day by day and is used is both action research and grounded theory. It does not seek to prove that (a) 'causes' (b) in the way typical of the natural sciences and in fact insists that the complexity of many situations prohibits 'proof' of this type. Peirce calls this kind of ordinary reasoning '*inference to the best explanation available at the time'*. This type of reasoning is judged to be *adequate* to most of our purposes in life[60] including, it can be argued those mental health nursing practices, which facilitate good care.

- **Staff Evaluation of the Model**: Staff evaluation for both pilot sites was positive although the staff response rate for the QEPH was disappointingly low (Qualified Nursing staff 64%, Nursing Assistants 10% Medical Staff, 30%).

8.1.2 What this study confirms in terms of other studies

This study has been focused on nursing practice in acute admission wards at the Queen Elizabeth Psychiatric Hospital. This present study indicates that there is a major dislocation of the representation or *public face* of nursing practice at the QEPH and *the reality behind that appearance* [61], at least as reflected in the testimony of nurses working on the acute wards. Two points are worth making in connection with this observation:

- *First of all*, a gap between the presentation of in-patient acute services (as evidenced, say, in the recorded minutes of meetings, in managerial policies and so on) and the reality of clinical nursing practice at the ward level has always existed in the mental health field and is recognised by the NHS Modernisation Agencies three booklets on creating an 'improvement culture' (2004) as one of the most difficult aspects of the present system to change. Research also indicates that this gap tends to widen in direct proportion to the organisational 'distance' of managers from the context of day-to-day nursing care on the wards. This is especially the case with respect to what Goffman (1961) famously termed 'total institutions' [62].

- *Second of all,* problems on the acute admission wards at the QEPH mirror similar problems within the acute in-patient services nation-wide as evidenced in the professional journals and other literature. These problems have led, in recent years, to a number of specific DoH directives[63], amongst which are that:

  - Acute in-patient care should be client-centred care that is sensitive to the needs of patients
  - Care should be individualised, comprehensive and continuous
  - A range of therapeutic options should be available
  - Staffing levels and skill mix must be geared to the provision of effective care

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[61] See Goffman, Erving (1974). Goffman rightly draws attention to the fact that the face which organisations present to the public has analogies to ' *a theatrical frame*' and has the attri,butes of a performance and a fabrication. Also see Goffman (1971), and (1961).

[62] According to Goffman (1961). - *" A total institutions may be defined as a place of residence and work where a large number of like-situated individual, cut off from the eider society for an appreciable period of time, together lead an enclosed, formally administered round of life*". The concept of a "total institution" is an elastic concept, Although Goffman focuses on "strong" examples of total institutions such as traditional mental hospitals, prisons, a 19th century man of war, and a monastery by using these "strong" examples he fairly describes the concept and applies it well to even less strong examples. Goffman gives the following characteristics of total institutions*:*

- *All aspects of life are conducted in the same place under the same authority;*
- *The individual is a member of a one class of persons "i.e. mental patient", and to that extent all are treated alike;*
- *All daily activities (over a 24-hour period) are tightly scheduled (i.e. Times of meals, medication rounds, Ward rounds etc);*
- *There is a sharp split between supervisors (doctors and nurses) and lower participants (patients) and;*
- *Information about the member's fate tends to be withheld.*

[63]National Service Framework for Mental Health, Modern Standards & Service Models, Department of Health (1999).; Clinical Governance: Quality in the New NHS DOH (1999). London; and DOH Directives: Addressing Acute Care Concerns, the Mental Health Policy Implementation Guide Adult Acute In-patient Care Provision 2002.

The findings of this study are therefore consistent with and confirm what is generally known, referenced and discussed within the literature review, namely:

1. The adult acute in-patient services in England are not working to the satisfaction of anybody [64].

2. The quality of care on acute wards has, for various reasons (historical, economic, and political) been badly compromised and is now under constant threat.

3. Acute wards are often places of risk, violence, restraint and custodial care where there is little therapeutic engagement between ward-based nurses and in-patient service users, places where patient care is not normally client-centred and care planning is, for the most part, a paper exercise.

4. There is confusion, ambivalence and uncertainty within modern mental health services about the role of mental health nursing on acute wards which is related to number of factors:

    a. The function and purpose of acute in-patient services are unclear or subject to strong differences of opinion, differences which reflect opposing philosophical views of what it means to be a human being and of the nature of sanity/madness.

    b. There is, concomitant with this, a lack of clarity within the nursing profession itself about the nature of its own knowledge base, its status and the appropriate domain of practice in relation to the other mental health disciplines such as medical psychiatry, psychology, social work and occupational therapy.

    c. In-patient acute mental health nursing (as opposed to nursing in the community) still tends to operate within the constraints and ideology of the psychiatric medical model. The medical model, although appropriate for psychiatrists, is not appropriate for nurses and has not, to date, resulted in any effective *nursing approaches* to the care of people with mental health problems.

5. On the other hand, the literature consulted is very clear in its basic identification of those nursing practices and approaches to care which are therapeutic and promote healing (See **5.1**) in contrast with those practices which are 'toxic' to personal growth and are therefore anti-therapeutic (See **2.1 - 2.3**)

6. Central to all these discussions is the therapeutic significance of the *quality of the nurse-patient relationship*. The therapeutic experience of patients is enhanced when nurses talk to them, spend quality time with them and where genuinely collaborative client-centred care planning is adopted as the fundamental principle underlying nursing care. Nursing care is not therapeutic when it does not reflect these basic principles

[64] Mental Health Policy Implementation Guide: Adult Acute In-patient Care Provision. London. DOH (2002)

and/or when nurses claim they just 'do not have time' to talk to their patients because of other more important tasks.

7. Wide dissemination and use of the Tidal Model nursing manual in conjunction with an appropriate re-training programme and the adoption of good management principles is an effective and efficient way to reform non-therapeutic nursing practices on acute wards. The Tidal Model provides both the tools and the structure to facilitate this in accord with good evidence-based nursing practice, recent DoH guidelines and directives and in a way that fits the recommendations of the National Services framework (DoH 1999).

8.1.3 What this study adds to other studies

8.1.3.1 The relational nature of empowerment

One finding of this study is that the feelings of powerlessness many QEPH nurses feel in the context of the present in-patient system tends to mirror in interesting ways the powerlessness that many patients feel over their own psychiatric symptoms and situation within that system. Thus the 'empowerment' of patients in and through collaborative care planning has proved to be instrumental in empowering nurses as well. This has led to an increase in staff morale and growing sense of professional competence. This also suggests that the empowerment of both nurses and service users is fundamentally and systemically linked in interesting ways that could have important implications for the reform of the mental health system as a whole.

An empowering interactions model of mental health nursing thus may have an untapped potential to facilitate change at the organisation level (as below, so above) with wider applications at different levels within the development of an improvement culture within the NHS, and thus to the specifically nursing contribution within the Birmingham and Solihull Mental Health NHS Trust.

8.1.3.2 Nursing perceptions of time

This study suggests that nursing perceptions of the flow and content of time during a shift are not entirely objective but are, in part, socially constructed. This has been indicated by other research (See **5.2**) but only as a general statement in relation to other issues. This study has confirmed that nursing perception of time are constructed within the nursing culture itself, and strongly influenced by nurses' expectations and (mis-) understandings of their role on acute wards purely in terms of containment of violence, mental disorder and risk management. The perceived lack of nursing time to talk to patients is thus more about the institutionally constructed nature of the nurse-patient relationship itself 'within the system' and the way in which nurses conceptualise mental health problems than it is about the actual amount of time available to nurses each shift.

This study has also indicated that nurses' understanding of their role tends to be unhelpfully restricted or confined within the parameters of a dominant medical model in ways which are counter-productive and mitigate against ward-based nurses finding *uniquely nursing solutions* to otherwise intractable problems which develop on acute wards.

If it were the high levels of clinical activity on the wards, and only that, which creates an absolute lack of time to talk to patients (as believed by many nurses), then *no changes in nursing practice would be possible at the QEPH under present conditions*. Contrary to this belief, this study has confirmed that time to talk to patients can be 'created' in and through reforming nursing practice according to good principles of change management in conjunction with a clear vision of and focus upon the proper domain of nursing care as this is distinguished from the other mental health professions such as medical psychiatry, psychology and social work.

8.2 Conclusion

The implementation of the Tidal Model on Tolkien Ward has resulted in positive experiences for both nurses and patients and a change in the therapeutic culture of the ward. The changes in nursing practice described in this study clearly have a functional relationship to the many beneficial outcomes also evidenced in this report. All of these outcomes are consistent with the findings of several other studies of the Tidal Model undertaken within the United Kingdom and New Zealand. See **(5.8)**.

8.2.1 Creating negative and positive communication feedback loops.

Analysis of the original QEPH nursing staff interviews (**Chapter Four**) identified an entrenched 'negative communication feedback loop' on the four acute wards which had the following characteristics:

Nurses claimed they were too busy doing other things to talk to their patients or to engage with them therapeutically on any regular or structured basis. However, evidence suggests that the failure of nurses to talk to patients and to get to know them and their needs properly leaves service users abandoned within a containment and custodial system of in-patient care. See (**2.1** and **2.3**). It is in such a context that service users tend to 'act out' in destructive ways. The nurse's role then becomes increasingly focused on suppressing that destructive or attention-seeking behaviour in order to keep the ward safe. The reason nurses then give for not engaging with patients therapeutically is that they are:

- Too busy – keeping the ward safe
- Too busy – 'fire-fighting' and crisis management
- Too busy doing one-to-one observations or 'sitting on the door'
- Too busy doing paper work and administration
- Too busy on the phone in the office
- Too busy being available to medics 'on demand'

Within the context of this negative feedback loop the main clinical and management objectives are confined to risk management, and 'fire-fighting'. Nurses then see themselves as caught up within a chaotic system within which they are constantly stressed and placed at risk whilst service users complain about the way in which they are treated and see their in-patient experience as non-therapeutic.

On the other hand, this study has provided evidence that suggests that a positive communications feedback loop can, with determination and effort, be created, that is capable of reversing some of the negative features of the present in-patient system. This involves at least two main tasks:

1. The first task *is to empower nursing staff to re-define their own role, within the multi-disciplinary team, so that nursing is re-focused upon the appropriate domain of nursing care*. This task involves, first of all, an initial and then an on-going in-service re-training and education programme based on an empowering interactions model of nursing practice where the emphasis is placed on the nurse-patient relationship as a genuine therapeutic (healing) partnership oriented towards recovery from mental health and other life-dominating problems, a partnership within which the patient's narrative and story is privileged in a client-centred way. See **Chapter Five: Why the Tidal Model?**

2. The next aspect of this process involves *building in structured time on the ward at different levels within the nursing process itself for good communications within the staff team, daily collaborative assessments and daily care planning with service users*. This is a key change management issue, which is on-going. It is an effort which will be resisted by the old nursing culture, a resistance that can be overcome with perseverance and senior management support.

With these changes in place a positive communications feedback loop can be created which facilitates positive changes in nursing perceptions, nursing practice and the nursing culture. This positive loop has the following impact on service users experience of in-patient treatment:

⇒ Patients' begin to feel their needs are being heard and acted upon
⇒ Leading to better communication within the nursing team and MDT
⇒ Patients, then become more willing to cooperate with and to 'own' their care plans because they know that their views have been heard and respected as well as acted on
⇒ Through this experience they begin to adopt a 'recovery oriented' attitude to their mental health and other problems
⇒ Leading to less disturbance on the ward, less restraints fewer untoward incidents, and to less 'acting out' through anger, frustration a sense of injustice or despair
⇒ Leading to less crisis management of the ward ('fire-fighting') and to a safer, more relaxed and therapeutically oriented-ward environment and thus to
⇒ More time for nurses to talk to patients in one-to-one and group settings and thus to
⇒ A substantial improvement in the therapeutic experience of patients on acute admission wards.

CHAPTER NINE: RECOMMENDATIONS

9.1 General recommendations for BSMHT:

The Director of Nursing and other Executive Directors of the Trust should consider the findings in this report with a view to implementing the Tidal Model more widely across BSMHT.

9.2 Recommendations for staff training and development:

The Director of Nursing should use the information contained in this report to influence the content of pre and post-registration nurse training.

APPENDICIES

10.1 Historical and Theoretical Background of the Tidal Model

Below is a brief précis of the work of Hildegard Peplau with an emphasis on its relation to the Tidal Model , along with précis of seven recent papers dealing directly with the theory, evidence base, and history of the Tidal Model.

Peplau, Hildegard *(1952/1988) Interpersonal Relations in Nursing: A Conceptual Frame of Reference for Psychodynamic Nursing,* Macmillan

Peplau's work provides both the historical and theoretical foundation (from within the nursing profession) for the creation of a robustly humanistic approach to nursing practice. Peplau locates the proper focus of nursing care within the context of human relationships rather than in the context of medical technology and diagnostic categories. Peplau's work provides an explicit foundation to the Tidal Model, which seeks to build carefully upon it in the light of current knowledge. As Barker (1999) points out:

"*Dr. Peplau suggested that if nursing is ever to become the holistic, person-focused activity which it believes it is already, then it must reject the notion of packaging people and their care according to medical diagnostic criteria. For Peplau - the focus of nursing is quite clear: we have no real interest in people's diseases or their health for that matter, nurses are interested in people's relationships with their illness, or with their health* ".

The shift in emphasis away from medical diagnosis towards interpersonal relationships changes the entire focus of many aspects of the traditional nurse-patient relationship.

- *Firstly*, according to Peplau, nursing practice should be focused on helping or facilitating (enabling) the patient to recognise and understand for themselves their difficulties and the extent of their need for help. This is not the same thing as getting the patient to agree with the doctor over a specific psychiatric diagnosis.
- *Secondly*, the patient needs to be helped by the nurse to recognize and to plan to use what professional services are in fact available and on offer;
- *Thirdly*, the energy deriving from tension and anxiety connected with 'felt needs' should be harnessed to positive means for defining, understanding, and meeting the problem at hand.

the three principles of broadly client-centred care outlined by Peplau above are reflected in the Tidal Model emphasis on daily care planning. Daily care plans are designed is to help clients to see their own role in making improvements (however small) in their mental health on a day-by-day basis. It seeks, through empowering therapeutic conversations with the nurse to improve patients' ability to solve their own problems thus increasing their self-esteem. The purpose of daily care planning is thus:

- To help patients on acute in-patient wards to break free from their sense of helplessness and passivity
- To help them work through difficult personal issues
- To help them regain 'control' over disturbing or 'out of control' thoughts, feelings and behaviours
- To encourage reality orientation 'normalisation' and problem resolution
- To help patients plan each day so they are not idle or bored on the ward
- To engage therapeutically with the patient to promote mental health

The Tidal Model seeks to apply good-evidenced based contemporary theories of empowerment within interpersonal relationships and educational environments to the nursing process itself. This is congruent with Peplau's vision of both patients and nurses working as partners together in what is essentially a democratic process of mutual learning and growth, a process, which is specifically

designed to overcome the sense of powerlessness, and passivity, which is often a feature of mental health problems as well as psychiatric nursing[65]. Peplau states:

To encourage the patient to participate in identifying and assessing his problem is to engage him as an active partner in an enterprise of great concern to him. Democratic method applied to nursing requires patient participation. It depends upon working toward consent and understanding of prevailing problems, related reality factors, and existing conditions by all participants. The power for accomplishing the tasks at hand, in ways that develop or expand personality, resides in the consent and understanding that motivate all persons concerned. By this definition of democratic power, many patients, or community members affected by an emergent difficulty, are powerless.(p23)

Barker, P (1999*), The Philosophy and Practice of Psychiatric Nursing*, Churchill Livingstone.

This collection of papers spans the last decade of the 20th century and focuses on some of the developments, controversies and dilemmas that continue to impact psychiatric and mental health nursing at the end of the 20th century. Within these essays, the interpersonalist 'conceptual frame' of Peplau is strongly evident along with other influences from other disciplines, which constitute the early growth of the Tidal Model, especially its emphasis on a non-reductive view of the human person and the need for nursing to develop a non-medical (rather than anti-medical) approach to mental health problems. Nursing should not be just 'a pale reflection of psychiatric medicine'.

Barker P, Reynolds W, Stevenson C (1997) The human science basis of psychiatric nursing: theory and practice*, Journal of Advanced Nursing 25(4) pp 660 - 667*

Building on Peplau's view that mental health nursing practice should be an interpersonal, investigative, nurturing and growth-provoking process undertaking in alliance with the patient this paper follows Peplau's lead by constructing a comprehensive theory of nursing practice which embodies her basic vision of the centrality of interpersonal relations in nursing care.

Nurses should not be involved in the diagnosis and treatment of mental illness, but in 'the diagnosis and treatment of human responses to actual and potential health problems'…. a subtle, but radical change in emphasis for psychiatric nurses trained to use medical diagnostic categories as the best way to 'understand' their patient's difficulties.

Barker at al. define the primary function of mental health nursing in the broadest possible way as *'addressing human problems'*. This involves four core assumptions:

1) Mental health nursing is an interactive, developmental human activity, more concerned with the future development of the person rather than with the hypothetical origins or 'causes' of that person's present mental and emotional distress. Nursing should be concerned with the promotion of the person's unique growth and development not simply with the suppression of the symptoms of distress or with getting the patient to confirm to the hospital social system. Growth and development within a 'recovery paradigm' will, of necessity, involve the patient's adjustment to the present situation, but also, where possible, the overcoming of many of the life problems associated with the patient's present mental health problems and psychiatric disorder.

2) The experience of mental distress associated with mental health problems is represented through public behavioural disturbance, or reports of private events that are known only to the individual concerned. Mental health nursing should involve providing the necessary therapeutic nursing milieu within which people can safely access and review those disturbing experiences. Such collaborative re-authoring of the person's life might involve the healing of past distress, the alleviation of present distress, and the opening of new ways to further the personal and spiritual development of the client with more effective functioning in the different spheres of life. If nurses are ever to 'work in partnership' with their clients they must begin with the clients' experience of themselves, and work with that unique experience, rather than with their experience of them as 'patients' who have a particular diagnoses.

[65] **Powerlessnes**s. One sub-theme of the original nursing interview of this report was the sense of powerlessness felt by nurses at the QEPH. They felt powerless to change a basically custodial and non-therapeutic in-patient system. The only alternative for them was to get out into community based nursing. The feeling of powerlessness and cynical resignation to the system tends to mirror in interesting ways the sense of powerlessness many patients feel as well.

3) The nurse and the person-in-care are engaged in a relationship based on mutual influence. It is assumed that the reflexive nature of the caring experience produces changes for both the nurse, and the person-in-care and significant others. Nursing involves caring-with rather than caring- for people, irrespective of the context of care. How nurses adapt themselves to meet the needs of the person-who-is-this-patient is the challenge, especially within an acute in-patient setting; not how the person adapts to nurses' constructions of them "as patients".

4) The experience of psychiatric disorder is translated into a variety of problems of everyday living. The practice of psychiatric nursing and care is thus located uniquely within the context of everyday life. As a result, nursing care is invariably an in vivo (in life) activity in which nurses in the context of a professionally bounded or defined relationship, share the life-space of their patients. Nursing practice should be focused on the person's relationship with self and others within the context of that persons' interpersonal world. Good nursing practice is thus focused on helping people address their human responses to their own mental health problems, rather that the disorders themselves which are, by definition, professional constructs.

Barker P, Jackson S and Stevenson C (1998) The need for psychiatric nursing: towards a multidimensional theory of caring*, Nursing Inquiry 1999 6 pp 103 -111*

In this major study, Barker et al. aimed to find out what a wide range of people with experiences of psychiatric care provision believed such provision to be, on the basis of their own experiences of 'the need for nursing'. This study has since become on of the key evidenced-based building stones upon which the Tidal Model is being developed.

The purpose of this grounded theory research was to define the 'core activity of psychiatric nursing', an activity that uniquely distinguishes what nurses actually do from what the other members of the mental health care team actually do. It sought to discover any consensus existing across mental health disciplines regarding the 'need for nursing' consistent with that distinction and difference. The research involved the use of separate focus groups including psychiatric nurses, social workers, service users, psychiatrists, carers, and 'other disciplines'.

The findings suggested that nurses needed to establish WHAT the person expected (needed) from the nurse, at any given moment.

Not surprisingly, people with a history of serious mental ill health, along with their families and life partners, placed a great deal of emphasis *on the value of being heard and being understood by the nurse and others*. Yet this expectation was in reality fairly complex in that it revealed three distinct nursing 'domains'. There were conceptualised as:

- **Ordinary Me (OM)** which relies on a natural 'ordinariness' in ways of relating to people one is helping
- **Pseudo-ordinary or Engineered Me (POEM)** which involves a more directly or professionally bounded presentation of the nurse's 'self' while still in 'ordinary me' mode
- **Professional Me (PM)** where the nurse does what she or he considers to be 'the best' for the person from what could be called a more professionally distanced 'evidence-based domain' of specialised knowledge and experience. In addition to this the nurse is working within statutory, professional boundaries and is a member of a team

These three domains are not sharply bounded, but fluid and inter-penetrate each other. One key aspect of the nurses skill and the art or craft of care is the ability to shift or 'toggle' from one domain to another as the circumstances require and as the relationship between the nurse and his or her patient changes over time. When the nurse is in OM mode the depth of knowing can be intimate (Barker uses the term 'professional closeness') or 'deep' whereas when in PM mode the depth of knowing is much more 'shallow' or distant and what is on display is the nurses evidenced-based knowledge. The central emergent 'core category' of this grounded theory research was **'Knowing You, Knowing Me'**.

The conclusion of the study was that the 'need' for psychiatric nursing was very clear and unequivocal, but also complex. Nurses, rather than developing new technical skills or new roles, need to develop new ways of fulfilling their traditional functions (basic human caring) in an increasingly complex and technological health care environment in which many reductionist views of the human person prevail more or less unchallenged.

The need for psychiatric nursing and for '**Knowing You, Knowing Me**' in the context of compassionate care is thus multi-dimensional and context dependent. This emphasizes the importance of establishing mental health nursing as an educative element at the very heart of interdisciplinary mental health care intervention[66].

Barker P (1996). Chaos and the way of Zen: psychiatric nursing and the 'uncertainty principle'. *Journal of Psychiatric and Mental health Nursing, 1996 3, pp 235 - 243*

In this more freewheeling philosophical essay Barker examines the need for a metaparadigm of mental health nursing or a "model of models". There is the need for this because the current models of nursing all fail to adequately define the unique 'domain' which defines mental health nursing care in distinction from the other mental health professions such as medical psychiatry, social work and counselling and because of the proliferation of nursing models most of which have not evolved out of the nursing profession itself.

Barker begins by contrasting the mechanistic model of classical Newtonian physics, which dominated not only the social and biological sciences, but also psychiatry for many generations, with the newer models 'of the new physics'[67] that have arisen in the early and mid 20th century along with the concepts of 'relativity' 'indeterminacy' and chaos theory, all of which have relevance in the search for a new paradigm of mental health nursing in context.

The classical Newtonian view of science assumes that the 'real world' is deterministic and operates like a machine *at every level of existence* purely by the way of the classical model of physical cause and effect. Although modern medicine derived some of its original explanatory power' from this model (as did 19th Century psychiatric medicine) much of the focus of that older model, on disturbed, pathological or abnormal human behaviour, has not over time been so amenable to simplistic one-to-one or unitary causal explanations or predictions.

Barker introduces various concepts from the 'new physics', especially that of 'chaos theory' and explores its relevance for mental health nursing and for understanding the nature of madness.

The need for a *metaparadigm* or *metatheory* (that is, a theory of theories) has become necessary today within mental health nursing because of the proliferation of many different types of nursing theories, which lack any conceptual coherence or stabilizing focus for current nursing practice. According to Barker:

"*Although some critics of the proliferation of nursing theory-construction in nursing challenge the utility of the specific theories (or models) the major challenge appears to involve the metaparadigm of nursing. Nursing, like other disciplines, may deploy multiple conceptual models. To be a discipline, nursing needs a metaparadigm which can act as an encapsulating unit, or framework, within which the more restricted...structures develop*."

Chaos theory reminds us that the world, even within the framework of its own lawfulness is also typified by constant flux, change, and the unpredictable nature of a lived life and the unpredictable contingencies of such a life. Notwithstanding the flux and change there is the reality, importance and necessity of constantly emergent and shifting boundaries of various kinds. One of these boundaries is that captured by such concepts as health/illness, sanity/madness, patient/nurse reality/fantasy and so. Good nursing and the exercise of compassionate care may be no more or less than the actions necessary for becoming part of the whole lived experience of the person-in-care and to that extent good nursing practice will always be very aware of emergent boundaries of various kinds:

"*like playing ball on running water*"

In addition to this, given the fact that the 'whole person' can only be understood linguistically (that is through the use of words, stories, concepts, metaphors). Psychiatric nursing is predicated upon the mutual authoring and re-authoring of human stories or narratives. According to de Shazer (1994)[68]

'Meaning is arrived at through negotiation within a specific context'

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[66] See Barker P (2000) The Tidal Model: Theory and Practice, unpublished manual reproduced under licence agreement by the Birmingham and Solihull Mental Health NSA Trust

[67] See Capra, Fritjof (1975) The Tao of Physics. Berkeley: Shambhala. (London: Wildwood House, 1975) & (1982) The Turning Point: Science, Society and the Rising Culture, Simon & Schuster, USA

[68] de Schazer S (1994)

Barker, Phil (2000). the tidal model of mental health care: personal caring within the chaos paradigm, *Mental and Health Care 4(2), 59-63*

The theme of 'chaos theory' is picked up again and explored in this paper as well as the need for providing a *metaparadigm* to help focus, anchor and give coherence to the mental health nursing profession and to nursing practice. Barker argues that psychiatric disorder is a state of change, which no one who has not experienced it can ever fully understand. He insists that good nursing practice involves not dismissing these chaotic experiences of madness, but on the contrary, seeks to understand them and help the individual come through those experiences, however dreadful and alienating. He then outlines the Tidal Model of caring whereby the nurse offers empathy, acceptance and acknowledgement, but within clear boundaries so that the 'life-saver' does not drown with the struggling 'swimmer' who is at risk of drowning. In this paper Barker also introduces the *'water metaphor'*.

"The Tidal Model draws its core philosophical metaphor from chaos theory, where the unpredictable – yet bounded – nature of human behaviour and experience can be compared to the flow and power of water"

Barker suggests that flowing water is an excellent visual aid' to chaos theory because the actual flow of water cannot be captured or predicted precisely...and we have to work with it if we are to swim in it. Specifically the metaphor of water suggests:

- The ebb and flow of our lives is reflected in the way we breathe in and out, like waves lapping at the shore
- All human life emerged physically from the ocean
- All of us emerged from the waters of our mother's womb
- Water is the universal metaphor for the cleansing of the spirit
- Water evokes the concept of drowning, a concept used frequently by people who are overwhelmed by their experiences
- The power of water is not easy to contain. We can scoop water from the sea, but we cannot scoop out a whole ocean
- The only way we can cope with the power of water is to learn how to live with its forces. We learn how to swim in water, or we build boats that float on waves
- Ultimately, however, the power of water is unpredictable and merits respect

The Tidal Model operates from four basic assumptions or starting points.

1) *The primary therapeutic focus in mental health care lies in the community.* People (in terms of the water or ocean metaphor) live 'on an ocean of experience' and psychiatric crisis is one thing, which might threaten to 'ship wreck' or 'drown them'. The aim of mental health care is thus to return people to that ocean of experience in reasonably fit sea going vessel so they may continue with their life journey on the natural ocean of experience which is life.

2) *Change is a constant, on-going process*, especially as it is understood in the paradigm of chaos theory. People keep changing whether they want to or not, or are aware of the changes or not. One of the main aims of individual and group intervention in the Tidal Model is to help people develop and increase their awareness of the small incremental changes that over time ultimately have a big impact on their lives.

3) *Empowerment lies at the heart of the caring process.* Nurses help people to identify how they might make greater charges in their lives and take on more responsibility for their life and all its related experiences, past, present and future.

4) *The nurse and the person in care are united (however temporarily) like dancers in a dance*. Nursing involves caring-with not caring for people. This has implications for the relationship and the kind of support nurses might need to maintain if they are to preserve the integrity of the caring process.

Barker, P. (2001.) The Tidal Model: developing an empowering, person-cantered approach to recovery within psychiatric and mental health nursing*, Journal of Psychiatric and Mental Health Nursing 8, 233-240*

This paper gives a summary of the above arguing that the Tidal Model extends and develops some of the traditional and classical assumptions about *the centrality and primacy of interpersonal relations within good nursing practice*. The model integrates discrete processes for re-empowering the person who has been radically disempowered by mental distress or by psychiatric services or both. The paper then reports briefly on the on-going evaluation of the model in practice on a number of cites in the UK and in other parts of the world.

Stevenson & Fletcher (2002) The Tidal Model: the questions answered*, Mental Health Practice 5,8 29-38*

This article gives a concise summary of the Tidal Model's evidence base, its key therapeutic assumptions and principles, its contribution to government policy initiatives, and gives (for the first time in a journal) detailed examples of the completed documentation of the Holistic Patient Assessment, Daily Care Plans, and Suicide Risk Assessment etc.

10. 2 Nursing holistic assessment form

TOLKIEN WARD NURSING HOLISTIC ASSESSMENT

Name:
Date:

How this began:

How this affected me:

How I felt in the beginning:

How things have changed over time:

The effect on my relationships:

Questions:

"What has brought you here (or) what do you need to talk about?"

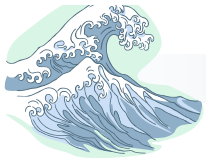
1) *Problem origins*: ...so, when did you first *notice*... (or) become aware of that?

2) *Past problem function*: ... and how did that *affect* you at first?

3) *Past emotions*: ... and how did you *feel* about that at the time?

4) *Developmental history*: ... and in what way has that changed over time?

5) *Relationships* : ... and how has that affected your *relationships with others?*



Name:

Date:

How do I feel now?:

What do I think this means?:

What does all this say about me, as a person?:

What needs to happen now / what do I want or wish would happen?:

What do I expect the nurse to do for me?:

6) *Current emotions*: ... and how do you feel about that *now*?

7) *Holistic content*: ... and what does all of that *mean* for you?

8) *Holistic context*: ... and what does that say about you as a person?

9) *Needs, wants, wishes*: ... and what do you *hope* would be done about that?

10) *Expectations*: ... and what do you think we can do for you here on the ward?

PROBLEM RATING SCALE

Evaluation of the problem

*** "To what extent does the problem *distress you*?"**
*** "To what extent does it *interfere* with your life?"**
*** "To what extent can you *control* it?"**

Distress

None 1 2 3 4 5 6 7 8 9 10

Extreme

Disruption

None 1 2 3 4 5 6 7 8 9 10

Extreme

Control

None 1 2 3 4 5 6 7 8 9 10

Complete

PROBLEM RATING

* List person's main problems / needs
* Check wording with person
* Enter rating for each problem /need (0 – 10)

PROBLEM	Distress	Disturbance	Control

Signature
Staff
Date

Name:
Date:

The people who are important:

The things that are important:

The ideas about life that are important:

Personal Resurces: **Ask the person to describe the personal assets or resources, which might help in the resolution of the problem.**

1) *Who* is important in your life – eg. Family, friends, groups, other people? Why are they important?

2) *What* is important in your life – home, money, possessions etc? Why are they important?

3) *What* are your beliefs about life in general – faith, personal philosophy, values?

Name:
Date:

How will I know the problem has been solved, or the need has been met?:

What needs to change for this to happen?:

Ask the person to describe what it would be like to be *without* the problem, or to have their need met.

1) *How* will you know when this need has been met, or this problem has been solved?

Give me an example of how things will be 'different'.

2) *What* needs to change to allow this to happen?

How will this change show itself – in you, other people, any other aspect of your everyday life?

10.3 Nursing guidance to the use of the holistic assessment

The Nursing Holistic Assessment[69]

How Does a Nursing Holistic Assessment Differ from Other Types of Assessment?

Traditional assessments of the person with mental health problems are usually conducted from the specialized perspective of some professional discipline and are communicated in the technical language of that discipline. Thus the person is seen from the limited vantage point of their psychological, social or physical functioning as understood by clinicians specializing in those scientific disciplines each focusing on one specific aspect of the person.

The result has been that, historically, professional constructions of the person's problem tend to 'break down' the presenting problem(s) into relatively isolated constituent parts or sub-problems, rather than working with the integral person as a whole. Traditional assessments also tend to be written in professional language or terminology.

Importance of Ordianry Language Statements in Assessments.

But, in reality people rarely talk naturally about different aspects of their lives or problems in any specialised way or use such terminology. Usually they experience their problems (if they are serious) as a 'life problem', which is both experienced and presented *as an integral whole*. People with mental health problems thus tend to use language, metaphors and self-descriptions that reflects this integral reality. The Tidal Model Nursing Holistic Assessment, in order to take account of this, differs from traditional assessment methods in two basic respects.

- The results of the Holistic Assessment are presented in the person's own 'voice' and words using natural, not technical language or professional jargon
- The Holistic Assessment emphasises collaboration and dialogue between the nurse and the patient, recognising that it is the 'person in care' who is the real 'expert' on their personal problems and needs

The Holistic Assessment is focused on the person's world of personal experience.

- The Holistic Assessment should be completed as soon as possible after the person is admitted, ideally within the first three days. It should be written *by the patient (person in care)* or *by the nurse using the patient's own words and phrases in the presence of the patient*

- This is *an empowering gesture*, which demonstrates that the person's own 'voice', words and self-descriptions are valued by the nurse and are an essential aspect of any collaborative assessment of the person's problems and situation

- When the assignment is completed the nurse and the person in care should both sign it as an accurate reflection of the discussion that has taken place

- The patient should then be offered a copy for their own reference or have one on file that they can access when and as needed. The completed Holistic Assessment can be referred to, now and again, as part of any future one-to-one sessions with the nurse, but is not to be done a second time.

[69] Adapted from Barker P (2000) The Tidal Model: Theory and Practice, unpublished manual reproduced under licence agreement by the Birmingham and Solihull Mental Health NSA Trust

- Following the Holistic Assessment the nurse and the person in care should discuss the aims of being in hospital, discharge criteria and what needs to happen during the first few days of admission, and any questions addressed. Both nurse and client should negotiate what they expect from each other and the nurse will *reinforce the importance of mutual collaboration in effective care planning*

The Aims of the Holistic Assessment

- To give the person an opportunity to describe, discuss and examine his or her experience of illness and health
- The assessment is written in the person's own words, e.g. '*The problem began when I lost my job*'
- To form the basis for developing a personal Care Plan based on the person's unique needs as they perceive them
- To develop a collaborative relationship with the person in care, one that emphasises 'working together' and exploring the person's needs and problems
- To develop an empowering relationship within which the nurse helps the person in care to make recovery focused, responsible and informed decisions and choices
- To find out 'who' this person is

Eight Key Points Of the Holistic Assessment

1. The Holistic Assessment should be written in the client/patient's own words and phrases, and a Core Care Plan completed based on that Assessment.
2. *The client should sign all paper work* and should be offered a copy. IF the person does not want a copy or refuses to sign the paper work it should be emphasised that he or she can change her or his mind at any time.
3. *If someone is not willing to engage, or unable to complete the Holistic Assessment* this should be discussed with them and the MDT and the specific reasons clarified.
4. The Holistic Assessment paperwork including the manual *Tidal Model: Theory and Practise* can be left with the person to be used by him or her to complete the assignment independently.
5. Alternatively the nurse can go back to the person over a number of days and weeks emphasising that his or her views, wants, wishes will shape the nursing care received. This will add to the development of trust and relationship building.
6. Until such time as the Holistic Assessment has been completed the Care Plan should include the following goals: a) engage with the patient. b) complete Holistic Assessment.
7. If the person *still refuses to engage,* an assessment using different sources of information should be constructed until the person is able or willing to participate in their care.
8. If and when clients express ideas considered in medical psychiatric terms to be 'delusional', *it should be remembered that these beliefs and ideas are real for the person/patient and are important for that person*. However these beliefs *should not* become the focus of a reality-disagreement between the nurse and the client. Rather, the patient's experience of living with what appear to be odd or unusual beliefs or experiences and the consequences of having these for that person should be explored

How Does A Nursing Assessment Differ From A Medical One?

- When the Holistic Assessment is carried out by a mental health nurse he or she is gathering important information about the person in care, information that will be highly relevant to the medical and other disciplines represented by the Multi Disciplinary Team (MDT).

- The Holistic Assessment should be presented to the MDT as an articulate nursing 'formulation' of the patent's problems which has been constructed in collaboration with the patient using the patient's own words and concepts and reflecting the patient's deepest concerns and issues.

- The Tidal Model does not deny the usefulness of Medical or professional Social Work or Psychological terminology. It does not disparage bio-medical constructions of the patient's disordered experience and behaviour.

- *Rather, the nursing assessment seeks to be a foil for these, by suggesting a Nursing perspective that complements the other disciplines, thus bringing 'the whole person' and their need for care into sharper focus.*

- For example, if a person has been medically diagnosed as suffering from a bi-polar psychiatric illness, the Tidal Model encourages exploration with the patient *of what it means for this person* to have racing thoughts in an elated mood and the problems this generates, or what it means for this person to be detained against their will in hospital right now under section of the Mental Health act, or to have this medical diagnosis or to be taking medication and so on.

- Similarly, a nursing Holistic Assessment might uncover the person's personal philosophy of life, spirituality, values or religious faith as well as a number of different kinds of explanations for their problem and how best to recover from it, including the usefulness of certain types of medication, cognitive behavioural therapy, the practice of their religious faith and the importance of their family in giving them support and help to cope with their mental health related problems. Thus the Tidal Model is consistent with both NSF and 'Capable Practitioner' recommendations.

Bill Gordon
Project Nurse

10.4. Initial 72-Hour Assessment and Care Plan

Name:

	Legal Status	Obs Level	Leave Status
Date **Hospital Day ( )** **Assessing Nurse**			

Primary Interventions: Nursing staff will endeavour to establish a therapeutic relationship with the patient, based on mutual respect, trust and collaboration as part of the process of undertaking a formal Nursing Holistic Assessment within three days of admission.
Activities of Daily Living: These will be monitored and assessed during this interim period. With special attention to 1) maintaining a safe environment, 2) communication issues 3) sexuality, 4) relationships with staff and other patients, 5) eating and drinking, 6) self care, 7) breathing and elimination, 8) religion, 9) any potential risk to self or others.
Initial Care Plan: This will, if possible, be constructed in collaboration with the patient and written in the patient's own words.

Patient's description of problem (in patient's own words):
Initial interim plan for care:

Continued Over >

Signed:..... Grade:.....

	Initial Observations and Evaluation			
Time		**CTRS**	**Sign**	**Grade**

Concerns and/or Recommendations

No.		**CTRS**	**Sign**	**Grade**

10.5 Daily care plan record

Name:

	Legal Status	Obs Level	Leave Status
Date **Hospital Day ( )** **Assessing Nurse**			

I will be ready for discharge when:.....

How do I feel today?

My plans for the next 24 hours are:

Patient's signature.....

Current Nursing Plan:	**CTRS**	**Sign**	**Grade**

IS THE DOCTOR'S WARD ROUND WITHIN THE NEXT 24 HOURS?
YES ( ) NO ( )
IF YES, PLEASE COMPLETE WARD ROUND FORM WITH THE PATIENT

Continued Over >>

	Observations and Evaluation			
Time		**CTRS**	**Sign**	**Grade**

Please Continue using Continuation Sheet >>>>

Any Concerns and/or Recommendations?

No.		**CTRS**	**Sign**	**Grade**

10.6 Nursing guidance for daily care planning

GUIDANCE FOR COMPLETING DAILY CARE PLANS[70]

What is the value of Daily Care Planning?

The value of doing Daily Care Plans is to help patients to recognise change and to help them to see their own role in making improvements (however small) in their mental health and in their ability to solve their own practical problems in living. The nurse offers praise and encouragement and identifies with the patients the next step or goals for the next day. The purpose of Daily Care Planning is:

1) To help patients break free from their sense of helplessness and passivity
2) To help patients work through difficult personal issues
3) To help patients regain 'control' over disturbing or 'out of control' thoughts, feelings and behaviours
4) To encourage reality orientation 'normalisation' and problem resolution
5) To help patients plan each day so they are not idle or bored on the ward
6) To **engage** therapeutically with the patient to promote mental health

Purposes of Engagement

1) To ascertain how the person/patient is feeling at any given moment in time
2) To appreciate more fully the nature of this person's experience
3) To work out how the nurse should respond in meeting this person's need for security, both physical and emotional, one day at a time

What about specific nursing care policies (such as observations), preparing patients for ECT, wound care, and other physical procedures?

These should be outlined on a separate Care Plan, filed in front of the Daily Care Plan for that day so that when these things happen both the patient and the nurse can plan for each day.

What about the role of Care Assistants (A Grades)?

One aspect of the Tidal Model involves raising the skills, profiles, and professional competence and esteem of Care Assistants. In order for the Tidal to 'work' on busy Acute Wards much of the day to day Care Planning needs to be delegated to Care Assistants, who work with the client in identifying practical and therapeutic goals for the day and helping him or her carry that out.

HOW IT WORKS: PLANNING INDIVIDUALIZED PATIENT CARE ONE DAY AT A TIME

1) Each Daily Care Plan should reflect a collaborative effort to help the patient solve specific problems over the next 24 hours. The most realistic (nursing) plan and the best type of nursing intervention…is the one that is in harmony with the needs, worldview, values and motivation of the person concern.
2) The Daily Care Plan should be written in the presence of the patient and checked with him or her to ensure that there is an agreed understanding of expectations as well as of the specific goals and plans.
3) Collaborative Care Planning should be for the next 24 hours, identifying specific areas of change (positive and negative) and constructing different kinds of solutions for the patient's own self-management.
4) AM, PM and Night Shift Care Plan allocation should be recorded in the 'Tidal Model' section of the Ward Diary or 'Tidal Book" and delegated from shift to shift.

[70] Adapted from Barker P (2000) The Tidal Model: Theory and Practice, unpublished manual reproduced under licence agreement by the Birmingham and Solihull Mental Health NSA Trust

5) All sections of the Daily Care Plan should be completed including.

a) Patient's discharge criteria: " I will be ready for discharge when…….. These should be the patient's own criteria in the patient's own words. This should involve asking the patient things like "*How will you know when you are ready to leave hospital*".
b) How do I feel today? Have a chat about today, How is it going? How are you coping today? Etc. Patients own words and expressions should be used.
c) Patient's goals in 'real time': "My plans for the next 24 hours are….". These, as well, should be the patient's own, in the patient's own words if possible. They may be simply things like '*To get off my Section and get out of hospital*' or "*To go to OT tomorrow*" or *to "prepare a list of things I want to ask the Dr in the Ward round*" or "*talk to a Nurse once a day about my problems*" or they may include things like making specific plans (i.e. a Safety Plan) for managing difficult, confusing, or angry feelings.
d) Nursing Goals 'in real time'. These will be specific nursing tasks to help the patient achieve her or his goals as well as other tasks associated with the patients day to day care.
e) Nursing observations/evaluation. Evaluation entries should be timed and dated and include all Observation Recording.

Bill Gordon
Project Nurse

10.7 Patient ward round plan

DATE……

NAME **DATE OF BIRTH** **DATE OF ADMISSION:**	**MHA STATUS** **OBSERVATION LEVEL** **LEAVE STATUS (Inc Sect 17)**
CONSULTANT	**NAMED PRIMARY NURSE**
WHAT KEY ISSUES DO I WANT TO RAISE AT THE WARD ROUND?	**HOW HAVE THINGS CHANGED FOR ME OVER THE PAST WEEK OR SO?** **WHY IS THIS?**
ANY SPECIFIC REQUESTS? **Am I happy for student nurses and/or student doctors to be present? YES [ ] NO [ ]**	**ANY CONCERNS OR QUESTIONS ABOUT MY MEDICATION OR TREATMENT?**

10.8 Patient observation/engagement care plan

NAME **OBSERVATION LEVEL** **REASONS GIVEN FOR OBSERVATION**	**TODAY'S DATE** **CONSULTANT** **NAMED NURSE**
HOW AM I FEELING?	**WHAT CAN OTHERS DO TO HELP ME COPE WITH MY FEELINGS AND SITUATION TODAY?**
ANY PRACTICAL THINGS THE NURSING STAFF CAN DO TO HELP TODAY?	**IF I FEEL ANXIOUS OR WORRIED ABOUT SOMETHING OR 'AT RISK' IN ANY WAY WHAT AM I GOING TO DO ABOUT IT?**
WHEN WILL I BE READY TO COME OFF OF ONE-TO-ONE OBSERVATIONS?	**MY PLANS FOR THE NEXT 24 HOURS ARE:**
PATIENT'S SIGNATURE: **DATE:**	**STAFF SIGNATURE** **DATE:**

Continued over>>>>>>>

Patient's name **Sheet number**

Observation level

Time	Nursing Observations and Evaluation	CTR	Sign	Grade

Please Continue using Observation/Engagement Continuation Sheet >>>>

10.9 Initial staff interview letter of consent

Dear.....

I am undertaking a number of recorded interviews of all grades of staff on Acute Admission wards at the QEPH. The purpose of these interviews is to find out how staff see their work and to seek their opinion on the quality of the mental health service they are providing right now for the patients on their ward and how that care might be improved.

I will be seeking to establish as objectively as possible some kind of 'bench mark' through asking some very open-ended questions. I hope to then be able to measure any changes of attitude and perception that might take place over a year's time. The usefulness of the outcomes of this research will depend, in part, on getting the opinions of as many nurses as possible within the QEPH about the service they are giving and how that accords with their own conception of 'good practice'.

Confidentiality:

Your name and the ward on which you work will remain totally confidential and anonymous.
My interview with you will be coded only by number along with your gender and grade (A-G)
The analysis will be undertaken only by myself and a third party who is not employed by BSMHT
The results may be published as part of a final report, a summary of which will be widely circulated within the Trust, and may be part of a larger research project on "Change in the NHS" being undertaken by the BSMHT and the University of Birmingham to appear after 2003.

Method:

The interview with myself will be conducted in privacy in a room off the ward.
I will give you the opportunity to hear your own and my voice on the recorder and another opportunity to give your own verbal assent before starting the interview.
If you are feeling uncomfortable please feel free to terminate the interview at any time.
I will tell you when I am turning the tape recorder on or off.
The interview should take between 30-45 minutes.

I really appreciate your co-operation. Lets hope the results of this research will help towards creating positive nurse-led changes at the QEPH.

Bill Gordon
Project Nurse

I agree to participate in this research project.....
Date:.....

10.10 Initial staff interview schedule

1. What is it like for you, at the moment, working on this ward?

1.1. Please explain
1.2. What is your role here?
1.2.1. How does this work out in practice?
1.2.2. What kind of things do you do?
1.2.2.1. What do you like most about your job?
1.2.2.2 What do you like least about your job?.
2.3. In your opinion what is the most important aspect of your job?

2. What, in your view, is the purpose of this ward?

2.1. Why, in your view, are most patients admitted?
2.2. What expectations do patents tend to have about their care?
2.2.1. What do they hope to achieve from a period of in-patient treatment?
2.2.2. To what extent do you think their hopes are realised?
2.2.3. What do patients tend to like most about their stay?
2.2.4. What do patients tend to like least about there stay?

3. How would you describe your relationship to patients?

3.1. How well do you think Individual Care Plans work on this ward?
3.1.1 If they are not working well, why not, in your opinion?
3.2. How much are patients involved with in the creation and regular review of their own nursing Care Plans?
3.2.1 If patients are not involved, why not, in your opinion?
3.3. How much time, per shift, do you tend to spend talking to or relating to patents in a therapeutic way?
3.3.1..... just relating to patients in an informal yet friendly and constructive way?
3.3.2..... in a structured one-to-one setting with clear goals and objectives?
2.3.3....in planned structured group settings?
3.4. What specific model of nursing care tends to be used on this ward?
3.4.1. Do you know of any nursing models?
3.4.1.1 If so, what model do you think might most improve patient care, and why?
3.4. How well do you think the nurses work together here as a team?
2.4.1. If well, why is this?
2.4.2. If not well, why is this?

4. How do you think this ward could be improved so that patients got a better service?

4.1. What changes do you think would need to first take place before that could happen?
4.1.1.How would those changes improve your own care and nursing practice?
4.1.2. What would you be doing more of?
4.1.3. What would you be doing less off?
4.2. How would you know these changes were improving patient care?
4.3. What kind of additional training/education do you think would improve your caring practice and professional development?
4.4. How would all of the above changes affect your job satisfaction?

10.11 Verbatim summary of initial nursing interviews

Summarised below are the statements made by the 10 nurses (Grades D-F) who participated in the interview. All four acute in-patient wards (Tennyson, Bronte, Owen and Tolkien) were represented.

What is it like for you, at the moment, working on your ward?

- *Very, very stressful because I am continually busy*
- *Very hectic, but enjoyable*
- *Very busy*
- *The ward is very stressful at the moment*
- *Quite frustrated*
- *Not very nice, not enjoying being there*
- *Very stressful*

Please explain

- *Not enough time to spend with patients, I spend most of time just running around a lot, but at the end of the day what have I actually done?*
- *There is just not enough time to do the job properly*
- *Little time to talk with patients because we are so busy*
- *There has been a lot of staff turnover recently leaving only a few experienced nurses to carry the ward.*
- *Since I qualified the work I have to do and the paper work I have to do takes me away from the patients. I don't like that. I have applied for a job in the community.*

What is your role here?
How does this work out in practice?
What kind of things do you do?

- *Most of my time is spent giving out medication, doing administration and checking up on Bank and Agency Staff to make sure they are doing their job, or doing observations.*
- *Most of the time I spend in the office dealing with the doctors and staff issues, administration, ward rounds, checking the staff alarms, doing medication rounds, counting the benzodiazepines, getting information from the Ward Clerk. I don't spend much time with patients.*
- *I have just become an F Grade so I am trying to get used to my new job. I see my job as giving support to the nurse team not so much relating to patients.*
- *My role is to care for patients. To listen to them, to be a go-between the patient and the medical staff. To speak for the patient, but most of my time is spent in doing things like allocating staff for supportive observations, doing drug rounds, ward rounds, and when possible spending time with patients.*
- *To look after the patients, admissions, care plans, manage staff, order the meals, make sure all, observations are covered.*
- *All the other things I have to do defeats the purpose for why I am here which is to spend time with and to help patients. That's very frustrating.*

What do you like MOST about your job?

- *Spending time talking with patients*
- *Spending time with patients, watching them get better*
- *Contact with patients*

- *The variety. No two days are the same*
- *Always like a challenge*

What do you like LEAST about your job?

- *Not being able to do spend time talking to patients*
- *I do not normally get much time to spend with patients*
- *That I cannot do the job I am supposed to be doing in terms of spending time with patients and helping them get better*
- *Not spending much time with patients, the amount of paper work, not enough staff, the constant stress etc*
- *Expecting to get punched in the face at some point*

In your opinion what is the most important aspect of your job?

- *The most important part of my job is to spend time with patients, but I am not doing that*
- *Patient care. But, this means having a well-run ward which is not in chaos so much of the time with only fire fighting and crisis management the main way of working*
- *To spend quality time with patients. They value and are helped when they spend time with the nursing staff. This is what they want to do*
- *The most important aspect of my job is to work closely with patients to help them identify their needs and work with them, but we really do not tend to do that very much*
- *To work as apart of a team and fed back to the team and to work with patients, to stabilize the patients. But, the time I spend with patients is minimal*

What, in your view, is the purpose of this ward?

- *To get people better. To prepare them for discharge*
- *Dealing with anything that comes through the door*
- *To have their medications sorted out. To have someone to talk to and to be in a safe place*
- *To give asylum and a safe environment for mentally ill people*
- *To provide a safe place for people in crisis*

Why, in your view, are most patients admitted?

- *I would like to think the majority are admitted because they are mentally ill, but in reality it seems like the real reason many are admitted is that they are just not coping with their personal circumstances and relationships. We get a lot of personality disorders. These are the ones who tend to keep being readmitted over and over again not the people who are genuinely mentally ill*
- *Psychiatric breakdown for a number of reasons. To have their medication reviewed and changed. Drug and alcohol problems*
- *Quite a few people come under Section with no or little insight. We get a lot of patients who are basically in crisis for one reason or another who are not really mentally ill*
- *People come in because they are mentally ill*
- *People are admitted because there is a crisis at home and either they or their family are not coping. Some come in because of drug or alcohol problems or even just because of accommodation problems*
- *Patients can be divided into two types, those with insight into their condition and those who do not. Those who do not have insight are the ones who cause problems on the ward and those who do have insight are easy to work with and tend to behave themselves*

What expectations do patents tend to have about their care?
What do they hope to achieve from a period of in-patient treatment?
To what extent do you think their hopes are realised?

- *Patients want to get better and 'get back out there' and to be discharged as soon as possible. There is little or anything for them to do on the ward*
- *To be back in a state where they can look after themselves*
- *They expect us to spend a lot of time with them and we do not. This sometimes makes them angry and resentful. On the other hand sometimes they expect staff to do everything and sometimes they get resentful and get angry at the idea that they need to take a few steps themselves*
- *Often they not know what to expect if this is their first admission. Others (revolving door) do and settled right in*
- *Patients feel they should be having more contact time with nurses. But, often time is not available to them when they need it the most*

What do patients tend to like MOST about their stay?

- *They tend to like socialising with other patients and tend to spend most of their time sitting in the smoking room socialising with other patients*
- *Being helped by the nurses, but many complain that the nurses are just not available when you need them*

What do patients tend to like LEAST about their stay?

- *Being confined to the ward or hospital against their wishes or other kinds of restrictions*
- *That our time is so very limited. We do not spend much time with patients because we are too busy with administration, paper work and answering the phone. This leaves many patients feeling angry and neglected. One patient said to me that she had been on our ward for a month and not a single nurse had spoken with her about her problems. She said that this had happened on her previous admission as well*

How would you describe your relationship to patients?

(All interviewees described their relationships to patients as being good or very good, but most were, for some reason unable to get more specific than that or to say why this was the case).

- *I get to like them over a period of time and I would hope they would get to like me*
- *Sometimes I take on a parental role because of the state they are in. I like to act as a distant friend or encourager*

How well do you think Individual Care Plans work on your ward?

- *To be honest they do not work very well at all. Care plans are done, but not really looked at. They tend to be put in the back of the notes. Some also tend to be so long and complicated that nobody bothers to reads them. Also they tend to be more or less the same for each patient*
- *They don't work at all. Staff on our ward are too busy to do proper care plans on a regular basis*
- *We do them, but we don't tend to refer to them at all, except in the case of very difficult patients. The ward could be run in essentially the same way if care plans were not done at all*

- *We do try to do these, but they do not tend to be individualized. It's the time factor again. We are "supposed to" go through a care plan with each patient, but this rarely happens*
- *These tend to be general care plans and not really individualised so people do not tend to work to the care plan. It tends to be just a paper exercise*
- *They work quite well. But, that depends on how hectic the ward is. Usually things are very chaotic, so care plans are not really being done. The time we give to each patient on a one to one basis is very minimal*
- *I don't think we do that very much, really. It's just not working*

If they are not working well, why not, in your opinion?

- *The reason they do not work well is that often not everyone on the team will agree with the plan a nurse has made because people have different opinions on how to manage things like self harm and so on. So what's the point?*
- *There is just not enough time spent with the patient to do them properly on an individualised basis and to work them through in any way*
- *The time is just not there to do proper care plans*

How much are patients involved with in the creation and regular review of their own nursing Care Plans?
If patients are not involved, why not, in your opinion?

- *They tend to be done without consulting the patient. Why? The patient's perception of what it means to get better tends to be very different from the medical views. This can create a lot of conflict. Also I know that if I showed patients the care plan I had written for them, many would get angry and upset so you don't want to upset the applecart*
- *There tends to be a real mismatch between the patients views of things and the nursing and medical views. So it would not be a good idea to show patients their care plans*
- *This does not happen. Patients are not involved in doing their own care plans or in setting their own goals*
- *Very little, hardly ever. Most patients are just not interested or are too unwell. But, there is really not enough time to do them anyway*
- *On occasions we struggle just to do basic nursing care and written care plans just do not feature in that kind of basic nursing at all. There is just not enough time to sit down with patients for 20 minutes or so to do a care plan or review a care plan with them*
- *Patients don't tend to know very much about their care plans on our ward and don't seem to express much interest. We set their goals for them. They are not well enough to set their own goals so we have to step in and do that for them*

How much time, per shift, do you tend to spend talking to or relating to patents in a structured one to one setting?

- *On the rare good days about and hour. But, on most days about 10 - 15 minutes, but you can never plan or structure that. There is no point in making an appointment to meet up with a patient because often when the time comes you are often busy elsewhere doing other things so what's the point? You just let the patient down*
- *The longest time I spend with patients is during the Ward Round in a group setting led by the doctor. That's a shame, but that is the truth*
- *On good days a couple of hours. But, on most days about 20-30 minutes or so at the most because the ward is so busy*

- *On a busy shift, spending time with individual patients just does not tend to happen. When things are not so busy we do the best we can*
- *About 15 minutes per shift*

In planned structured group settings?

- *Groups do start up now and again on our ward through the initiative of one or more nurses, but is soon discontinued because there is not enough time or staff and other activities and duties tend to make running groups impossible*
- *There is no point. There is not sufficient time on the ward for nurses to run groups*
- *None. You are so busy you can't plan anything or keep to commitments*
- *Groups? Hardly. Although on occasion we try to run groups on the weekend*

What specific model of nursing care tends to be used on this ward?
Do you know of any nursing models?
If so, what model do you think might most improve patient care, and why?

- *None. We don't use any specific model on our ward; everyone works in his or her own way*
- *To a large extent we are dictated to be the medical model. This is because of the way the hospital is actually run and the way decisions affecting the patient are actually made on the ward by the Consultants*
- *Patients sometimes feel 'so doped up' that they see no point in sitting down with nursing staff to talk about anything*
- *We do not operate any specific nursing model. There are too many Consultants on the Ward. Sometimes the ward feels like a busy Accident and Emergency Ward. Staff are very stressed out*
- *We joke and say 'eclectic', but in reality we do not have one*
- *Quite a few nursing models were mentioned at College, but I have never seen one properly in operation*
- *I don't know what model might improve care*

How well do you think the nurses work together here as a team?
If well, why is this?
If not well, why is this?

- *We tend to work really well together*
- *When we don't work well it is usually because of poor communications and everyone being under such stress all the time*

How do you think this ward could be improved so that patients got a better service?
What changes do you think would need to first take place before that could happen?

- *The physical environment is very bad. There are too many patients on the ward and not enough interview rooms. Having less bank and agency staff would help because you have to keep running about checking up on them all the time to make sure they are doing their job. So we need a better environment, and more qualified staff*
- *We need a morale boost. Sometimes I am so stressed that I cannot do my job properly*
- *More time to free me up to do my job properly- more one-to-one patient care = less running about, less paper work and administration*
- *Being able to sit down and talk to patients on a regular basis*

- *To spend more on to one time with patients in a structured way and having "more organised" activities would reduce the chaos*
- *Having the sort of care where you spend more time with patients. Care would improve when patients have a sense of setting their own goals and are more involved in their own care plans. Before this could take place, sufficient time would need to be made so you do not have to keep saying in the midst of talking to a patient 'Sorry I have to go, something has just came up'. You would then feel you were not just reacting to situations on the ward, 'fire-fighting' and containing things, but you would be more proactive*
- *More staff or fewer patients*
- *More qualified staff OR less patients so nursing staff could spend more time with patients doing things like relapse prevention and working therapeutically with patients*
- *We do a lot of things that do not directly related to patient care. This takes up most of our time which leaves the patients without proper care*
- *The phone is constantly ringing, other tasks need doing that are part of the job, doing supportive observations, constantly dealing with social workers and doctors and things like that are what keep us from spending time with patients*

How would those changes improve your own care and nursing practice? What would you be doing more of?

- *Talking to patient*

What would you be doing less off?

- *Administration and office work, being available on demand to doctors, social workers and others, answering the phone (which rings constantly), having to constantly check up on Bank and Agency Staff to see if they are doing their job*

How would you know these changes were improving patient care?

- *Spending more time with patients would lead to less stress, patients would be happier, less tension, less violence*

What kind of additional training/education do you think would improve your caring practice and professional development?

- *Counselling courses, training on dealing with aggressive patients, not just MAPA*

10.12 Qualified Nurses' Questionnaire

This questionnaire seeks your evaluation of the Tidal Model and your opinions about how the introduction of the Tidal Model has impacted your work with patients on Tolkien Ward. Please begin by answering the following questions.

What is your job on Tolkien Ward?

How long have you been working on Tolkien Ward?

Please answer the questions below by rating on the scale from 1-5 how using the Tidal Model compares with your previous way of working on busy acute admission wards.

Satisfaction

1 Much Worse	2 Worse	3 About the Same	4 Better	5 Much Better

The following questions ask you to give your own sense of satisfaction with your use of the Tidal Model. Using the scale above please answer the following questions.

1) To what extent does the Tidal Model enhance your professional practice? My sense of professional nursing competence is now [ ]
2) To what extent does the Tidal Model help you to focus more clearly on the patient's need for nursing care? My sense of focus is now [ ]
3) To what extent does the Tidal Model help you develop a helping relationship with the person in your care? My ability now [ ]
4) To what extent does the Tidal Model help you to develop an understanding of the person in your care? My understanding is now [ ]
5) To what extent does the Tidal Model help you to construct collaborative nursing care plans, which express the views of the patient? My opportunity and ability to do this is now [ ]
6) To what extent does the care plan element o the Tidal Model enhance your sense of job satisfaction? My job satisfaction in this area is now [ ]
7) To what extent does the Nursing Holistic Assessment element of the Tidal Model enhance your assessment skills? My skills in this area are now [ ]

1 Much Worse	2 Worse	3 About the Same	4 Better	5 Much Better

8) Using the rating scale above rate the over all quality of the nursing care on Tolkien Ward, as you perceive that, in comparison to the way you worked before using the Tidal Model. In your opinion the care is [ ]

Please comment.

9) How do you think the Tidal Model could be improved and your nursing practice on the ward brought more in harmony with the therapeutic principles of engagement, collaboration and empowerment?

Training and Supervision

10) To use and develop the model fully, do you think that nay further training/support/supervision would be useful? YES [ ] NO [ ]
11) If you have answered YES to the above question, *what kind of training, support and supervision* would be most helpful?

12) Are current nursing care and staff team issues discussed at depth on a regular basis within staff clinical supervision sessions or in nursing care support groups outside daily staff handovers (between shifts)? YES [ ] NO [ ]
13) If NO, do you find the daily staff handovers 'slot' adequate to deal effectively with many of the personal, managerial and care issues that often arise during the course of each shift? YES [ ] NO [ ]

14) If NO, why not?

Comparison with Other Models

15) What nursing model were you using prior to your use of the Tidal Model on Tolkien Ward?

The following questions ask you to compare the Tidal Model with the model (or way of working) being used on other Wards at the QEPH or prior to the introduction of the Tidal Model on Tolkien Ward. Please, use the scale below to score your answers

1 Much Worse	2 Worse	3 About the Same	4 Better	5 Much Better

16) In general, how does the Tidal Model compare with the nursing model you were using before? [ ]

17) In terms of the initial nursing assessment of the patient on admission, how does the Tidal Model Holistic Assessment compare with the kind of assessment you were using before? [ ]

18) How does the Tidal Model care planning element compare with the way in which you did care plans before? [ ]

19) In terms of time, to what extent is the Tidal Model more or less efficient that the one it has replaced, or the one you have used before? [ ]

1 Much Worse	2 Worse	3 About the Same	4 Better	5 Much Better

20) In terms of communication with nursing colleagues, how does the Tidal Model compare with the one you used before? [ ]

21) In terms of communicating with the MDT (Multi-disciplinary team) how does the Tidal Model compare with the one you have used before? [ ]

Please note below any additional comments you would like to make about the use of the Tidal Model on Ward 5.

10.13 Multi-Disciplinary Team Questionnaire

In October 2002 Tolkien Ward began to implement the Tidal Model, a new nursing model that seeks to place the patient at the centre of care and to raise the standard of nursing care on Tolkien Ward. This brief questionnaire seeks to determine the perceptions of members of the MDT on the impact of the Tidal Model on nursing practice since the Tidal Model was introduced. The results of your evaluation will be very helpful in assisting us in the on-going development of the Model. Your opinion, positive, negative, or indifferent will be valued.

General

1 Much Worse	2 Worse	3 About the Same	4 Better	5 Much Better

1) Using the scale above how do you rate the nursing care now being provided in comparison with the model or way of working it has replaced or is used on other wards? [ ]

Please comment.

1 Not Satisfied	2 OK	3 Satisfied

2) Using the scale above, how satisfied are you, at the moment, with the information you have been receiving regarding the Tidal Model and its implementation on Tolkien Ward? [ ]

Please Comment.

3) How well do you think you understand the principles underlying the Tidal Model?

4) What are these principles, in your view?

5) Do you feel a half-day's training in the Tidal Model would be of interest or of use to you and other members of the MDT? YES [ ] NO [ ]

Communications

1 Very Poor	2 Poor	3 OK	4 Good	5 Excellent

6) Using the scale above, how do you rate the communications and contributions of the nursing team within the MDT? [ ]

Please Comment:

Any additional comments you would like to make will be greatly appreciated.

What discipline do you belong to?

10.14 Patient Information Sheet

About this research

A new nursing practice model (called the Tidal Model) was introduced on Tolkien Ward on the 10th of October 2002. The Tidal Model uses specific nursing practices to ensure genuinely person-centered care planning in order to empower people with acute mental health problems. We are keen to get your opinion and views to help us evaluate our efforts to do this and to change nursing practice on Tolkien ward over the past year.

We are looking for between four to eight patients who would like to share their experience. Your story about your experiences of the nursing care you been receiving on Tolkien Ward will be very helpful to us in our attempt to develop the kind of positive nursing care that helps people to positively cope with or recover from their mental health problems.

What does the research involve?

We would like to talk to you about your experiences of the nursing care you have been receiving on Tolkien Ward. We would like you to tell us about what the nurse did for you and how that helped you to cope with or to recover from your mental health problems. We would like to meet up with you once, for approximately one hour to hear your story, and to discuss our understanding of your story and check that our understanding is the same as yours.

As we routinely do when using the Tidal Model, we will make notes using your own words during the interview and we will check with you to make sure that what is written down is exactly what you want to be written down.

Your participation will be entirely voluntary (your choice). You do not have to take part in this research at all, and if you choose not to this will be respected and will not affect any future care or treatment.

You do not have to answer all the questions and you are free to stop the interview at any time. If you become distressed at any time during the interview, we will stop and staff will be available for assistance.

If you do agree to take part you are free to withdraw from the study at any time without having to give any reason for doing so.

What happens to the information?

As the information gained from this research will benefit other nurses as well as future in-patients on Tolkien Ward and elsewhere within the Hospital, on completion, the findings of this project may be published or used in conference or seminar presentations. But, no material that could personally identify you will be used in any reports, verbal or written.

You have our assurance that any information you share will remain confidential. What we discuss in the interview will not be passed onto anyone else on Tolkien Ward unless it affects your safety or someone else's safety. For safety reasons, we will let the staff on that day know who will be interviewed and when.

All notes from the interview will be kept locked in a safe place by the Tidal Model Project Nurse Bill Gordon, and will be kept separate from your medical file and destroyed on completion of the project. Only the Consent Form will be placed on your medical file.

If you have any queries or concerns about your rights as a participant in this study you may wish to contact:

Theresa Morton.
Research Manager
QEPH
Tel: 0121-678-2123

Patients Advice and Liaison Service (PALS)
Birmingham and Solihull Mental Health NHS Trust
71 Fentham Road
Erdington,
Birmingham
B23 6AL
Tel: 0121-685-7444

Further information about any aspect of this study can be obtained from Bill Gordon

Bill Gordon
Project Nurse
Birmingham and Solihull Mental Health Trust
(Mobile) 07985882912
(Email) Billemail@Mac.com

10 .15 Patient consent form

I have read and I understand the Information Sheet dated November 26, 2003 for volunteers taking part in the study designed to evaluate the Tidal Model and I have had an opportunity to discuss this study with the lead researcher, Bill Gordon and I am satisfied with the answers I have been given.

- I understand that taking part in this study is entirely voluntary (my choice) and that I may withdraw from the study at any time and that this will in no way affect my continuing nursing care.
- I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.
- During the interview I do not have to answer any questions if I do not want to. I can stop the interview at any time.
- I have had time to consider whether to take part.
- I know whom to contact if I have any questions about the study.
- If I become distressed during interviews I know that the researcher will provide support and if I wish refer me to my named nurse or the consumer advocate for further assistance.
- I know that at the end of the project any notes will be kept by the researcher until the project is written up and then destroyed.

I, _____hereby consent to take part in this study.
(participant)

Signed: _____
Date: _____

Explained by: _____
Signed: _____
Date: _____

For further information, please contact:
Bill Gordon
Project Nurse
Birmingham and Solihull Mental Health Trust
(Mobile) 07985882119
(Email) Billemail@Mac.com

10.16 Patient interview schedule

EVALUATING THE TIDAL MODEL

Pseudonym:_____

Interviewer: _____

Date: _____
Time: _____

Location: _____

1: Introductions

2: Settle in. Is the time available – approximately one hour?

3: Review consent and information sheet with the participant

4:Questions or comments?
Choice of Pseudonym?

5: Explain that the interview will be conducted by recording the participant's own words.

6: Check still OK with participant before proceeding.

From your experience, how would you describe the main aims of the care provided by the nursing staff using the Tidal Model?

Talk to me about the things nurses on the ward have been doing that have been helpful for your recovery

Open the interview by explaining that in this interview our interest is on how the Tidal Model has influenced nursing care on Tolkien Ward

We will take down each point as you mention them, using your own words.

FOLLOW-UP QUESTIONS

- **Aims of the Tidal Model:**

"From your perspective what is it that you feel is the purpose of the nursing care and involvement using the Tidal Model specifically"

- **Collaboration and Empowerment**

- Was your own story given full attention?
- Were your own views respected?
- Were your words recorded verbatim?
- What did you think of the Nursing Holistic Assessment?
- Was the care plan focused on your actual needs, wants and wishes?
- In terms of what you HAVE found helpful what is the difference that has made the difference for your recovery?

How have you found the care plan aspect of the Tidal Model?

What other comments about the Tidal Model would you like to make?

- **General Support**

From your experience were your needs supported, respected and acknowledged by the nursing staff?

Have the nurses helped you be more clear about your personal goals?

Could you give some examples of how they did this?

- **Supporting a day-to-day activity programme.**

" What do you think about your daily activity programme? Does it work for you?"

- **Supporting Recovery"**

" How have the nurses helped you to move towards discharge from hospital/"

- **Further Comments**:
- What has not been so helpful for your recovery?

- How does use of the Tidal Model compare to any previous experience you have had of nursing care?

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