Acute Care Psychiatric Nursing Interventions:
The Experience of Expert Nurses

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Abstract

Psychiatric nursing interventions are integral to the health and care of mental health clients. These interventions are embedded into every day nursing practice. The purpose of this research was to explore psychiatric nurses’ lived experiences providing nursing interventions to adult clients in acute care settings. Hermeneutic phenomenology, as outlined by van Manen, was utilized. Six expert psychiatric nurses, with many years of acute care practice in providing care to clients with complex problems through the use of critical skill provision, were recruited through purposive and snowball sampling. Data were collected through the use of open-ended, semi-structured research questions delivered through conversational interviews.

Data analysis illuminated integrated themes of awareness and person-centered care (PCC). Awareness was further categorized into subthemes of self-awareness, awareness of the client, and situational awareness. PCC involved subthemes of delivering PCC plans; determining goals; fostering empathy, support, and hope; listening in one-to-one interactions; person-centered teaching; and enhancing coping strategies. Awareness and PCC interventions were harmonious and reciprocal in practice. Awareness was required to provide PCC and through the practice of PCC awareness grew. Use of the interventions involved a complex interplay of skills that were embodied into the caring responses provided by psychiatric nurses.

Keywords: Psychiatric nursing, interventions, acute care, mental health, hermeneutic phenomenology, awareness, person-centered care, presence, coping strategies
Acknowledgments

I truly am a psychiatric nurse at heart. This study began with a desire to contribute valuable knowledge to a profession that I hold dear. My goal was to contribute research that would ultimately benefit client care. Acute care psychiatric nurses are front-line professionals whose care and compassion impact the recoveries of the people served. The scope of inquiry was narrowed down to focus on expert practice in order to hear from those who were providing exceptional care and give language to the interventions delivered. I have much gratitude towards everyone who offered their support and encouragement during a time that was both challenging and rewarding.

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A special thanks goes out to the six participants who agreed to participate in the study. Thank-you for taking the time to openly and honestly share your knowledge of psychiatric nursing interventions. I will be forever grateful. Your voices have contributed to the psychiatric
nursing knowledgebase and your practice has made a difference.

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Chapter 1: Introduction

Psychiatric nursing is a specialized nursing profession (College of Registered Nurses of Manitoba [CRNM] & College of Registered Psychiatric Nurses of Manitoba [CRPNM], 2010) and has been central to most aspects of mental health care provision. Psychiatric nursing interventions have been integral to the health and care of mental health clients (Delaney & Ferguson, 2011). Psychiatric nurses have provided care for persons with highly complex and rapidly changing health conditions and behaviors (CRNM & CRPNM, 2010). The profession of modern day psychiatric nursing has been in a process of change, especially within acute care environments, as care provision has been shifting from acute care to community settings (Delaney, 2012). Acute care inpatient mental health settings are hospital environments designed to provide intensive care to persons diagnosed with complex mental health conditions such as schizophrenia, bipolar disorder, and/or major depression (Simpson, 2009); for the purpose of this study the term acute care will be used to refer to these environments.

The researcher has had six years of psychiatric nursing experience practicing in acute care settings with adult persons experiencing mental illness. I became aware very early in my career that psychiatric nursing was a challenging profession. The focus of care was entirely on the persons receiving services, although their health care needs were complex and no simple solutions were sufficient to assist persons in their recoveries. Acute care has been fast paced; a psychiatric nurse required rapid assessment and critical thinking skills to practice safely and effectively.

My first years of practice were a steep learning experience. I looked to psychiatric nurses, whom I considered to be experts, for mentorship. I asked countless questions and made mistakes. I viewed each mistake as a learning opportunity and my practiced evolved. Overtime, I became
skilled in recognizing the health care needs of persons in care. The care I provided seemed to become second nature as I became more confident in my role as a psychiatric nurse.

A common question faced by many psychiatric nurses, the researcher included, has been ‘what do psychiatric nurses do?’ Albeit, I have had many years of experience, this challenging question was difficult to answer. My response was often ‘we help people.’ This response lead to more questions than it answered; how do we help people? What does this helping role look like in practice? What interventions do psychiatric nurses use? And more importantly what do psychiatric nurses know in order to do what they do? These questions were important to answer in order to advocate for the profession and assist novice psychiatric nurses in developing knowledge and skill. Understanding what psychiatric nurses know and do will assist these professionals to question their knowledge, detect assumptions and biases, and identify alternative ways of thinking and practicing (Rogers, 2005) in complex, acute care settings. The role of a psychiatric nurse has not been well understood by the public and other health care professionals. A stigma has commonly shadowed mental health and a psychiatric nurse’s knowledge has been essential to inform the public and other health care professionals to combat this stigma.

Literature on psychiatric nursing practice was reviewed to explore modern day psychiatric nursing knowledge and interventions and ways that this knowledge and these interventions were applied with adult clients in acute care settings. The focus of research has often been centered on community care settings (Muskett, 2014). Research into psychiatric nursing practice and interventions, particularly in acute care settings, was required as documentation of the knowledge base was limited (Shanley & Jubb-Shanley, 2007; Sharac, McCrone, Sabes-Figuera, & Csipke, 2010). Many psychiatric nursing interventions were embedded into care rather than discrete activities. These practices may go unnoticed by others
and therefore are referred to as invisible interventions (Cleary, Hunt, Horsfall, & Deacon, 2011; Coombs, Crookes, & Curtis, 2013). Psychiatric nurses have been delivering important services in the day to day care of persons residing in acute care, however a common language to describe the care being provided and the interventions delivered was lacking.

The purpose of this research was to explore psychiatric nurses’ lived experiences providing nursing interventions in the care of adult clients in acute care settings. Hermeneutic phenomenology was utilized to answer the question: what are the lived experiences of psychiatric nurses in delivering nursing interventions to adult clients in acute care settings? Research findings may assist psychiatric nurses in further 1) recognizing and understanding the knowledge they use, 2) developing their skills, and 3) providing meaningful care in acute care settings. Practice, policy, education, and research may be influenced with this new knowledge.
Chapter 2: Literature Review

Psychiatric nursing has been associated with disease prevention, health promotion, and treatment of mental health problems (CRNM & CRPNM, 2010). Psychiatric nurses have delivered multiple interventions simultaneously while providing care for the complex health needs of clients (CRNM & CRPNM, 2010). The practice of psychiatric nursing has been moving away from the medical focus on illness and disease, towards a rehabilitative and recovery-oriented framework (Caldwell, Sclanfani, Swarbrick, & Piren, 2010). Promoting health within a collaborative relationship has been an essential role of a psychiatric nurse (Caldwell et al., 2010).

The practice of modern day psychiatric nursing has been in a process of change, especially within acute care environments (Simpson, 2009). Emphasis has been placed on trauma-informed and community-based care (Muskett, 2014). The role of the psychiatric nurse has centered on supporting mental health recovery and rehabilitation (Barker & Buchanan-Barker, 2011). Integral aspects of psychiatric nursing included holistic health care (McEvoy & Duffy, 2008), self-awareness (Scheick, 2011), therapeutic relationships (Reynolds, 2009), mental health recovery (Barker & Buchanan-Barker, 2010), acute care psychiatry (Thibeault, Trudeau, d'Entremont, & Brown, 2010), trauma-informed care (Muskett, 2014), narrative and presence (Delaney, 2012), and mindfulness (Campbell, 2009; Johnson & Reed, 2011). Changes in delivering psychiatric nursing interventions to adult clients in acute care environments were reported (Muskett, 2014; Sharac et al., 2010). Minimal research was available on current methods used by psychiatric nurses in acute care settings (Shanley & Jubb-Shanley, 2007; Sharac et al., 2010). The integral aspects of psychiatric nursing, changes within acute care settings, and implications for research have been outlined to assist with providing rationale for the research.
Holistic Health Care

Nurses have traditionally viewed the person as whole; examining the interrelations of a person’s mind, body, and soul (McEvoy & Duffy, 2008). Nursing involved commitment to the wholeness of persons through dynamic person-centered acts of caring (Rogers, 1994); the commitment to wholeness has been the foundation of holistic health care. In psychiatric nursing, the whole person is greater than and different from the sum of the parts (McEvoy & Duffy, 2008). Physical, mental, social, cultural, environmental, and spiritual features of persons were unified elements of health (Parse, 1990) and cannot be separated (Mariano, 2007). A holistic nurse perceived whole persons, not the diagnoses, and supported them to manage their lives in the face of illness (Dziopa & Ahern, 2008). Understanding the characteristics of a person’s experience has been an important aspect of facilitating understanding of the whole person (Hall & Powell, 2011; U.S. Department of Health and Human Services, 2009). Holistic nursing focused on protecting, promoting, supporting, and optimizing health and wellness, as well as preventing illness and injury (Mariano, 2007).

Holistic healing required a collaborative approach to care (Mariano, 2007). Holistic self-awareness assisted with cultivation of the therapeutic relationship with a focus on harmony, wholeness, peace, and healing (Mariano, 2007; McEvoy & Duffy, 2008). Consequences of achieving holistic practice were satisfaction and personal as well as professional development although at times such practice may have been emotionally draining. (McEvoy & Duffy, 2008). Psychiatric nurses have experienced difficulty in achieving holistic practice for a variety of reasons. Movement towards specialist practices have the potential to fragment the view of a person to parts (McEvoy & Duffy, 2008). Reflective practice may serve to minimize these difficulties (McEvoy & Duffy, 2008). A holistic nurse strived for self-awareness and engaged in
self-care (Mariano, 2007). Self-awareness has been achieved through reflection on the mind, body, and spirit (Cumbie, 2001).

**Self-Awareness in Psychiatric Nursing**

Psychiatric nurses offered aspects of themselves to provide therapeutic care (Sant & Patterson, 2013). The therapeutic use of self has been an instrument utilized to deliver nursing care (Eckroth-Bucher, 2010). Self-awareness has been a dynamic, transformative process of knowing the self (Cumbie, 2001). Self-awareness involved the use of insight and presence to guide genuine nursing care (Eckroth-Bucher, 2010). The quality of care that psychiatric nurses provided was closely related to their ability to show empathy and listen effectively to others, while maintaining their sense of self-awareness in these encounters (Engin & Cam, 2009). Self-awareness often has been key to establishing therapeutic partnerships (Dziopa & Ahern, 2009). Self-awareness was positively correlated with a nurse’s use of empathy and development of therapeutic relationships (Engin & Cam, 2009).

**The Therapeutic Relationship**

The desire to care for others has prompted psychiatric nurses to be present within therapeutic relationships. The interpersonal connection between psychiatric nurses and clients has been the essence of psychiatric nursing (Sant & Patterson, 2013). The aim of the therapeutic relationship has been to help the client increase his/her capabilities to achieve more favourable health outcomes (Reynolds, 2009). Conveying an empathetic attitude, providing individualized approaches to care, promoting dignity, being present, matching interventions to client needs, offering information and education, and maintaining a less restrictive approach were found to be crucial elements in developing a therapeutic relationship (Cleary, 2003). Non-judgemental acceptance and openness to the experience of building the therapeutic relationship were
Persons in acute distress often experienced fragmentation of relationships including fragmentation of the relationships they have with themselves (Simpson, 2009). Within a therapeutic relationship, nurses assisted clients in understanding their experiences of health and of distress (Simpson, 2009). Active engagement from attentive and supportive nurses assisted with development of a therapeutic relationship (Thibeault et al., 2010). Therapeutic relationships served as the foundation for more structured and complex interventions that were built on the understanding of a psychiatric nurse’s roles and identities (Browne, Hurley, & Lakeman, 2014). The therapeutic relationship has been crucial to client-centred care provision and mental health recovery.

**Mental Health Recovery**

The concept of recovery has become highly influential in mental health policy and psychiatric nursing practice (Barker & Buchanan-Barker, 2011). Recovery has been described as a process that is used to assist persons to live their lives in meaningful ways, when provided with the appropriate personal, interpersonal, and social resources (Barker & Buchanan-Barker, 2011). In the recovery model, mental health clients have had substantive roles in their own care and mental health services evolved to be client driven (Caldwell et al., 2010). Psychiatric rehabilitative interventions have been used to support persons living with mental illnesses in skill development, to increase their capacity to live, learn, socialize, and work more independently and effectively (Anthony, Cohen, Farkas, & Gagne, 2002). Rehabilitative plans and interventions provided a roadmap for recovery (Anthony et al., 2002).

The process of recovery has been focused on client self-management through building on strengths and supporting limitations (Anthony et al., 2002). Interventions aligned with the
recovery model included active participation from clients, including homework assignments, modeling, journaling, and reality-testing exercises (Caldwell et al., 2010). Relapse prevention and planning should include awareness of triggers, coping strategies, involvement with others, and self-medication strategies (Caldwell et al., 2010). The recovery process often has been associated with community-based care although these principles and practices have been established within psychiatric acute care settings.

**Acute Care Psychiatric Nursing**

Effective care in critical situations has been the core of psychiatric nursing (Landeweer, Abma, & Widdershoven, 2010). The health care needs of clients may be unpredictable and create an urgent, emergent, or crisis situation (CRNM & CRPNM, 2010). The purpose of an acute care unit has been to provide short-term admission to hospital for the purpose of psychiatric assessment, treatment, and care (Simpson, 2009). Acute care has been required to provide systematic assessment and short-term intensive care for people who are unable to be treated in community settings (Cleary, 2004). The primary aim of hospitalization has often involved emotion stabilization through nursing care and support (Simpson, 2009). Clinical situations that resulted in admission to hospital often included an acute mental illness or worsening symptomology, chronic disorders that did not respond to treatment, indication that a person was a danger to self or others, the need for frequent observation, client residence not conducive to recovery, the need to establish therapeutic relationships with health care professionals, crisis stabilization (Cleary, 2004), medical treatment, and/or provision of respite for community caregivers (Bowers, 2005).

Psychiatric nurses, who work in settings with high rates of client turnover, often experienced many unpredictable events (CRNM & CRPNM, 2010). The care needs of people
admitted to acute care units had become increasingly complex and challenging in terms of illness and behaviour (Simpson, 2009). Increased acuity levels of acute care settings and a lack of emphasis on milieu may contribute to use of rigid and oppressive practices on these units (Thibeault et al., 2010). Routine practices such as ward rules, ward rounds, search procedures, locked doors, and the use of seclusion and restraint have been experienced by clients to be re-traumatizing, emotionally unsafe, and disempowering (Muskett, 2014). Acute care psychiatric nursing has been in a state of flux and movement has been toward trauma-informed care.

Trauma-informed Care

Persons who have experienced trauma were considered to represent the greatest portion of people accessing mental health services (Muskett, 2014). Trauma-informed care has been an emerging practice affecting psychiatric nursing (Muskett, 2014). Trauma-informed interventions have been practiced to reduce the use of coercion, seclusion, and restraint in acute care settings (Landeweer et al., 2010). Client participation has been an essential component of trauma-informed care and has been key to preventing re-traumatization (Regan, 2010). In trauma-informed care, clients need to feel valued, connected, and informed (Muskett, 2014). Staff worked in mindful and empowering ways to promote and protect the autonomy of clients (Muskett, 2014). Mindfulness, which is non-judgmental present moment awareness (Kabat-Zinn, 2013), has been a beneficial nursing intervention within a trauma-informed environment as the use of mindfulness may address experiential avoidance that is associated with trauma histories (Thompson, Arnkoff, & Glass, 2011). Trauma-informed healthcare providers understood that the person’s current crisis may be reflective of past trauma (U.S. Department of Health and Human Services, 2009). Nurses have used empathy and presence to assist with understanding the meaning of a person’s trauma history by listening to client narrative (Delaney, 2012; Delaney &
Client Narrative and Psychiatric Nursing Presence

The theme of client narrative has been described as an essential component in psychiatric nursing practice (Barker & Buchanan-Barker, 2011; Casey & Long, 2003). The focus of psychiatric nursing has been located in careful and collaborative examination of the lived experiences of persons in care (Reynolds, 2009). The use of narrative has been a powerful tool to understand the lived experience of mental illness from the perspective of mental health clients (Casey & Long, 2003). A method of delivering client-centered care has been understanding the meaning behind the client experience (Cleary, 2003). Open dialogue and holistic understanding of client identified problems has been found to facilitate better health outcomes (Caldwell et al., 2010). A psychiatric nurse who was truly present created an open relationship that transcended beyond the moment to grasp the person’s hopes and dreams (Parse, 2010).

Psychiatric nursing presence involved straightforward and sincere engagement (Delaney, 2012). Nurses utilized their hearts and minds to pay attention on purpose (Delaney, 2012). Presence, or being with the client, has been essential to understand the client’s narrative of health and illness (Delaney, 2012). The therapeutic relationship has been fostered through the nurse’s presence with a person in distress (Simpson, 2009). Presence has been an element of mindful practice (Delaney & Ferguson, 2011). Mindfulness in nursing was found to be a transformative process, where the nurse develops the ability to be present with acceptance, awareness, and attention (White, 2014).

Mindfulness

Mindfulness has been defined as a multifaceted concept that involves attention, awareness, and metacognition (Tusaie & Edds, 2009). Mindfulness has been described as a
practice of present moment awareness, where attention is directed to thoughts, emotions, and physical sensations (Kabat-Zinn, 2013). Mindfulness-based interventions assisted in preventing disease, promoting health, and treating chronic health problems (Chiesa & Serritti, 2009), with minimal reports of adverse side effects and relapse following the interventions (Shonin, Gordon, & Griffins, 2013). Antecedents to mindfulness were the ability to attend to the present moment and willingness to endure uncomfortable feelings (Tusaie & Edds, 2009). Mindfulness was a natural, although poorly developed, quality of mind that involved synchronization of the mind and body to happenings in the here and now (Campbell, 2009). Mindfulness strategies focused on self-responsibility and supported positive behaviour changes (Ruff & Mackenzie, 2009). Mindfulness was considered to be a skill and a nursing tool (Tusaie & Edds, 2009). Psychiatric nurses used mindfulness as a skill to be present and aware during care provision.

Mindfulness, as a nursing tool, involved practice in delivering mindfulness-based interventions directly to clients. Mindfulness may be incorporated into psychiatric nursing practice through formal and informal interventions. Formal mindful interventions included breathing exercises, guided imagery, meditation, hatha yoga, and body scans (Kabat-Zinn, 2012). Hatha yoga has been a form of meditation that involved a series of body postures and stretches to achieve flexibility of the body and the mind (Kabat-Zinn, 2012). The body scan has been a whole body meditation that involved sitting or lying, while making a concerted effort to pay attention to body sensations present in that moment (Dreeben, Mamberg, & Salmon, 2013). Delivery of informal mindfulness interventions involved client education and practice incorporating present moment awareness into activities of daily life (Cullen, 2011) such as walking and driving. The interventions were selected based on client preferences (Dobkin, Irving, & Amar, 2012).

Psychiatric nursing has been a holistic practice and has been well aligned with
mindfulness (White, 2014). Pattern identification, examining the person as a whole, and the therapeutic relationship has been the central focus of the discipline of nursing (Newman, Smith, Pharris, & Jones, 2008). Psychiatric nurses were required to be fully present, in the moment, to learn and understand what was meaningful to the client while allowing patterns to unfold (Newman et al., 2008). Persons were identified by patterns of consciousness which included awareness of self within a larger system (Newman et al., 2008). Patterns and possibilities emerge when psychiatric nursing care has been aimed at understanding the whole person (Newman et al., 2008). Personal and professional practice of mindfulness in acute care psychiatric nursing has been required to address changes that have occurred in the treatment of mental health clients as greater emphasis has been placed on the ‘here and now’ (Shanley & Jubb-Shanley, 2007).

Changes in Acute Care Psychiatric Nursing

The practice of psychiatric nursing in acute care environments has been undergoing change. Mental health services were in the process of implementing recovery-orientated frameworks (Delaney, 2012) and trauma-informed care (Muskett, 2014). Client care shifted from acute care to community environments (Cleary, 2003; Simpson, 2009). The shift towards community health services resulted in increased patient acuity of inpatient units, decreased length of stay, focus on crisis stabilization and referral, and changing patient expectations of services in acute care settings (Cleary, 2003). The changes in mental health services resulted in ambiguity related to psychiatric nursing roles (Shanley & Jubb-Shanley, 2007) particularly in acute care settings (Delaney, 2012).

Stress, burnout, and attrition rates have been high in nursing (White, 2014). Stress of psychiatric nurses in acute care settings has been higher than that of nurses in other specialties or settings (Brady, O'Connor, Burgermeister, & Hanson, 2012). Psychiatric nurses have been at risk
of energy depletion from interactions with clients experiencing emotional pain, lack of boundaries, and ineffective coping (Sant & Patterson, 2013). Self-awareness and self-protective strategies have been suggested to protect nurses’ health from burnout (Sant & Patterson, 2013).

Acute care psychiatric nurses have been working in increasingly complex environments characterized by multiple priorities and new demands (Cleary, 2004). Demands placed on nurses included administrative and organizational duties along with management of staffing issues and high workloads (Cleary, 2003). Given these difficulties many nurses were forced to practice in the 'here and now' with little lead time to plan care (Cleary, 2004). Overall, clients were satisfied with mental health services and therapeutic relationships, although they were dissatisfied with over-reliance on medication, use of coercion, emphasis on medical power, and lack of autonomy (Browne et al., 2014). Research into psychiatric nursing knowledge, practice and interventions, particularly in acute care mental health settings, was indicated as the current knowledge base was limited and the change in mental health services and psychiatric nursing has been ongoing (Shanley & Jubb-Shanley, 2007).

**Implications for Research and Psychiatric Nursing Practice**

Current research applicable to modern day acute care psychiatry (Shanley & Jubb-Shanley, 2007) and knowledge of therapeutic practice of psychiatric nursing was lacking. Psychiatric nurses have become central to mental health care yet little research was available to demonstrate the knowledge and therapeutic interventions offered by these health care professionals (Browne et al., 2014). Knowledge gained from phenomenological research may offer important insight into psychiatric nursing practices (White, 2014).

The practice of psychiatric nursing has been adapting and changing with advancements in mental health care. Hermeneutic phenomenology has been useful in examining contextual
features of experiences that have direct relevance to practice (Lopez & Willis, 2004). The phenomenological approach was used to gain a deeper understanding of psychiatric nursing interventions being offered by psychiatric nurses to adult clients in acute care settings. Increased understanding may affect acute care psychiatric nurses’ abilities to provide holistic care to address the changes and complex demands faced in this profession. Reflection on the findings and translation of knowledge has implications for practice, policy, education, and research related to mental health care and service delivery within and beyond psychiatric nursing practice (Lopez & Willis, 2004).
Chapter 3: Research Method

Hermeneutic phenomenology as research method was utilized to gain rich understanding and insight into the lived experience of acute care psychiatric nurses. This method was selected to unveil concealed meaning and provide sensitive awareness into the phenomenon (Streubert & Carpenter, 2011). Use of hermeneutic phenomenology as method assisted the researcher to uncover the embedded meaning of acute care psychiatric nursing interventions through textual analysis (Dowling, 2004). Phenomenology as research method was used to reflect on and in practice, and to prepare for practice to strengthen thoughtful action (van Manen, 2014). The research method, ethical considerations, data generation and management, as well as analysis have been outlined and were consistent with hermeneutic phenomenology.

Research Method

Hermeneutic phenomenology was applied as the research method, as described by van Manen (1997). The researcher allowed the text to portray its uniqueness to embrace the meaning held by participants (Dowling, 2004). Participant selection, field work, and data collection was conducted according to the ethical standards of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2014). The role of the researcher, research questions, hermeneutic phenomenological steps, participant selection, and research field have been described in detail.

Researcher’s role.

The researcher has practiced as a registered psychiatric nurse. Her educational preparation included a Bachelor of Science in Psychiatric Nursing and current enrollment in the Master of Psychiatric Nursing program through Brandon University. Her areas of professional
practice included acute care psychiatric nursing and nursing education. The researcher practiced holistic, recovery-oriented, and trauma-informed psychiatric nursing. The researcher’s background, presumptions, and knowledge were required for meaningful undertaking of research (Dowling, 2004; Lopez & Willis, 2004; van Manen, 1997). The researcher was an instrument of inquiry obtaining a role within the hermeneutic circle (Dowling, 2004). The researcher stayed immersed in and dwelt with the data and within herself to allow the text to offer new understanding and insight through a reciprocal process of interpretation, gaze, and wonder (Smythe, Ironside, Sims, Swenson, & Spence, 2008; Spence, 2001). The research will contribute to the researcher’s thesis and a manuscript will be published. There is no associated conflict of interest.

Hermeneutic phenomenology involved the study of the life world as experienced rather than as one conceptualizes or theorizes (van Manen, 1997). Bracketing is a rigid strategy to identify the researchers own beliefs about the phenomenon. However in van Manen’s method (1997), such strategies are recognized as useful goals while not being fully achievable, as the researcher is never fully separate from influencing the data analysis. The researcher’s understandings, beliefs, biases, assumptions, presumptions, and theories related to psychiatric nursing were made explicit as described by van Manen (1997). The first step of reflexivity was to examine one’s own lived experience (van Manen, 1996). The researcher openly questioned and reflected on assumptions and pre-understanding throughout the research process.

Reduction is a phenomenological device that was utilized to discover the essence of the phenomenon (van Manen, 1997). To come to an understanding of the essential structure of the phenomenon reflection occurred through the practice of reduction (van Manen, 1997). Reduction involved awakening to a sense of wonder and amazement of the phenomenon (van Manen,
The researcher made an ongoing and concerted effort to overcome subjective feelings, preferences, inclinations, and expectations that would prevent her from understanding the lived experiences of others (van Manen, 1997). Reduction was utilized to set aside understanding of theories and conceptualizations of the phenomenon (van Manen, 1997). The researcher made a concerted effort to remove herself, her thoughts, and influence in all phases of research and analysis to understand the lived experiences of psychiatric nurses working with adult clients in acute care settings.

**Research questions.**

In hermeneutic phenomenological research emphasis was placed on understanding the meaning of lived experience (van Manen, 1997). The researcher aimed to understand the experience of psychiatric nurses, who practice in acute care. The purpose of the interview was to explore and gather experiential narrative to develop an understanding of the phenomenon (van Manen, 1997). Research using hermeneutic phenomenology as method entailed asking participant’s broad and general questions, which focused attention on gathering data to facilitate textual and structural portrayals of the participants’ experiences. Data were collected through the use of open-ended, semi-structured research questions delivered through conversational interviews. The participants were asked to describe the phenomenon as fully and deeply, as they were able (Jasper, 1994) to gain understanding of the lived experiences of psychiatric nurses in acute care settings.

Hermeneutic phenomenology was utilized to answer the research question, “what are the lived experiences of psychiatric nurses in delivering nursing interventions to adult clients in acute care settings?” Additional questions included: What does it mean to you to be a psychiatric nurse practicing in acute care? How do you view psychiatric nursing interventions? What is your
experience in using psychiatric nursing interventions in acute care? How do you know when you are using a psychiatric nursing intervention? What factors have an influence on your ability to deliver these interventions? Please refer to Appendix A, the interview guide.

The purpose of the research questions was to discover the existential structures of the experience and gain a deepened understanding of psychiatric nursing knowledge and practice (van Manen, 1989). Hermeneutic phenomenology was used to encourage awareness of the details of everyday practice that may be taken for granted (van Manen, 1989). Understanding meaning behind being a psychiatric nurse working with adult clients in acute care environments is central to understanding the phenomenon.

**Hermeneutic phenomenological steps.**

Hermeneutic phenomenological research method was utilized to explore psychiatric nurses’ lived experiences providing nursing interventions to adult clients in acute care mental health settings based on procedural steps identified by van Manen (1997),

1. turning to a phenomenon which seriously interests us and commits us to the world;
2. investigating experience as we live it rather than as we conceptualize it;
3. reflecting on essential themes which characterize the phenomenon;
4. describing the phenomenon through the art of writing and rewriting;
5. maintaining a strong and orientated pedagogical relation to the phenomenon;
6. balancing the research context by considering parts and whole (p. 30-31).

In-depth interviews were conducted with six expert psychiatric nurses. The nurses openly shared details on their lived experiences of providing psychiatric nursing interventions. Additional detail regarding the careful selection of phenomenological themes and subthemes has been included in chapters four and five.
Participant selection and research field.

Purposive and snowball sampling was utilized to determine participants for interview. Six psychiatric nurses, who currently practiced in acute care settings, within a large urban city on the Canadian prairies, were invited to participate. Participants were recruited until sufficient information had been gathered to provide meaningful analysis. Expert psychiatric nurses were recruited and interviewed to gain a rich understanding of the psychiatric nursing interventions being offered to adult clients in acute care mental health settings. An expert nurse, as described by Benner (1984), is a nurse who has an intuitive grasp of clinical situations. The expert nurse is highly efficient and effective in care provision (Benner, 1984). Knowledge and skills critical to acute care psychiatric nursing center on awareness, presence, attending to the needs of the client and unit milieu, compassionate caring, and capacity to maintain a balanced practice (Delaney & Johnson, 2006). Ability to establish and maintain a therapeutic relationship has been an essential psychiatric nursing role (Caldwell et al., 2010). Expert psychiatric nurses’ deliver excellent care, which was associated with improved client outcomes and experiences. Expert psychiatric nurses, with many years of acute care practice in providing quality care to clients with complex problems through the use of critical skill provision, were invited to participate in the study.

The participant inclusion criteria involved working in current acute care psychiatric nursing practice with adult clients in a large urban Canadian prairie city, engaging in front-line psychiatric nursing, holding active psychiatric nursing registration, being an expert psychiatric nurse as outlined by Benner (1984) and recognized by peers, practicing critical psychiatric nursing skills as outlined by Delaney and Johnson (2006), demonstrating an intuitive ability to establish and maintain therapeutic relationships, having many years of experience in acute care settings, and agreeing to discuss psychiatric nursing interventions. Registered nurses, who
worked in acute care settings, were not interviewed as the difference in educational backgrounds may be a variable that would influence the results. Psychiatric nursing practice in rural acute care settings was an exclusion criteria as mental health care provision and resources in rural communities differed from services and resources available in urban communities.

Research into the experiences of expert psychiatric nurses was utilized to illuminate understanding into meaningful methods of psychiatric nursing practice. Knowledge of expert psychiatric nursing interventions may assist psychiatric nurses generally and those, who work in acute care environments, specifically. Identifying and discussing the interventions utilized by expert psychiatric nurses may assist novice psychiatric nurses in their skill development.

Three expert psychiatric nurses were recruited based on the researcher’s professional knowledge and experience, while adhering to the inclusion criteria. Bias has been present in purposive sampling although the inclusion criteria are sound. Snowball sampling was utilized to recruit three additional participants; each expert psychiatric nurse interviewed was asked to suggest an expert psychiatric nurse based on the nurse’s professional experiences, practice, and the inclusion criteria, until enough information was gathered to provide meaningful analysis. A skill of an expert nurse is the ability to recognize expertise in nursing practice. Please refer to Appendix B, the letter of invitation.

The interviews occurred in a private environment of the participant’s choice such as her home or other place of comfort. The researcher did not interact with participants about the study prior to recruitment.

**Ethical Considerations**

Research ethics review board approval was obtained from Brandon University; please refer to Appendix C, the ethics certificate. Consent was free, informed, ongoing, and clearly
documented. Consent was obtained prior to involvement and throughout the research process. Participation was voluntary; participants were made aware that they may withdraw from the study at any point; refer to Appendix D, the consent form. Participants were made aware of the purpose of research and dissemination strategy; deception, coercion, leading questions, and other forms of persuasion did not occur. Participants were treated with equality and dignity through trusting relationships. Contribution did not situate participants in conditions of undue risk or harm (Streubert & Carpenter, 2011).

Privacy and confidentiality were maintained. The researcher was the only person aware of the participants’ identities; otherwise the participants’ anonymity was maintained. Information remained confidential. Identifiers were replaced with pseudonyms. Data were not utilized outside of the scope of consent.

A transcriptionist was hired following a conversation about the importance of confidentiality and steps to maintain confidentiality. Pseudonyms were utilized to protect the participants’ identities. The transcriptionist signed a confidentiality agreement prior to receiving data. The transcriptionist was instructed by the researcher to delete all electronic files at completion of the data analysis process. The transcriptionist emailed confirmation that all electronic files were deleted.

**Data Generation and Management**

The data of qualitative research has been the narrative of participants’ lived experiences (van Manen, 1997). Data collection consisted of audio-taped, semi-structured interviews utilizing open-ended questions as outlined in the interview guide, refer to Appendix A. Participants were interviewed privately for data generation. Immediately following the interview detailed field notes were written. Field notes were utilized to describe the environment, the participants’ non-
verbal expressions and body language, changes in position, and other observations not captured by audio-recording (Streubert & Carpenter, 2011). The purpose of the field notes was to describe and not interpret the participants’ experiences to preserve the context and integrity of the data. The audio-taped interviews were transcribed verbatim by a paid transcriptionist and verified for integrity by the researcher.

All computerized data including audio-tapes were password protected, saved on a flash drive, and accessed only by the researcher, thesis advisor, and transcriber. The flash drive and written notes are stored under lock and key at the researcher’s place of residence. Computerized data and notes will be destroyed following the thesis defense and dissemination of research findings.

**Data Analysis**

Data analysis centered on the use of van Manen’s method of phenomenology (1997). Data were analyzed for meaningful themes. Phenomenological themes are the experiential structures that make up the experience (van Manen, 1997). As the data collection commenced, so did the data analysis. The purpose of data analysis was to preserve the unique experiences of participants through interpretation of shared meaning (Jasper, 1994; van Manen, 1997). Reflexivity was adhered to during analysis. Reflexivity involved three steps; the researcher reflected on her emotions, background, history, and experiences in relation to the text, she read the narrative for ways that she responded emotionally and intellectually to the person, and she wrote her reactions and interpretations to grasp the blurred boundary of interpretation prior to analysis (Mauthner & Doucet, 2003). Texts were analyzed in relation to the contextual features of the lived experience (Lopez & Willis, 2004). A complete interpretive account was gained utilizing a circular process (Allen & Jensen, 1990). Textual analysis remained constant through
all stages of inquiry. The researcher immersed herself in the data to illuminate in-depth, rich, contextual understanding (van Manen, 1997). Attention to phenomenological methodology was maintained throughout the research process. An audit trail was maintained to assist with trustworthiness and authenticity of the data.

Data analysis was conducted to determine psychiatric nursing interventions primarily involved themes of awareness and person-centered care (PCC). Meaningful methods of providing psychiatric nursing care were illuminated through descriptions of self-awareness; awareness of the client; situational awareness; delivering PCC plans; determining goals; fostering empathy, support, and hope; listening in one-to-one interactions; person-centered teaching; and enhancing coping strategies. The professional background of the participants and thematic findings will be discussed in detail in the following chapters.
Chapter 4: Research Findings

The purpose of this hermeneutic phenomenology research was to explore psychiatric nurses’ lived experiences of providing psychiatric nursing interventions, when working with adult clients in acute care settings. In this chapter the professional backgrounds of the participants interviewed and phenomenological themes related to their experiences delivering psychiatric nursing interventions will be summarized. Data were analyzed for themes that connected the participants’ experiences. Themes and subthemes were identified from the participants’ responses. Themes of awareness and PCC were uncovered. Awareness was further categorized to include subthemes of self-awareness, awareness of the client, and situational awareness. The theme of PCC was described in terms of delivering PCC plans; determining goals; fostering empathy, support, and hope; listening in one-to-one interactions; person-centered teaching; and enhancing coping strategies. The themes of awareness and PCC were reciprocal and harmonious in psychiatric nursing practice. Awareness was required to deliver PCC and through the practice of PCC, awareness evolved.

All of the expert psychiatric nurses were open to discussing their experiences in delivering psychiatric nursing interventions. Rich descriptions were gathered on the lived experiences of psychiatric nurses practicing in acute care settings. Details of the everyday practices of psychiatric nurses were often unspoken and taken for granted. The meaning of being a psychiatric nurse practicing in acute care settings was illuminated from the detailed descriptions provided by six expert psychiatric nurses. Although their professional backgrounds were somewhat diverse, the psychiatric nurses voiced comparable experiences in delivering psychiatric nursing interventions.
Psychiatric Nursing Participants

Six expert psychiatric nurses with many years of acute care practice in providing care to clients with complex diagnoses through the use of critical skill provision participated in the study. At the date of the interview, each participant practiced in acute care psychiatric nursing settings with adult clients in a large urban Canadian prairie city. The participant engaged in front-line psychiatric nursing and held active psychiatric nursing registration. The participant was determined to be an expert psychiatric nurse as outlined by Benner (1984) and Delaney and Johnson (2006), practicing critical psychiatric nursing skills and demonstrating an intuitive ability to establish and maintain therapeutic relationships, as assessed by the researcher or by another expert psychiatric nurse, who had agreed to participate in the study. Each participant openly discussed psychiatric nursing interventions in a semi-structured interview.

The participants’ professional backgrounds differed in terms of years of experience in acute care with adult clients. All six psychiatric nursing participants were alike in their expert ability to deliver psychiatric nursing interventions. All six participants were female. One person declined participation in the study as part of the researcher’s initial purposive sampling strategy. This person was a male psychiatric nurse, who met the inclusion and exclusion criteria, but declined participation in the study. No reason for decline was offered. This person was the only potential participant who declined participation in the study. Attrition did not occur.

Table 1 has been presented to highlight the participants’ characteristics in terms of age, years of experience psychiatric nursing in acute care urban settings with adult populations, and total years of psychiatric nursing practice. Erin, Amanda, and Kristy (pseudonyms) were selected to be participants by the researcher utilizing purposive sampling employing the inclusion and exclusion criteria. These participants identified Dana, Meg, and Sara (pseudonyms) to be expert
nurses after reviewing and reflecting on the criteria for inclusion. The participants recruited, utilizing the second phase of sampling or snowball sampling, had 7 to 7.5 total years of psychiatric nursing experience, whereas the participants recruited initially by utilizing purposive sampling total years of experience had from 13 to 46 years of experience. The total years of experience did not appear to have an impact on the themes identified. The themes identified were consistent across all the participants’ voiced experiences.

The two participants with 40 to 46 total years of experience had a Psychiatric Nursing Diploma whereas the other four participants had 7 to 13 total years of experience held a Bachelor of Science in Psychiatric Nursing as their highest educational credential. The difference in educational preparation did not appear to influence the findings as all of the participants voiced common understandings.

Table 1

Participant Demographic Information

<table>
<thead>
<tr>
<th>Participants Name</th>
<th>Age</th>
<th>Educational Preparation</th>
<th>Years of Practice in Acute Care Urban Settings with Adult Clients</th>
<th>Total Years of Psychiatric Nursing Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erin</td>
<td>65</td>
<td>Psychiatric Nursing Diploma</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>Kristy</td>
<td>60</td>
<td>Psychiatric Nursing Diploma</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Amanda</td>
<td>37</td>
<td>Bachelor of Science in Psychiatric Nursing</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Sara</td>
<td>33</td>
<td>Bachelor of Science in Psychiatric Nursing</td>
<td>7</td>
<td>7.3</td>
</tr>
<tr>
<td>Dana</td>
<td>33</td>
<td>Bachelor of Science in Psychiatric Nursing</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Meg</td>
<td>27</td>
<td>Bachelor of Science in Psychiatric Nursing</td>
<td>6</td>
<td>7.5</td>
</tr>
</tbody>
</table>
Erin was the only participant to work solely in acute care urban settings with adult populations throughout the course of her psychiatric nursing profession. Kristy has had a range of experience practicing several years in non-acute care settings, such as an outpatient department, and years of experience in acute care rural settings or with non-adult clients. Amanda and Dana had previously worked in rural settings. Sara and Meg spent short periods of time working with non-adult clients, such as child and adolescent populations. Regardless of the participants’ experience, all of the participants actively practiced as psychiatric nurses in acute care urban settings with adult clients at the date of the interview. A more detailed description of the participants’ psychiatric nursing practice has not been included to protect the identity of the participants. The psychiatric nursing community is relatively small and participants could be identified based on their practice experience.

**Phenomenological Themes**

Throughout the interviews, participants provided rich descriptions of their experiences in delivering psychiatric nursing interventions. Data analysis centered on the use of van Manen’s method of phenomenology (1997). Data were analyzed for meaningful themes. Phenomenological themes are the experiential structures that make up the experience (van Manen, 1997). The purpose of data analysis was to preserve the unique experiences of participants through interpretation of shared meaning (Jasper, 1994; van Manen, 1997). Direct quotes from each participant have been included whenever possible to share her voice. Themes and subthemes emerged through an in-depth circular analysis of the interview transcripts.

Table 2 has been presented to illustrate the themes and subthemes uncovered by the researcher during data analysis. Awareness was discussed in terms of self-awareness, awareness of the client, and situational awareness. All forms of awareness are required to deliver person-
centered psychiatric nursing interventions. The theme of PCC was prominent in much of the participants’ recounts of psychiatric nursing. Subthemes of PCC were delivering PCC plans; determining goals; fostering empathy, support, and hope; listening in one-to-one interactions; person-centered teaching; and enhancing coping strategies. Awareness and PCC were reciprocal in practice. Awareness was required to provide PCC and through the practice of PCC awareness was enhanced.

Table 2

Phenomenological Themes and Subthemes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness</td>
<td>Self-Awareness</td>
</tr>
<tr>
<td></td>
<td>Awareness of the Client</td>
</tr>
<tr>
<td></td>
<td>Situational Awareness</td>
</tr>
<tr>
<td>Person-Centered Care</td>
<td>Delivering Person-Centered Care Plans</td>
</tr>
<tr>
<td></td>
<td>Determining Goals</td>
</tr>
<tr>
<td></td>
<td>Fostering Empathy, Support, and Hope</td>
</tr>
<tr>
<td></td>
<td>Listening in One-to-One Interactions</td>
</tr>
<tr>
<td></td>
<td>Person-Centered Teaching</td>
</tr>
<tr>
<td></td>
<td>Enhancing Coping Strategies</td>
</tr>
</tbody>
</table>

In this chapter several terms were utilized to describe the adult clients who were residing in acute care settings. The participants often referred to this population as *patients* whereas the researcher preferred to use *clients* or *persons*. The terms patients, clients, and persons will be utilized to describe adult clients residing in acute care settings. Each theme and subtheme listed in Table 2 will be discussed in detail including direct quotes from the participants whenever possible to capture the essence of their experiences.

**Awareness.**

A theme voiced by the participants was one of awareness. An integral factor was self-awareness; noticing ways that the complex dynamics of an acute care mental health unit
impacted the psychiatric nurse in the present moment. An aspect of self-awareness was intuition, instinct, or having a gut feeling that the psychiatric nurse should intervene or investigate a situation further. Awareness of the clients under the psychiatric nurses’ care involved ongoing assessment and observation of those clients. The participants identified a need to know clients under the psychiatric nurse’s care specifically, as well as all of the clients residing on the ward generally. Awareness was discussed in terms of noticing environmental factors, time constraints, and the social interactions between clients residing on the acute care unit. Noticing, observing, paying attention, and assessing were commonly stated terms synonymous with awareness. Awareness factors lead to an improved ability to deliver PCC. Integrated awareness of the self, other, and environment provided the nurse with insight into PCC provision.

**Self-awareness.**

All of the participants discussed the importance of self-awareness in delivering psychiatric nursing interventions. Understanding ones thoughts, emotions, and actions was described as important to empathize with the client and deliver the appropriate psychiatric nursing intervention. Knowing the self was described as a key component to ensure that professional boundaries were maintained. All of the participants reported that intuition, or a gut feeling, assisted with the assessment process and with maintaining safety.

The process of noticing emotions that occurred within oneself was a component of self-awareness. Dana discussed the process of noticing her emotional states changing in relation to the emotions of others, “*people are anxious and other people are upset, you can start feeling the same way. So, you know, it's important that, as nurses, we can acknowledge that we're feeling this way and kind of, why are we feeling this way.*” Sara also reported that a component of self-awareness was acknowledging that her personal emotions may be impacted by that of the client,
“aware of your feelings and how you’re responding to different clients and if you need to, like, talk about it and debrief with coworkers and do that appropriately... I can sense what people are feeling or I take on what they're feeling.”

Erin discussed being aware of personal strengths, interpersonal characteristics, and traits, which had a positive impact on her ability to provide client care, “having a sense of humor is very good... The whole thing is you as a whole person, not just one part of you... one of the beauties of that is you bring yourself to it and make it adapt for how you are.” Erin found that knowing herself enhanced her ability to practice using the therapeutic use of the whole self.

Methods of incorporating self-awareness into practice were discussed by several of the participants. Sara talked about the experience of being self-aware while providing psychiatric nursing care, “being aware of your body language, being aware of your tone of voice, being aware of, let's say, patients you can't really work therapeutically with, so just being aware of sort of yourself and areas of knowledge that you need improvement on.” Methods to enhance self-awareness were reported by Sara, “you just want to be mindful of how you're coming across during your interactions... Be aware of things like body language. You always want to be aware of your tone and keep it in check.”

All the participants discussed intuition, or having a gut feeling, about the appropriate intervention to utilize and the proper time to utilize the intervention. Meg voiced, “be aware almost all the time... It's just an ongoing, daily process... If you feel something isn't going right or you haven't seen a patient in a while, you might get that gut feeling, like, I should go and check on them. So it's sort of an intuitive feeling.”

The expert psychiatric nurses paid attention to their intuition and used this form of knowing to guide their interventions. Erin described intuition as developing an instinct on
knowing the appropriate time to communicate and provide interventions. Erin reported, “a lot of the skills just come with the years of practice... It's just so instinctive in terms of lowering your voice when you're talking to somebody who's agitated, just being calm, your stance, the distance between you.” Amanda discussed similar experiences about planning and delivering interventions based on her intuition, “I'm really picking up on sort of the energy around the unit, the energy a specific individual's displaying... If you want to label it, you could call it like a nurses' intuition.” Amanda described a proactive approach of picking up on suitable cues that a client was communicating and planning interventions based on the cues that were sensed, although were difficult to describe.

The participants often reported difficulty in explaining the experience of intuition. Personal understanding of intuition was developed through experience in clinical practice. The skill of intervening based on intuitive feelings was fostered over years of psychiatric nursing. Sensations of intuition served as a signal or cue for the psychiatric nurses to take action and investigate situations further. Erin stated, “if you have a tingly feeling in the back of your neck, make sure you pay attention. Always be aware. If it doesn't feel right, act on it... You just need to pay attention to your surroundings.” Intuitions were utilized to guide interventions and provide safety measure for the self, team members, and the client.

All of the participants discussed boundaries as a feature of psychiatric nursing. An aspect of self-awareness involved ongoing reflection to assist with maintaining boundaries in practice. Erin stated, “it's important that you maintain your professional role... and not get personally involved; you can empathize, but you're not their brother; you're not the friend; you're a nurse, and you have to be a therapeutic tool.” On the topic of boundaries Kristy stated, “either my words inform my attitude or I can see my attitude through my words... To be aware that (this)
person (is) reminding me of somebody... Be aware that there is that boundary there.” Awareness of boundaries was described as a process of noticing by Meg. “Part of it is to know about the transference and counter-transference that can happen.” Sara discussed boundaries further, “maintaining professional boundaries in terms of your role as a nurse, which is different from if you were there just being you. You have to remember that you hold the power in the relationship. We do what we can to try to equalize that power, but we’re the key holders.”

Amanda discussed the importance of reflective practice in developing self-awareness, “it's really just about reflecting and really just about understanding yourself and understanding who you are in psychiatric nursing practice... You can run into some trouble with psychiatric nurses or nurses in general is when they're not reflective, they tend to become a little more rigid.” A key component of delivering PCC was knowing the self. Reflection aided in the provision of PCC by the nurse remaining flexible in approach and intervention to base care on the needs of the person. Self-awareness was described as an essential skill of a psychiatric nurse. Self-awareness was required as an element of personal knowing that served as the basis for developing awareness of the client.

*Awareness of the client.*

The participants described the process of developing awareness of the client through the process of ongoing assessments and observations. Paying attention, observing, and noticing were key terms stated by the participants during discussion on methods to increase levels of awareness. The purpose of developing awareness of persons in care was to employ interventions that best met the needs of clients in the present moment. Dana described the process of observing through noticing, “their body language that they're just kind of in tune with what you're talking about. If someone's just distracted... you need to think, this is not the right time, what else is
going on for them, and maybe just shift the focus.” Meg discussed the importance of paying attention to clients under her care around-the-clock. “You observe. Being front line, you're often at the desk or just on the ward, so you're just kind of paying attention to actions of patients... All the time you’re paying attention. Even when they're sleeping, you're paying attention to how much they're sleeping.”

Knowing the client was described as a component of ensuring safety. Sara described experiences of noticing that a person may be experiencing anxiety or agitation by noticing changes in the person’s body language along with the importance of recognizing the early warning signs that a client may need assistance, “when there's a change in how they're behaving... Just acknowledging that and going to talk to the person and – and try to open a dialogue about what's going on and see how – what would help and what's helped before and what we can do and, again, try to work together.” Amanda discussed awareness of the client as a factor to provide safety, “it's about talking to the person, finding out their risk of safety – like, what's their risk of suicide, do they have a history, doing the suicide assessment stuff for sure. And going from there and making sure, like, the rest of the team has communicated.” The psychiatric nurses noticed when something had changed with a client and approached them for a conversation to verify if their assessment was correct. Knowing the client assisted the expert psychiatric nurses in noticing subtle cues of a change in behavior. Communication with team members was another important factor, as the care provided was multi-disciplinary.

Several of the participants noted that seclusion, or locking a person in a room from which he/she cannot exit, was an intervention utilized to enhance safety, when a client behaved violently. Seclusion was noted to be utilized as a last resort to enhance unit safety by removing and isolating a person, who had become physically aggressive. Methods such as therapeutic
communication and de-escalation techniques were utilized prior to seclusion. Sara reported, “so (seclusion) is an intervention that we do use, but not often. Usually, you want to be hands-off, and seclusion is something that – we want it to be last resort at all times... I've never really been the nurse of someone who got secluded.”

Meg noted that if a person was acting in a dangerous manner her intervention was to provide a safe environment in the “least harmful way. Ask patients to go into their room before, obviously - a seclusion room - or ask patients to go into the relaxation room.” Meg found that providing persons with several choices regarding safe spaces to dwell was a successful method of distancing agitated persons from others on the ward without use of seclusion.

Providing PCC in a safe environment was a fundamental component of psychiatric nursing care. Amanda reported that observation was one level of providing safety. Through observation she was able to get to know persons and build the therapeutic relationship, “we're certainly looking at safety as the number one priority... To make sure this person is safe, comfortable, and what can we do to sort of help them get through their day and through their stay on the unit... It's also about what the patient feels they need to make them feel safe.” Awareness of the client involved observational skills along with engagement and communication with the client to learn more about their experiences.

Awareness was more than noticing and observing. To achieve awareness ongoing formal assessments were conducted with clients. Amanda discussed assessment skills, “you certainly have to have a really solid foundation for your assessment skills because you're getting so many people coming in and out, you just have to be really sort of quick and efficient at what you're doing.” While discussing suicide assessments, Amanda highlighted the importance of listening to client narrative, “it's really about the person telling their story but us as nurses and therapeutic
providers being able to pick up sort of those triggers that would set off (a) red flag... Checking in with people, seeing how their thoughts are, seeing if anything has changed.” A suicide assessment was one method that the expert psychiatric nurses utilized to heighten awareness of the client. The process of gaining awareness was ongoing as a person’s thoughts could change from moment to moment and having frequent contact, or ‘check-ins’ with persons in care was important. Amanda, Kristy, Meg, and Dana also described that psychiatric nurses needed to be present and available to clients.

Awareness of a client was an ongoing process that required skill to notice if something had changed for that person. Sara stated “you always know what's going on with your patients, and then if there's any change, then you're going to do more of a thorough assessment to see what's going on.” Sara described the importance of getting to know a person when someone was first admitted to the acute care unit. She also recognized that persons can change, and remaining current with all persons under her care, regardless of their length of stay in the acute care setting was important.

Awareness and assessment of all persons under the psychiatrics nurses care was commonly discussed by each participant. Awareness of the client was utilized to improve communication and plan the appropriate person-centered intervention. In addition to knowing a client as an individual, the psychiatric nurses recognized the importance of being aware of all persons residing in the acute care environment as well as the ward milieu, which were elements of situational awareness.

**Situational awareness.**

Situational awareness involved noticing all of elements of an environment, in time and space, to understand the comprehensive meaning of the elements and predict their status in the
near future. Task completion in complex and dynamic environments required ongoing assessment of the situation, as situations were in states of flux. Situational awareness was required to understand complex environmental situations and take appropriate actions. Situational awareness required attention, knowledge, and responsiveness. The participants described knowledge and skill utilizing situational awareness to assess the acute care milieu, client relationships, and the multi-disciplinary team.

Awareness of the acute care environment or milieu was discussed by all of the participants. When discussing environmental safety, Kristy reported that ensuring safety of the acute care unit required “the attunement of your colleagues to the acuity of the environment.” This statement highlighted that situational awareness was not the responsibility of one psychiatric nurse; situational awareness required a team approach. Kristy reported that a skill of a psychiatric nurse was “to be available, to be attuned to what's going on in the environment around them (client), around all of us and how that's impacting them.” Erin discussed the importance of assessing the environment, “a hard part is also learning how to manage staff and to run a ward is a big thing, and it's a skill, and it takes time.”

Several of the participants highlighted the importance of keeping the staff or team aware of the situation. When discussing working in a very acute ward, Kristy stated, “there's lots of different things happening, it's sort of trying to keep everybody aware and knowing what's going on.” As acute care has been multi-disciplinary, each member of the team communicated their assessments of all persons receiving care, along with the unit dynamics and energy.

The participants often discussed the interplay that occurred between persons in care and the nursing staff. Kristy reported, “you're nursing the whole unit, even though you are only responsible for certain people.” Dana seconded this observation, “nurses are on top of all of
their patients and how one person could be impacting the rest of them.” Amanda stated that psychiatric nurses, “have to be aware what's happening on the ward and the biggest thing is getting to know your patients, building relationships and building trust.” When discussing the complex milieu of acute care settings Meg stated, “you're always looking and always keeping a good eye on everything that's going on.”

Situational awareness involved the experience of space and time. The participants perceived challenges in providing interventions based on unit acuity and time constraints. Amanda reported, “you have to have really good planning and organizational skills to really sort of work on that unit. Because... it's so busy that you just have to know how to prioritize.” Dana discussed the importance of being aware of ward dynamics and individual client factors to assist with prioritizing care, “I have to prioritize what I’m doing with people. If someone is screaming and yelling on the unit, that's my priority at that point... Every psychiatric nurse working in acute care wishes that we had more time to spend with people.” Awareness of time and how one person was affecting others assisted these psychiatric nurses in care provision and planning.

Amanda discussed the unit acuity and lack of time as being a barrier to providing psychiatric nursing interventions, “you're torn between so many places that you don't always have the time to spend with people. So that's kind of a number one sort of barrier is not always having the time.” Sara and Meg also voiced that the lack of time component was a challenge in providing care.

Kristy reported that the acuity of acute care units had increased over time. Kristy provided a comparison on ways that the increase in acuity in these settings changed since she began nursing 40 years ago, “(the acuity is) getting progressively tighter... There would be a lot more community things that they would go to. A lot more one-on-one time...Given the acuity,
most of my time... is spent (on) preventing crises from happening on the unit, making sure people are safe.” Kristy noticed that throughout the course of her career the acuity of the unit had increased and staffing levels had decreased, which resulted in less time available to provide recovery-oriented PCC.

Time and acuity were described as challenges to providing psychiatric nursing interventions. The expert psychiatric nurses developed skill in situational awareness to address the challenges associated with reduced time and increased acuity. To achieve situational awareness the psychiatric nurse paid attention to the complex dynamics of the unit milieu. Nurses scanned the environment to obtain clinical cues such as objects, noise, temperature, and hazards. The scans captured the physical and social conditions of the unit milieu at that moment in time. The purpose of the scan was awareness and planning. Levels of awareness increased through experience in the practice environment and ongoing reflection. Awareness was utilized to guide interventions. Awareness of the situation, the client, and the self were key components in providing PCC.

**Person-centered care.**

Psychiatric nurses delivered care to assist clients throughout their recovery process. A client’s stay on an acute care mental health unit was only one aspect of the recovery process. Clients deserved care that was tailored to their strengths, goals, and needs. The theme of PCC was described in terms of delivering PCC plans; determining goals; fostering empathy, support, and hope; listening in one-to-one interactions; person-centered teaching; and enhancing coping strategies. A component of psychiatric nursing involved putting the client first to create PCC plans. The PCC plans were built on the client’s goals and hopes for the future. Psychiatric nursing care provision was empathic and supportive for the purpose of instilling hope within the
client. A role of a psychiatric nurse was to listen; active and reflective listening often took place during private, or one-to-one, interactions. Person-centered teaching was provided and an effort was made to assist in enhancing the client’s coping skills to facilitate recovery.

**Delivering person-centered care plans.**

The ongoing process of becoming aware of all clients receiving services in acute care was described as a requirement for the psychiatric nurse to stay current with the clients in that moment. Awareness was a form of knowing. The psychiatric nurses utilized this form of knowing to develop PCC plans with clients. The creation of PCC plans was described to be a collaborative process in which the client was an active participant. The purpose of formulating a care plan was to provide consistency in care provision and increase safety. PCC plans were flexible and changed, based on the strengths, goals, and stage of recovery that the client was in at the present time.

Amanda discussed the importance of devising and revising individualized care plans, “part of what I do is I work with people to make their own care plan. What do you want this admission to look like? And the consistency piece of that being carried through is often done through reports and our notes and our documentation.” Amanda voiced that a new care plan was created with persons as their recovery processes evolved. The plan of care changed based on the client’s unique strengths and goals. A role of the psychiatric nurse was to ensure the plan was communicated to all members of the team.

Dana reported that PCC was about being open and flexible to deliver individualized interventions based on the client needs, not on institutional rules, “the personal safety plans are really helpful. It really helps them feel like we want to understand them better... not feeling like they're understood has really led to a lot of escalated behavior in the past.” Amanda also talked
of providing flexible PCC as a means to increase client safety, “our care plans are designed based on what the patient or what the client’s needs... maintaining safety is about partnering with your patient.” These participants found that involving clients in care planning and being flexible helped to improve client safety and reduce agitation and conflict.

Erin reported that care was based on the client’s interests and planning care was a collaborative experience, “incorporate the patient and share with the patient... They're often quite amazed at how well you actually know them and because you don't just focus on what they need, you focus on their strengths and their values.” Erin found that the collaboration assisted with building rapport with the client. Erin often discussed the importance of providing holistic care; seeing the whole person and not the illness.

PCC was a collaborative experience that involved the mental health team and this team included the client. Sara reported that PCC took effort and engaging the client in the collaborative process could be difficult, “trying to get them involved in their care and engage in their recovery as well, which can be challenging depending on the person.” This observation spoke to the self-efficacy of a particular client in a particular moment, as clients were at various stages of wellness in the recovery process. In discussion, Sara offered a method to address this challenge, “choice is a really big thing to provide for people that don't necessarily have choice when being in a hospital is so restrictive.” PCC plans were created to assist persons in their recovery processes. The recovery journey was unique and individualized and PCC plans were reflective of this uniqueness. The plans helped give a person a voice and an element of choice in an otherwise restrictive environment. Creation of PCC plans helped to align the nurse and client on the path towards client-directed goals.

Descriptions of PCC were central in many of the statements provided by the participants.
Often overlap between themes and subthemes were apparent, as psychiatric nursing interventions were complex phenomena. PCC plans were devised based on the clients’ goals for their recoveries and these goals may not be the same as the goals that the treatment teams perceived to be important. Providing PCC was a circular process of getting to know the client, understanding his/her goals, devising and delivering a care plan, and then revisiting that plan at times of change.

**Determining goals.**

PCC was based on each client’s unique goals. An intervention of the psychiatric nurse was to listen in an effort to understand the person’s goals and collaborate to form and implement a PCC plan. Determining person’s goals helped to facilitate recovery and instill hope. Goals were based on the person’s strengths and values. Awareness and understanding of the client’s perspective was required to determine goals and deliver PCC based on those goals.

Meg discussed goal planning as a process of talking with a client and getting to know ways that the person envisioned his/her future. This process was described as “instilling hope that things will get better, talking to them about goals and staying well. Talking about the relaxation techniques. So you’re using all those interventions and working with the patients to help them get back to life.” Sara discussed a person-centered approach to goal planning, “trying to see what they want in their life and how they can work towards those things, and then hopefully that'll be an avenue for showing them that to obtain some of those goals.”

Dana reported that the focus of goal planning often involved examining the client’s short-term goals; things that could be achieved in the near future as the care provided was acute. Dana also reported that this process was person-centered, “our goals are not necessarily their goals. We have to make sure we’re all on the same page... by involving the patient in their care...What
we necessarily think should happen for patients is not necessarily what they want and what they need in their life.” Erin also emphasized the importance of person-centered goal planning, “you always need to know what their goals are. Their goals may be totally different than what your goals are. So even if you don't agree, it's their decision, their choice, and you have to honor that.” Goal planning was about knowing the client and offering choices. Kristy stated, “psychiatric nursing is not advice giving” highlighting that the client would know the best directions for his/her life and the role of the treatment team was to offer choices for the person to make informed decisions.

Psychiatric nurses were responsible for the provision of safety, security, and holistic care. Admission to acute care, especially for persons who have not experienced prior admissions, could be anxiety provoking for a variety of reasons. Psychiatric nurses utilized many forms of awareness in an attempt to understand each client’s experiences. PCC was delivered through listening to person’s goals and helping him/her develop strategies to strive for goal attainment. Person-centered understanding was required to develop therapeutic relationships based on empathy, support, and hope.

**Fostering empathy, support, and hope.**

Empathy, support, and hope were components of care described by all of the participants. Empathy was a process of trying to understand the other person’s perspective and the meaning that the viewpoint held for that person. Empathic care was utilized to assist in supporting persons throughout their recovery. Hope has been an essential component of recovery. These interventions were harmonious in practice.

Kristy described methods of providing empathic care in a process of understanding the experiences of the client to impart a sense of hope. To celebrate small improvements in mental
health was to foster a sense of hope. Kristy stated “sometimes, it just all feels so big that that's all you can see and it doesn't feel – you don't see that, oh, there has been some shift... That's something you can take hope from.” Using an empathic approach to examine the client’s present moment experience was utilized to instill hope that change was possible.

Dana communicated the importance of focusing on positive attributes of persons in care, stating “when people are at their worst and you can see them at their best.” Dana described a process of offering empathy and support to assist the client in recognizing hope for the future and seeing that change was possible. Meg discussed the importance of providing PCC and summarized this phenomenon stating, “empathize when things maybe didn't go very well. Instilling hope that things can get better. So often just a lot of active listening and providing support, reassurance.” Sara concluded, “treating people like people and not another number, and always just having compassion and empathy is my approach, being genuine.”

Amanda discussed the therapeutic use of self and the process of offering comfort and support to persons in emotional distress, “I don't always have the answer for questions, I want to be able to comfort them in a way that's comfortable for them.” Amanda reported that she aimed to intervene in a supportive manner regardless of whether or not she knows the cause of the person’s distress. Interventions were delivered in a person-centered manner to help comfort and support persons.

Sara also described methods to help empathize with the clients experience, “validating and normalizing are huge. They're very important for people because people think that they're the only ones experiencing what they're experiencing... Allowing people to feel what they want to feel and not telling them not to. Sometimes people just don't know how to respond to emotions.” Empathy was seen as having a profound effect on helping to understand, validate, and normalize
the person’s experience, while imparting insight into emotional regulation.

Erin voiced that a component of empathy and support was seeing the person, not the illness, “spending a lot of time with people and getting to know them, and as they get better, you have to keep in mind that what they’re displaying when they’re ill is not necessarily what they’re like when they’re well.” Amanda voiced a similar statement, “get to know them as people, not as patients... has been huge in sort of building that alliance with people to have them, you know, feel comfortable being open and honest.” Offering empathy and support assisted with building the therapeutic relationship.

Dana reported that the role of a nurse was to, “be a support... Someone to help encourage them to, you know, do whatever they need to do while they're in the hospital, advocate for them... If they don't have the voice, that we can either encourage them or we can kind of speak up on their behalf.” Amanda found that support was more about the persons in care; family and friends and any extensions of that person outside of hospital required support as well, “supportive therapy is really that initial relationship building, making them feel comfortable,... I also like to recognize that when people come in they have an extension outside of themselves that are out in the community whether that be their follow-up, whether that be their family.” Sara described support as a form of advocacy, “using my voice to help my person I'm working with so that they're heard.” Dana, Amanda, and Sara’s descriptions of support involved viewing the whole person as a method to build relationships while providing care.

Much like the discussion on PCC, statements of empathy, support, and instilling hope could be found in various other categories or themes as well. One-to-one interactions were described as taking place in private settings where the psychiatric nurse aimed to listen and get to know the client.
Listening in one-to-one interactions.

Listening was identified as an important role of a psychiatric nurse. Listening was described as an active process of paying attention to the client’s communication and helping to find meaning behind the messages. Active and reflective listening commonly took place during one-to-one interactions.

Meg reported that active listening was an important intervention, “you're paying attention to the person. Have eye contact. You might rest your hand on their shoulder at times if they're crying. Just look like you're engaging. Nod your head, maybe ask for further clarification.” Sara termed the process as therapeutic communication, “providing active listening and doing all the basic skills of paraphrasing; coming from a non-judgmental point of view and just being supportive and a safe place for people to open up.” Active listening for Sara involved, “use of silence... Showing that you're listening through your body language... Maintaining good eye contact... Then to also throw in some paraphrasing and validation.” Kristy termed this intervention as compassionate listening, “that deeper level of listening... When you're telling me this story or these symptoms or whatever, how do you interpret that and how does that impact your life?... To listen with that extra ear, you know, is not just to the content but to the meaning.”

Active and reflective listening involved presence on the part of the psychiatric nurse. Often this goal was achieved through one-to-one interactions. One-to-one interactions were instances where the psychiatric nurse and client met privately. Erin described the meetings as “taking the patient aside, sitting, listening, being empathetic, just letting them vent, no matter how long it takes... Getting them to focus on what's current and what we can deal with... Help them move on in their recovery.”

Amanda reported that one-to-one interactions were, “the time that you set aside with your
individual clients, and it's based on what their needs are.” Sara described one-to-one interactions as, “spending time without an agenda and trying to get to know the person. Sometimes, that really can be challenging, especially when someone’s been so connected with their illness for so long… It's challenging because you want to try to get them reengaged with life.” Kristy also described one-to-one interactions as being a person-centered event that required awareness of the client prior to entering the meeting, “to make myself available to have a one-on-one conversation as much as they can tolerate it... Sometimes, those one-on-ones are like brief little three-minute contacts as opposed to a 20 or 30 minute conversation... Hearing about how they are in that moment, how they are with whatever treatment is going on... and how they understand that.”

All of the participants described listening and understanding the client throughout ongoing, private contacts as a component of psychiatric nursing. The psychiatric nurse listened to the client in an effort to understand the client’s strengths, desires, and goals. Interventions were person-centered to meet that person’s needs. When the psychiatric nurse began to understand the client needs, she could begin planning more formal interventions. The nurses described teaching as a formal intervention.

**Person-centered teaching.**

All participants described person-centered teaching as a psychiatric nursing intervention. Teaching was often noted to take place during the one-to-one interactions. Teaching involved providing psychoeducation and mental health resource information. The participants discussed the importance of teaching about the illness to reduce stigma, provide hope, and assist persons with their recovery processes.

Amanda discussed teaching as an intervention to reduce stigma, “part of my role as a
psychiatric nurse has been to sort of try and break that stigma a little bit and really partner with patients and families to teach them about mental illness and what it is. And also, trying to work with people to educate them that people can have mental illness but they can still be productive, they can still work, they can still lead normal lives.” The teaching process, for Amanda, was about providing mental health education and instilling hope that recovery was possible. She also highlighted the importance of providing the client and family with information on community resources to continue recovery outside of acute care settings.

Dana discussed teaching as a safety measure to assist persons in understanding mental health, mental illness, and recovery, “teaching is one of the most important things as a nurse that we can do, so in keeping people safe, you know, teaching them about their illness, medications... about recovery and what that means.” Sara summarized, “teaching and educating is a primary part of our roles. We educate in terms of a lot of skill-building, coping, try to teach self-soothing, medication teaching.”

When discussing teaching strategies, Kristy mentioned the importance of body awareness, “how can you tell when you're being triggered because your body will tell you... Being aware of how everything is connected... So be aware of that feeling. But also sort of be aware of what thought preceded that. Because feelings don't just come out of the blue normally.” Dana talked of the importance of knowing the connections between thoughts and feelings, “teaching people about their feelings is important... CBT (cognitive behavioral therapy) stuff is really helpful. Because sometimes, people just don't put two and two together... And how that's impacting their life.” Teaching was a person-centered intervention as the nurse provided education and also offered strategies to assist persons in learning more about their thoughts and emotions.
The participants commonly conveyed that psychoeducation was an essential psychiatric nursing intervention. Erin reported that knowing about the person’s illness was important, but also having a holistic perspective and incorporating other forms of education into the intervention of teaching was key, “as a teacher, you need to teach them about their illness and it may take a while... How to learn coping skills through OT (occupational therapy) and recreational activities... Patients get other illnesses besides mental health issues, so you need to be aware and treat those conditions as well.”

Education for these expert psychiatric nurses was about providing information, but more importantly explaining ways that this information impacted clients and their lives. The information provided was delivered to help persons cope with their illnesses to assist with their recovery. Teaching about coping strategies was discussed by all of the participants. The expert psychiatric nurses looked beyond simply providing education on coping strategies; they made efforts to become aware of strategies that the client had found effective in the past to incorporate this information into the person’s care plan.

**Enhancing coping strategies.**

An important aspect of teaching was assisting persons in recognizing, developing, and enhancing their coping skills. Enhancing coping strategies was a personalized approach based on the client’s strengths, desires, and needs. Strengths included cognitive abilities, social supports and resources, physical skills, physiological resources, and cultural alliances. The aim of this intervention was to build on the person’s internal resources to facilitate recovery and inspire hope. Examples of coping strategies listed by the participants included progressive muscle relaxation, meditation, breathing exercises, and problem solving. A goal was to enhance the
coping strategies so that persons were able to access these skills independently, outside of acute care settings.

Dana discussed that coping strategies need to be developed in regards to the current issues that the client may be facing, “my focus needs to be on helping this person cope with what they're doing right now.” Amanda stated that coping skills were discussed with clients as methods to improve client safety, “the one-to-one time you spend with people just giving them a chance to tell their story and offering them different techniques to stay safe whether it be sort of journaling their thoughts, talking to us, finding other peers on the unit they can talk to.” Kristy reported that a psychiatric nurse was front-line in teaching person-centered coping skills, “you talk about sort of what does work for you, what have you seen work for other people, what hasn't worked for you. This is what I know some people have tried or have you ever thought about this.” Kristy also reported that assisting persons in enhancing their coping skills was a key role of a psychiatric nurse.

Sara discussed interventions that she created to assist the teaching process, “I have a package when people come in... different distraction ideas, teaching how to journal, doing guided deep breathing or progressive muscle relaxation.” Sara reported that initially she guided persons through the process of learning new skills and she also liked to draw on the skills and strengths that clients had already developed, “people have skills already on their own, so finding out what works themselves and then just building off of those skills... Chances are, this isn't their first crisis, so they do have skills underneath, but it can get a bit clouded when they're feeling so much distress.” The psychiatric nurses had active roles in helping persons recognize effective coping strategies that they could use outside of acute care settings. Existing strengths were explored to help build on those skills. Enhancing coping strategies were person-centered
Dana voiced the importance of helping clients to learn about causes of anger, anxiety, or thoughts of suicide along with teaching coping skills such as “going through how to relax... Actively participating in an activity, be it, muscle relaxation or deep breathing... Give them the tools they need to try to do it themselves.” Meg frequently mentioned assisting persons in developing coping strategies. Meg described the process as, “help patients help themselves.”

Meg discussed the importance of listening to the client experience and challenging that experience in an effort to instill hope, while offering strategies to assist in coping with distress.

Coping strategies were often discussed in relation to goal setting. Erin often talked of taking a holistic stance to help facilitate goal achievement and reduce potential barriers, “advocate for your patient in terms of making sure that they get what they deserve in terms of treatment, and if there's some barriers, you need to help break down those barriers... Be a bridge between families in learning how to reconnect with families.” Kristy explored client-coping strategies by inquiring about activities that the person did outside of hospital to cope, “things like relaxation, things like meditation, things like what do you do for fun... So stress reduction... Problem solving, looking at goal setting... You've probably run into problems like this before, so how did you cope with that – like, sort of drawing on your own strength and resources.”

Enhancing a client’s coping strategies was a psychiatric nursing intervention. This intervention involved awareness of the client to build on skills and strengths that the person possessed. Coping strategies were explored with clients to help facilitate goal achievement and reduce associated barriers. Education was provided to further strengthen the client’s skills, knowledge base, and ability to effectively practice the strategies independently. To achieve PCC,
the psychiatric nurse modelled and practiced strategies with clients, based on his/her assessment at that time.

Two key themes reported by the psychiatric nurses were awareness and PCC. The rich descriptions provided by the participants were useful to gain insight into the phenomena of psychiatric nursing knowledge and interventions. The process of learning the proper time to intervene and which interventions were appropriate was assessed based on the psychiatric nurse’s awareness of the self, the client, and the situation. This practice was difficult for the participants to describe as the process of becoming aware was reciprocal. A holistic assessment involved all forms of knowing to become aware of the multifaceted factors occurring within an acute care setting at any given moment. Awareness was essential to deliver PCC. The two themes were dependent upon one another in a continuous and interrelated process. All aspects of PCC were integrated into holistic, recovery-oriented practices through a complex interplay of psychiatric nursing skills and interventions. Psychiatric nursing interventions were not tasks. The interventions were dynamic and diverse based the present situation and the needs of persons in care. The findings will be further discussed and implications for practice, policy, education, and research will be described for all themes and subthemes in the following chapter.
Chapter 5: Discussion

Many interventions that psychiatric nurses complete may not be noticed by others and therefore may be referred to as invisible interventions (Cleary et al., 2011). Much knowledge that psychiatric nurses possess has been unspoken. The data analysis process provided insight into the lived experiences of expert psychiatric nurses and illuminated their actions and interventions. Hermeneutic phenomenology was applied to unveil the concealed meanings of being psychiatric nurses practicing in acute care settings with adult populations. Much expertise gained from clinical practice become second nature to psychiatric nurses. Therefore such actions may be difficult to articulate. Hermeneutic phenomenology was applied to gain rich understanding into the essence or common understanding of psychiatric nursing interventions. The purpose of hermeneutic phenomenology was to explore lived experiences (van Manen, 1997); the manner, by which psychiatric nurses practice, is their lived experience.

During the data collection and data analysis processes, importance was placed on remaining true to the participants’ stories and voices. Throughout the interviews, interventions stated by the participants were noted following prompts from the researcher to provide more detail about each intervention. This strategy was utilized to determine essential themes that characterized the phenomenon. Much consistency in the participants’ accounts of psychiatric nursing interventions was uncovered.

This chapter will include articulation of the roles of psychiatric nurses practicing in acute care environments and the interventions utilized. The descriptions provided by the participants were consistent with and add to the psychiatric nursing knowledge base. Reflection on the psychiatric nursing interventions voiced by the participants will be discussed along with the interpretation of ways that this knowledge may be employed by other psychiatric nurses.
practicing in acute care environments.

The researcher reviewed literature related to psychiatric nursing, nursing in general, and non-nursing disciplines to thoroughly understand and discuss the themes identified. Each theme contributed to the overall essence of psychiatric nursing interventions. The theme of awareness will be discussed in relation to subthemes of self-awareness, awareness of the client, and situational awareness. The theme of PCC will be described through subthemes of delivering PCC plans; determining goals; fostering empathy, support, and hope; listening in one-to-one interactions; person-centered teaching; and enhancing coping strategies. Dividing the PCC into subthemes was difficult as much overlap was apparent and each aspect was harmonious or interrelated, and cohesive in practice. Awareness and PCC interventions were unified and embedded into the responses provided by psychiatric nurses. Implications for practice, policy, education, and research for each subtheme were integrated into the corresponding discussion. The research findings inform and build upon to the psychiatric nursing knowledgebase. Understanding of the themes, awareness and PCC, may be utilized to assist psychiatric nurses in providing meaningful care.

Awareness

The process of becoming aware took place in the present moment involving an interplay of self-awareness, awareness of the client, and situational awareness. Reflection and clinical experience enhanced all forms of awareness (Jack & Miller, 2008). Much literature was available on self-awareness and awareness of the client in nursing practice. This literature was synonymous with the descriptions provided by the participants. Scant research was available on situational awareness in nursing practice although this field is beginning to emerge (Patterson, Procter, & Toffoli, 2016).
Nursing practice with present moment awareness had a positive impact on unit safety (Hirst, 2003). To practice successfully in recovery-oriented acute care units, psychiatric nurses needed to have psychological awareness to be present during interactions with clients (Delaney, 2012). Self-awareness involved reflection, critical thinking, and problem solving to promote informed knowledgeable practice (Eckroth-Bucher, 2010).

**Self-awareness.**

Self-awareness has been foundational to psychiatric nursing (Sant & Patterson, 2013). Self-awareness involved the process of knowing, questioning, and understanding one's thoughts, feelings, beliefs, and values to consciously guide care and deliver nursing interventions (Eckroth-Bucher, 2010). Self-awareness was a conscious, ongoing (Rasheed, 2015), voluntary process of introspection (Eckroth-Bucher, 2010). All of the participants described the importance of knowing the self as a prerequisite for providing PCC. Elements of knowing the self were noticing one's thoughts and feelings in the moment to plan actions, implement nursing interventions, and maintain boundaries. Self-awareness was described in terms of intuition or having a gut feeling that action or investigation was required. Expert nurses were able to anticipate changes to the clients' condition based on feelings of intuition, scientific knowledge, and experience (Benner, 1997).

During the preliminary stages of data analysis intuition, boundaries, and self-awareness were coded as separate themes. When the transcripts were reviewed as a whole it became clear that all of the aspects were discussed in terms of self-awareness. The psychiatric nurse required self-awareness to notice intuitive feelings and reflect on boundaries in order to deliver expert care. Self-awareness involved the use of insight and presence to guide genuine nursing care (Eckroth-Bucher, 2010).
Self-awareness was key to establishing therapeutic communication (Eckroth-Bucher, 2010, Engin & Cam, 2009, Sant & Patterson, 2013) and PCC (Rawlinson, 1990). The core of psychiatric nursing has been the therapeutic relationship (Registered Psychiatric Nurses of Canada [RPNC], 2010). Understanding of the self was required to be a therapeutic provider, who crafted care to meet the needs of clients (Foster, McAllister, & O’Brien, 2006). Antecedents for self-awareness included an enduring concept of self and ability to reflect on personal and professional memories and experiences (Eckroth-Bucher, 2010). Self-awareness, reflection, and self-management of thoughts, feelings, and attitudes towards clients has been an essential component in the development of the therapeutic relationship (Zugai, Stein-Parbury, & Roche, 2015). The participants noted that self-awareness was required to sense ways that their emotions impacted the clients and vice versa in continuous cycles of reflection.

Psychiatric nurses required awareness into their professional strengths and limitations to act as therapeutic providers. Self-awareness was recognized as being an ethical requirement for psychiatric nurses’ professional practice (RPNC, 2010). Psychiatric nurses needed to be aware of their own limitations and use professional judgement (RPNC, 2010). Personal knowing has been a form of awareness, which involved the therapeutic use of self to ascertain ethical and moral implementation of interventions (Carper, 1978; Foster et al., 2006).

Self-awareness was used to enhance critical thinking and assist psychiatric nurses to respond objectively (South, 2007). Self-awareness, debriefing, and ongoing supervision and education were important factors to create and maintain professional boundaries (Peternelj-Taylor & Yonge, 2003). Methods to enhance self-awareness included reflective journal writing (Chirema, 2007; Eckroth-Bucher, 2010), maintaining a professional portfolio (Mantzoukas & Jasper, 2004; Rasheed, 2015), clinical supervision, and meditation (Jack & Smith, 2007). All of
the participants discussed the importance of reflective practice as an element of facilitating self-awareness. An expert nurse was reflective (Rolfe, 1997).

Reflection-on-action allowed the nurse to examine past decisions and the knowledge involved and helped to restructure understandings (Heath, 1998). Sara highlighted the importance of reflecting-on-action and debriefing with co-workers to enhance self-awareness. Proactive methods to prompt reflection-on-action included use of a portfolio to track professional and personal development may assist with tracking achievements and determining where future learning should take place (Rasheed, 2015). Aspects for reflection included body language, touch, gaze, speech, attitudes, values, beliefs, prejudices, assumptions, feelings, countertransference, culture, religious beliefs (Eckroth-Bucher, 2010), biases, and prejudices (Rasheed, 2015).

Self-awareness education may be provided to health care professionals through clinical supervision and ongoing mentorship to assist with the advancement of expert practice (Engin & Cam, 2009). Reflection on practice may be guided by a skilled supervisor (Welsh & Lyons, 2001). Experienced nurses should act as role models to novice and student nurses (McCutcheon & Pincombe, 2001). A mentorship program may help with increasing self-awareness (Cleary et al., 2011; Jack & Miller, 2008; Mantzoukas & Jasper, 2004; Rasheed, 2015) and could be organizationally developed and supported (O’Donovan, 2006).

Undergraduate nursing education should include aspects on the development of self-awareness (Healy & McSharry, 2011; Rasheed, 2015) and reflective practice (Basset, Baker, & Cross, 2015). Educational techniques such as simulation and psychodrama may support development of awareness (Payne, 2015; Rasheed, 2015). Simulation has been an educational strategy, which can mimic practice scenarios such as crisis situations in the classroom to inspire
critical thinking, judgement, and nursing skills (Payne, 2015). Computer based simulations can assist with clinical cue recognition (Burbach & Thompson, 2014). Development of standardized computer simulation scenarios have potential to enable researchers to evaluate the efficacy of this form of teaching (Burbach & Thompson, 2014).

Students can use reflection as a learning tool to develop practice (O’Donovan, 2006). Comprehensive mental health practicums may be required to help facilitate PCC in psychiatric nursing students (Choi et al., 2016). Educators need to use a range of tools, such as journals, reflective essays, clinical case studies, and narrative descriptions to encourage and assess levels of reflection over a period of time (Horton-Deutsch & Sherwood, 2008). Educational strategies to facilitate reflection are listening, responding, collaborating, prompting, questioning, modeling, and using silence (Bulman, Lathlean, & Gobbi, 2014). Some students will benefit more than others (Chirema, 2007) as reflection is a voluntary process (Eckroth-Bucher, 2010). Additional research is required on ways to sustain reflective practices following graduation and long into professional practice. Intuition was a component of nursing knowledge, which required clinical experience and ongoing reflection in order to develop and utilize this form of knowing in practice.

**Intuition.**

Intuition required an aspect of personal knowing or self-awareness (Johansen & O’Brien, 2015; McCutcheon & Pincombe, 2001). Many definitions of intuition were offered in the literature. Intuition has been described as an experience that involved looking forward to predict ways that a situation may play out by looking back at past experiences based on pattern recognition and creative use of knowledge (Hogarth, 2010). Intuition was used to address and integrate multiple complex pieces of information; this knowledge was unconsciously translated
into patterns (Witteeman, Spaanjaars, & Aarts, 2012). Intuition has involved an integration of memory and pattern recognition and has been described as a sixth sense (Holm & Severinsson, 2016). The experience of intuition has been the result of the interaction of knowledge, experience, and clinical expertise (McCutcheon & Pincombe, 2001). Intuition has been identified as holistic awareness and a complex component of clinical judgement (Rew, 2000). The definition offered in the literature, which was most consistent with the experiences of the participants, was that intuition involved the experience of sudden emotional awareness and reflection that lead to arousal of conscious thought and emotions working together as a catalyst to form action (Holm & Severinsson, 2016). Psychiatric nursing practice and experience aided the participants in noticing physical sensations of intuition and utilizing this awareness to guide interventions.

Nursing researchers supported the concept of intuition as a valid form of knowing in nursing (Green, 2012; Rew, 1986; 1987; Rew & Barrow, 1989; 2007; Smith, 2009). Intuition has been noted as holistic, complex, and critical to nursing as it serves as a cue to implement an intervention at that moment in time (Robert, Tilley, & Petersen, 2014). Intuition may act as a form of clinical insight (Witteeman et al., 2012). The development of intuition required knowledge, skill, and a clear understanding of the goals of nursing (Green, 2012). Nursing intuition involved a sense of being able to read the clients cues (Holm & Severinsson, 2016).

The physical and emotional awareness associated with intuition was experienced as a connection with the clients; through spending time with clients the nurse picked up on clients’ clinical cues and was able to read and sense their energy (Holm & Severinsson, 2016). Nurses described intuition as a way of knowing something immediately as a whole, which improved with experience and informed judgment and action (Rew & Barrow, 2007). Intuition involved
understanding without clear rational to explain this understanding (Benner & Tanner, 1987) therefore nurses have had difficulty verbalizing the use of intuitive practice (Smith, 2009).

A common description involved noticing a sensory component of intuition often referred to as gut feelings (Smith, 2009), which were often sensed during a critical situation (Rew, 1991). The intuitive feeling was actually a cognitive process utilized for critical thinking to assist with assessment and clinical action leading to PCC (Robert et al., 2014). Intuitive knowing has been attained after years of reflective practice (Epp, 2008; Rew, 2000), clinical experience (Witteman et al., 2012), and ongoing learning (Hogarth, 2010). Educational preparation has laid the foundation for development of intuition and expert practice. Similar to reflection, the concept of intuition should be discussed and promoted as part of educational preparation for psychiatric nurses (Robert et al., 2014). Creating learning environments, which are similar to clinical practice conditions, may assist with the formation of expertise (Hogarth, 2010).

Intuition was a subjective experience, which may be best understood qualitatively (Welsh & Lyons, 2001). More studies need to be conducted to explore the nature and use of intuition with nurses at every level of practice including new graduates, expert practitioners, and leaders (Holm & Severinsson, 2016) and across more specializations of nursing (Robert et al., 2014). Collaboration with other disciplines may further our understanding of intuition (Hassani, Abdi, & Jalali, 2016) and other forms of self-awareness including use of boundaries.

**Boundaries.**

An aspect of self-awareness has involved knowing the self to provide safe and professional care based on the needs of clients. Boundaries included limits that allowed for safe connections with the persons in care as staff held positions of power (Malone, Reed, Norbeck, Hindsman, & Knowles, 2004). The participants reported that the goal of boundary awareness
was to equalize or share the power that psychiatric nurses possessed within the therapeutic relationship. Boundaries were utilized to bridge the gap between nurses’ power and the clients’ vulnerability (Hanna & Suplee, 2013; RPNC, 2010). Recovery-oriented services rejected the use of authoritarian, professional power, in order to focus on client choice, dignity, and respect (Mental Health Commission of Canada [MHCC], 2015). Professional boundaries helped the nurse to interact professionally based on each client’s needs and preferences (Hanna & Suplee, 2013) and assisted with maintaining safety on the unit (Harris, 2014).

Boundaries helped to protect the integrity of the client and nurse as they worked together within the therapeutic relationship (Dziopa & Ahern, 2008). The essence of psychiatric nursing has been the therapeutic relationship; in the relationship, nurses may run the risk of crossing boundaries as they may be frequently exposed to situations where boundaries are tested (Peternelj-Taylor & Yonge, 2003). Self-awareness and reflection were key in defining professional boundaries to ensure that safe care was provided (Jack & Miller, 2008). Psychiatric nurses needed to be aware of themselves and understand the effects that they had on others and their surroundings (Engin & Cam, 2009).

Clarifying boundaries has been a challenging task for the mental health systems; practice environments must offer multidisciplinary discussions and other safe avenues for staff to examine boundaries and share ethical dilemmas (Malone et al., 2004). Awareness of boundaries required ongoing dialogue and discourse between leaders, educators, and nurses (Peternelj-Taylor & Yonge, 2003). Proactive approaches such as self-awareness, self-monitoring, peer debriefing, regular feedback, clinical supervision (Peternelj-Taylor & Yonge, 2003), workshops, and educational videos (Malone et al., 2004) were essential to maintaining boundaries and providing safe care.
Policies need to be updated and used to clearly explain boundaries, boundary violations, ethical best practice, and ways to report violations along with consistent disciplinary action (Malone et al., 2004). A review of policies and procedures on boundaries should be incorporated into annual health care employee education (Hanna & Suplee, 2013). In addition, clients should be informed of the purpose of boundaries in the therapeutic relationship (Peternelj-Taylor & Yonge, 2003). Awareness of boundaries should be required for all health care professionals and this awareness should begin prior to entering practice.

Education on boundaries has been integral to nursing curricula (Peternelj-Taylor & Yonge, 2003). Discussions on boundaries, ethics, personal space, and therapeutic touch should be incorporated into various points of the education programs (Hanna & Suplee, 2013). Development of standardized tools, which provide an opportunity for self-evaluation and reflection on boundaries, should be required (Peternelj-Taylor & Yonge, 2003). Awareness of the self and the client was required to provide PCC and maintain boundaries.

**Awareness of the client.**

Awareness involved knowing the persons in care (Delaney & Johnson, 2006). Noticing, assessing, observing, and paying attention were ongoing activities that the psychiatric nurse completed to become aware of clients. The process of becoming aware of clients assisted nurses by providing insight into the actions and health conditions of clients under the psychiatric nurses’ care specifically, as well as all of the clients residing on the ward generally (Hamilton & Manias, 2007). More specific detail on knowing the client and delivering interventions will be discussed in terms of PCC as this process was unified in practice.

The theme of awareness provided insight into methods that psychiatric nurses performed to gain knowledge that guided interventions. Interventions were delivered based on a complex
interplay of a variety of forms of knowing; awareness of the client was one form of knowing. All of the participants discussed the importance of knowing the client well enough to provide PCC. Awareness of the client was achieved through an ongoing process of observing persons from a distance along with talking to them individually. Observation or paying attention to the actions of persons in care along with individualized, comprehensive assessments were methods employed to become aware of the client.

Nurses have some level of responsibility for every person residing on the ward, which contributed to the need to nurse the population on the unit as a whole (Cleary et al., 2011; Cleary, Hunt, Horsfall, & Deacon, 2012). A component of knowing the client involved observation and formal assessments of clients in care and the unit as a whole. Awareness of change prompted the psychiatric nurses to engage the client and complete a more formal assessment. Keeping persons safe has been accomplished through trusting relationships, teamwork, risk assessment, monitoring, and observation (Bowers, 2005).

**Observation.**

One method of caring for clients and maintaining safety was through observation (Engin & Cam, 2009; Muralidharan & Fenton, 2006). Observations may be visual or auditory with the purpose of noticing moment to moment changes of persons in care (Cleary et al., 2011) and the acute care milieu or atmosphere. Observation has involved checking in on a person every 15 to 30 minutes, having one-to-one presence of staff to client at all times, and using suicide precautions (Horsfall & Cleary, 2000; Manna, 2010; Muralidharan & Fenton, 2006).

Assessment required extended observation of the person’s behaviors along with interaction with the person and communication amongst members of the health care team (Bowers, 2005). Verbal and non-verbal clinical cues that a client displays ranged from subtle to
overt and signaled changes in the client’s condition; these cues were often intuitively recognized by nursing staff (Burbach & Thompson, 2014). The psychiatric nurse participants highlighted that noticing changes served as a cue to interact and engage with clients. Successful nursing practice involved the ability to develop a grasp of significant clinical cues, for early intervention and prevention (Burbach & Thompson, 2014).

Psychiatric nurses frequently held two roles, which often conflicted. These roles included providing a safe and secure environment, while attempting to provide therapeutic, individualized nursing care (O’Brien & Cole, 2003). Managing aggression has been a challenging aspect of psychiatric nursing practice as many persons in care have been distressed and some have been hospitalized against their will (Cleary, Horsfall, O’Hara-Aarons, Jackson, & Hunt, 2012). The roles of a psychiatric nurse has included a dual role of balancing client restrictions with enhancing autonomy (Zugai et al., 2015). Nurses recognized that restrictive practices such as seclusion should only be utilized when safety was compromised (Sowers, 2005). Individualized plans have helped staff facilitate interventions and de-escalate aggressive behaviors prior to the use of seclusion (Sowers, 2005). Reasonable flexibility (Hurley, 2009), which has been given to each individual persons in care, has enhanced PCC and the dignity of persons residing in these restrictive environments (Cleary, Hunt, et al., 2012).

Observation has become a time-consuming process and may run the risk of becoming a task to be completed rather than a meaningful practice (Buchanan-Barker & Barker, 2005). An alternative to observation has been engagement (Barker, 2001; Buchanan-Barker & Barker, 2005) where the nurse interacted with persons in care rather than being a detached observer (Benner, Tanner, & Chesla, 1992). Rapport and engagement were highly valued by clients rather than simply being observed or watched (Barker & Rolfe, 2000). Expert nursing practice involved
individualized, active, and meaningful engagement with clients (O’Brien & Cole, 2003) rather than institutionalized observation (Stewart, Bowers, & Warburton, 2009). The descriptions provided by the participants were consistent with that of engagement.

Psychiatric nurses have been well positioned to create atmospheres of connection, engagement, and affirmation through the provision of recovery-oriented and trauma-informed care (Antai-Otong, 2016a; Thibeault et al., 2010). Trauma-informed care involved awareness of the potential presence of trauma, which clients may have experienced, and delivery of interventions to enhance psychological and physical safety (Isobel & Edwards, 2017). Essential components of trauma-informed care has been the therapeutic relationship (Muskett, 2014) and creation of individualized and flexible care plans (Isobel & Edwards, 2017). Partnering with the client was associated with increased levels of safety and reduced the use of seclusion in acute care settings (Sowers, 2005). The principles of recovery and characteristics of trauma-informed care should be incorporated into policies, procedures, and practices (Huckshorn, 2004). Additional research is required on methods to achieve safety in acute care without the use of seclusion (Green et al., 2014; Muralidharan & Fenton, 2006).

Active engagement needs to be incorporated in policy, guidelines, and practice (Kettles & Addo, 2009). Policies need to be developed in collaboration with service users (O’Brien & Cole, 2003). Nursing practice has been marked by an awareness of the client’s behaviors, attending to situations, and noticing changes in the milieu (Delaney & Johnson, 2006). The expert psychiatric nurses, who were interviewed, highlighted the importance of paying attention for the purpose of assessment and action. The assessment process typically involved nursing observation and interaction with clients to develop relationships, where the persons were able to share their thoughts and concerns (Bowers, 2005), and nurses could learn their stories.
Assessment.

Assessment has been identified as the foundation of psychiatric nursing practice and the groundwork for determining interventions (Coombs et al., 2013). Nurses have kept persons in care and others safe by completing short and long-term risk assessments (Bowers, 2005). A component of assessment involved recognition of the interplay of mental and physical health (MHCC, 2015). Assessment also included noticing environmental risks such as sharp objects, broken equipment, and missing chords (Billings, 2004) along with individualized client assessment. Risk assessment and subsequent safety planning have been tools commonly utilized in mental health care.

Risk assessment and safety planning have been important aspects of psychiatric nursing practice (Higgins, Doyle, Downes, et al., 2016). The purpose of a suicide risk assessment has been to identify and address risk utilizing person-centered interventions (Billings, 2004). The participants reported that use of risk assessments were utilized for the purpose of safety planning. A suicide risk assessment should be conducted through clinical curiosity and sensitive interest (Billings, 2004).

In acute care environments, risk assessments were often focused on high consequence and low frequency situations such as suicide, violence towards others, and absconding from the ward (Higgins, Doyle, Downes, et al., 2016). Assessment of risks also should include persons’ vulnerability factors, such as violence from a partner, financial exploitation, homelessness, loss of employment, loss of social supports, adverse side effects from medication, stigmatization, sexual vulnerability, poor physical health, self-neglect, and vicarious traumatization, to provide a more inclusive understanding of persons in care (Higgins, Doyle, Downes, et al., 2016; Higgins, Doyle, Morrissey, Downes, Gill, & Bailey, 2016). Psychiatric nurses need to balance the risks
assessed with rights of client (Grotto et al., 2014). Risk management and risk elimination are never totally possible, although risk may be minimized through use of clinician interventions (Higgins, Doyle, Morrissey, et al., 2016).

Assessments should be collaborative, involving the persons and their family, and include safety planning (Higgins, Doyle, Downes, et al., 2016). Safety planning required a recovery-oriented approach through collaborative care and a holistic risk assessment (Higgins, Doyle, Downes, et al., 2016). Clinical judgement has been a problem-solving activity, which began with assessment, followed by interventions, and subsequent evaluation of the interventions (Tanner, 2006).

Assessment of a client has become essential to mental health care although little consistency in the content of a comprehensive assessment was found in the research (Coombs et al., 2013). The assessment for the expert psychiatric nurses was ongoing and independent of that of other professionals as thoughts and emotions could change quickly. The participants recognized the need to check in with clients regularly and remain available if needed. Expert nurses checked on persons even if they were not responsible for their care (Sitterding, Ebright, Broome, Patterson, & Wuchner, 2014). A better understanding of the factors that govern a comprehensive assessment and ways that practice can be developed, supported, and evaluated is required to improve practice and safety (Coombs et al., 2013).

Limited research was available on conceptualization of risk by practitioners, methods to engage in safety planning, and strategies for the promotion of protective factors (Higgins, Doyle, Downes, et al., 2016). Involving clients in risk management strategies such as violence, aggression, self-harm, suicide, and mental health relapse over short and long-term periods of time has been an essential aspect of PCC (Woods, 2013). Risk assessment was effective only if a
plan was put into place to address the risks (Higgins, Doyle, Morrissey, et al., 2016). Care plans, when used correctly and consistently, may have reduced potential risk outcomes (Higgins, Doyle, Morrissey, et al., 2016), when they were developed in partnership with the client (Grotto et al., 2014).

Policies and procedures require review and revision with client involvement to include a comprehensive definition of risk along with recovery-oriented language (Higgins, Doyle, Downes, et al., 2016). Risk assessment and management should be guided by organizational policies and procedures (Higgins, Doyle, Morrissey, et al., 2016). Organizations should promote use of valid tools to guide assessment and safety planning (Higgins, Doyle, Morrissey, et al., 2016), such as personal safety plans (Huckshorn, 2004). Risk assessment tools and plans can assist, not replace, clinical judgement (Woods, 2013). Tools should be developed, which engage the client instead of simply completing checklists to enhance risk assessment and safety planning; meaningful engagement is required in collaborative safety planning (Higgins, Doyle, Downes, et al., 2016). Clinical judgement involved engaging with the client and knowing his/her patterns of responses along with the context of the situation (Tanner, 2006). Psychiatric nurses require awareness of all persons residing on the ward along with the awareness of the milieu.

**Situational Awareness.**

The phenomenon of situational awareness, also known as situation awareness, was first identified in the field of air traffic control (Endsley, 1995; 2015). The principles and constructs of situational awareness have been adapted to other complex environments such as healthcare (Endsley, 1995) and have been applicable to nursing (Sitterding et al., 2014). Situational awareness has been studied in medical areas such as anesthesiology (McIlvaine, 2007; Schulz, Endsley, Kochs, Gelb, & Wagner, 2013), personal care homes (Taylor, Sims, & Haines, 2014;
Taylor, Sims, & Hill, 2015), primary care (Singh et al., 2012), and emergency services (Blandford & Wong, 2004; Lowe, Ireland, Ross, & Ker, 2016; Reichenbach, 2009; Williams, Quested, & Cooper, 2013). Little research has been conducted into situational awareness in nursing (Sitterding et al., 2014; Stubbings, Chaboyer, & McMurray, 2012; Tower & Chaboyer, 2013) and nursing education (McKenna et al., 2014). Scant research on situational awareness in psychiatric nursing was available, therefore more research is required (Patterson et al., 2016).

Situational awareness was the “perception of elements in the environment in a volume of time and space, the comprehension of their meaning and the projection of their status in the near future” (Fore & Sculli, 2013, p. 2613). Simply put, situational awareness involved being aware of what was happening in the environment (Patterson et al., 2016) and viewing the situation as a whole for the purpose of decision making (Endsley, 1995) and anticipating risks (McIlvaine, 2007). Being able to recognize critical cues about an environment and comprehend the future status of the situation has been identified as an important decision making skill, which required use of all five senses (Blandford & Wong, 2004). Skilled situational awareness increased with time and experience within an environment (Endsley, 1995).

The goal of situational awareness was to form a holistic picture of the setting and understand the significance of events and cues to predict future states of the environment (Endsley, 1995). The term environment was considered to be the immediate physical space around one; the total setting, not selected parts (Endsley, 1995). In nursing this environment has been referred to as the milieu. The milieu has been considered to be the psychological, physical, social, political, and spiritual components of the acute care environment (Thibeault et al., 2010). Situational awareness has been used to assess the status of the milieu, client interactions and relationships, and team dynamics.
Situational awareness in nursing has remained generally unexplored (Sitterding, Broome, Everett, & Ebright, 2012). This subtheme was difficult to determine; it was originally coded as separate topics of time constraints and environmental awareness. The context of the discussions involved nursing the population of the unit as a whole with emphasis on maintaining safety for all. Situational awareness combined the interplay of understanding the dynamics of the unit milieu, prioritizing care, managing time constants, and nursing the acute care unit as a whole. The subtheme of situational awareness offered insight into the milieu of an acute care ward and details into psychiatric nursing interventions, which provided care for the environmental and situational contexts of the milieu. Vigilance and monitoring has required elements of situational awareness (Fore & Sculli, 2013). Clinical cues were observed through the practice of nurses constantly scanning the environment to have current knowledge of the environment (Sitterding et al., 2014) much like the process described for awareness of the client. Awareness of the client and situational awareness were unified in practice.

Psychiatric nurses aimed to balance the needs of a particular individual with the needs of the unit (Delaney & Johnson, 2006). This balancing act was achieved through sophisticated assessment skills and observation of the tone and pace of the unit, to gain an intuitive grasp of the situation and knowing when to intervene and when not to intervene (Delaney & Johnson, 2006). The phenomenon of situation awareness provided insight into ways that psychiatric nurses cared for the entire ward. The descriptions provided by the participants added to the existing knowledgebase as little research has been conducted on nursing skills that assisted with maintaining a safe unit (Delaney & Johnson, 2006).

Situational awareness has become a strategy by which practitioners identify, use, and make meaning of multiple cues and environmental elements (Patterson et al., 2016). Acute care
units have become busy, demanding, and stressful areas (Barker & Rolfe, 2000; O’Donovan & Gijbels, 2006). Many decisions have been made in the context of dynamically changing situations, therefore situational awareness has become crucial (Blandford & Wong, 2004) in psychiatric nursing. Situational awareness was critical for clinical decision making and enhanced client safety (Fore & Sculli, 2013; Gluyas & Harris, 2016; McKenna et al., 2014).

A challenge in providing psychiatric nursing interventions was a lack of time. Nursing staff needed to have protected time to be available and responsive to needs and concerns of persons in care (Chiovitti, 2008). Large client assignments, staff turnover, administrative tasks, documentation demands, insufficient resources (Green et al., 2014), inconsistent and poor staffing, and an overreliance on the medical model were organizational barriers that created difficulties for psychiatric nurses, who were striving to provide PCC and build therapeutic relationships (O’Donovan & Gijbels, 2006; Pazargadi, Moghadam, Khoshknab, Renani, & Molazem, 2015). Staffing complements must be correlated with the acuity of the acute care environment to enhance safety (Gerolamo, 2004).

Psychiatric nurses are members of a multidisciplinary team. Teamwork between health care professionals and the client has been required to safely deliver PCC in acute care settings (Cleary, Horsfall, et al., 2012). Team situational awareness encompassed the information known by members of a multidisciplinary team (Schulz et al., 2013). Team situational awareness took place when several individuals were working together to achieve a common goal (Endsley, 1995). Developing and maintaining team situational awareness required clear communication, awareness of responsibilities, and ongoing reassessment (Gluyas & Harris, 2016; Reichenbach, 2009) to coordinate action (Endsley, 1995). Unit based huddles every four hours, between the charge nurse and the bedside nurse, helped to improve communication and awareness in a
medical setting (Brady et al., 2013) and may be beneficial to trial in psychiatric nursing settings. Reminders and checklists improved individual and team situational awareness (Gluyas & Harris, 2016) and reduced pressure on memory (Brady et al., 2013; McIlvaine, 2007).

Research into situational awareness and nursing was sparse as this concept has only recently been applied to health care settings (Sitterding et al., 2014; Stubbings et al., 2012). Additional research on situational awareness and nursing (Sitterding et al., 2014; Stubbings et al., 2012; Tower & Chaboyer, 2013), nursing education (McKenna et al., 2014), and psychiatric nursing is needed (Patterson et al., 2016). Research on skills, which are essential to situational awareness, may inform education and training of clinical decision making in nurses (Stubbings et al., 2012).

Situational awareness should be incorporated into undergraduate curricula (McKenna et al., 2014; Stubbings et al., 2012). Situational awareness may be taught, when the learner has become actively involved and engaged (Endsley, 1995), although ways to develop this ability in health care providers remains unclear and requires investigation (Schulz et al., 2013). Formal models such as checklists were helpful to assist novice nurses to organize, guide, and prioritize their knowledge, information, and inquiry; through these models skilled pattern recognition can be taught (Benner & Tanner, 1987). Simulation-based education may provide a safe environment to evaluate and develop (Lowe et al., 2016) all forms of awareness.

Educators have followed reflective practice models and examined clinical situations to help students understand the balance between individual care and the milieu (Delaney & Johnson, 2006). Exploring pattern recognition has been key to viewing the whole of the situation and can be taught through case studies, feedback by preceptors, and guidance from expert nurses (Benner & Tanner, 1987). Educators can teach about the importance of pattern recognition
Pattern recognition has involved categorization of short and long-term memory and application to the current situation to assist with individualized interventions (Payne, 2015).

All of the components of awareness were experienced synchronously in practice. An expert psychiatric nurse required all forms of awareness to effectively deliver PCC. Common features of each form of awareness included the need for ongoing, present moment, attentiveness and reflection. Practitioners using PCC invested heavily on understanding the lived experience of the client; this understanding occurred through a process of reflection and attention to the client and his/her experiences (Graham, 2001). Knowledge generated from awareness contributed to the psychiatric nurses’ ability to provide individualized interventions based on the needs of the persons in an acute care setting and the unit as a whole.

**Person-Centered Care**

Many psychiatric nursing roles have been considered to be behind the scenes or invisible in nature (Cleary, Hunt, et al., 2012). Delivering PCC plans; determining goals; fostering empathy, support, and hope; listening in one-to-one interactions; person-centered teaching; and enhancing coping strategies were identified as interventions. During data analysis, dividing PCC into subthemes was challenging as each aspect was harmonious in practice and much commonality was noted in descriptions. PCC interventions were not discrete in nature; each intervention was linked with another through the art of psychiatric nursing.

Movement away from the authoritarian, medical model in psychiatric nursing has resulted in increased awareness for the need of person-centered and recovery-oriented approaches to care (Green et al., 2014; Shanley & Jubb-Shanley, 2007). Involvement of persons living with a mental illness in service delivery, such as peer support initiatives, has been a growing aspect of recovery-oriented care (Green et al., 2014). PCC has been defined as a holistic
approach to delivering care, which is respectful, individualized, flexible, and negotiable, through an empowering therapeutic relationship (Morgan & Yoder, 2012). PCC has been founded on respect, empowerment, autonomy (Morgan & Yoder, 2012), hope, connection, and partnership (Shanley & Jubb-Shanley, 2007).

PCC has been accomplished through listening to persons life stories (Morgan & Yoder, 2012) and their hopes and dreams (Pitkänen, Hätönen, Kuosmanen, & Välimäki, 2008). Recovery has been fostered through holistic understanding of the social, cultural, spiritual, political, and economic contexts of persons’ lives (MHCC, 2015). The expert psychiatric nurses positioned themselves to be present and available to persons in the delivery of PCC (Cleary, Hunt, et al., 2012). Person-centered interventions were delivered collaboratively, authentically, and compassionately with effort to understand the clients’ perspectives, cultures, and concerns (Green et al., 2014). PCC involved matching interactions with the persons’ capabilities and receptiveness (Chiovitti, 2008). PCC entailed letting go of nurses’ personal agendas and honoring that of the persons in care (Bunkers, 2012) through the creation of individualized PCC plans.

**Delivering person-centered care plans.**

Persons in care have become full partners in decision making (RPNC, 2010) and care planning. Psychiatric nursing interventions should be individualized and based on the client’s strengths, desires, and needs (Pitkänen et al., 2008). Delivering PCC plans has been based on collaboration and choice (MHCC, 2015). Possible benefits of PCC included improved self-confidence, quality of life, independence, coping skills, and health (Wigham et al., 2008). Persons residing in acute care settings wanted information regarding their care, input into decision making (Hill & Laugharne, 2006), and active participation in their recovery (Hätönen,
Kuosmanen, Malkavaara, & Välimäki, 2008). All persons should have the right to determine their unique paths of recovery (MHCC, 2015).

Much of the available literature was focused on the importance of collaboration as an essential component in providing PCC. The participants provided practical examples of methods to engage persons in care in the collaborative process. Terms such as active partners and choice were frequently stated when describing collaboration. The purpose of collaboration was to devise a care plan based on each client’s strengths, goals, and health care needs to facilitate recovery. A holistic approach to care planning was highlighted.

PCC plans were formed in collaboration with persons in care, where all parties worked together as equal (Koivunen, Huhtasalo, Makkonen, Välimäki, & Hätönen, 2012; Madson, Loigon, & Lane, 2009; MHCC, 2015). PCC was well placed to support the therapeutic alliance based on mutual respect, trust, unconditional positive regard, and compassion (Cleary, Horsfall, & Escott, 2015). Involving persons in care empowered them to enhance positive aspects of their lives (Shanley & Jubb-Shanley, 2007).

Persons should be empowered to create their care plans by specifying behaviors and circumstances that they want to change, to assist with ownership and motivation to take action (Sniehotta, 2009). The plans must be created by the person with input and collaboration from professional and personal supports (Copeland, 2001; MHCC, 2015). PCC plans were used to enhance partnerships through power-sharing and problem solving to achieve common goals (Shanley & Jubb-Shanley, 2007). Health care providers used language that was empowering (Walker, 2006) and affirmed clients’ personal identities beyond their diagnoses (MHCC, 2015).

PCC plans, such as personal safety plans, were used to emphasize ownership and commitment of the clients and helped them to feel secure in their recovery processes (Buchanan-
Personal safety plans were individualized and aimed to enhance quality of life from the person’s perspective (Pitkänen et al., 2008). The participants discussed the use of personal safety plans to help direct interventions based on the client’s preferences and needs. Personal safety plans were devised to deliver person-centered interventions and reduce risks assessed. PCC plans were utilized to identify individualized coping strategies, stressful triggers, social supports, helpful medications, and preferred treatments (Copeland, 2001; Huckshorn, 2004). Client participation in planning has been a hallmark to recovery-oriented services (Sowers, 2005). Organizations should have tools in place to employ the use of PCC plans (Huckshorn, 2004).

Psychiatric nurses required individualized understanding of interventions that may increase comfort and decrease vulnerability of persons in care (U.S. Department of Health and Human Services, 2009); one size does not fit all. Through PCC planning, the persons in care created their own plans; this process assisted with ownership and motivation to take action (Sniehotta, 2009). PCC plans were founded on collaboration and partnership (MHCC, 2015). Additional details were provided to the process of care planning as the care plans often were devised during one-to-one interventions between the psychiatric nurse and the person in care. Goal setting often has been incorporated into PCC plans (Clarke, Crowe, Oades, & Deane, 2009).

Determining goals.

A goal has encompassed a wide variety of aims and desires (Street, 2001). Goal setting has required a person-centered approach (Doig, Prescott, Fleming, Cornwell, & Kuipers, 2015; Houston, Tatum, Guy, Mikrut, & Yoder, 2016). Goals laid the groundwork for therapeutic interventions (Wollburg & Braukhaus, 2010) and were essential to recovery (McGuire, Lysaker,
& Wasmuth, 2015). The expert psychiatric nursing participants described the process of using goals to form PCC plans and as an avenue to assist persons in the recovery process. Determining goals and assisting with goal achievement were described as important roles of a psychiatric nurse, even if the nurse did not agree with the goals stated. Collaborative goal setting allowed an avenue for clients and psychiatric nurses to work together therapeutically (McGuire et al., 2015). The therapeutic relationship was reciprocal, where both parties were resourceful and active in the pursuit of person-centered goals (Borg & Kristiansen, 2004).

Person-centered goal planning was utilized to enhance client motivation and direct attention towards goal achievement (Clarke et al., 2009). Setting goals helped people to take ownership for their recoveries (McGuire et al., 2015). Goals could be discovered through eliciting, recognizing, strengthening, and reinforcing messages that the client communicated about desires to change; attention was given to statements of desire, and ability, as well as reasons and needs to change (Miller & Moyers, 2006). Goal orientation referred to ways that individuals strived for success (Taing, Smith, Signla, Johnson, & Chang, 2013). Goal setting involved identifying methods and strategies required to pursue the goal and criteria for measuring successes (Mann, Ridder, & Fujita, 2013). The process of determining goals and creating plans for goal achievement required careful consideration (Thorgren & Wincent, 2013).

People needed to be aware of methods to achieve goals along with potential setbacks and barriers (Mann et al., 2013). Persons may face a variety of barriers or lack the resources required for goal achievement (Sniehotta, Schwarzer, Scholz, & Schüz, 2005). Resources and strategies needed to be in place to help the person cope with anticipated barriers (Sniehotta et al., 2005). Persons revised their goals over time (Taing et al., 2013) and review of their care plans was important in order to ensure congruency with their current goals.
Self-regulation involved various processes undertaken by people during the pursuit and attainment of goals (Mann et al., 2013). Through behavioral self-regulation new patterns of responses could evolve to extinguish old habits that were not conducive to recovery (Sniehotta, 2009). Goal striving involved actions taken, whether conscious or unconscious, that promoted goal success (Mann et al., 2013). Before goals could be obtained pathways must be in place to reach the perceived goals (Coppock, Owen, Zagarskas, & Schmidt, 2010) and address unmet needs (Green et al., 2014). The combination of developing multiple pathways and having the self-efficacy to achieve the goals was essential to overcome challenges (Coppock et al., 2010).

Elements included when setting goals were identifying and defining measurable goals, setting goals that were important to the person, developing strategies to attain goals, determining a timeframe for review, monitoring progress, providing feedback, and clarifying problem-solving barriers (Clarke et al., 2009). A schedule for activity and routine may be used to help facilitate the incorporation of goal striving behaviors into everyday life (Rhodes, 2014). Determining goals was multifaceted, as one strategy to achieve a goal may have conflicted with a personal conviction (McGuire et al., 2015), such as wanting to reduce the occurrence of auditory hallucinations without the use of antipsychotic medication. A person-centered intervention utilized by many health care professions to assist persons in reducing ambivalence to change was motivational interviewing (MI).

MI has been described as a method to engage persons to make positive behavioral changes and improve health outcomes (Lundahl et al., 2013). MI has been noted as a brief (Moyers, Miller, & Hendrickson, 2005), person-centered, and goal directed intervention (Miller & Moyers, 2006). MI has been well suited for psychiatric nursing in acute care environments. MI has been paired with other strategies and approaches to address a wide variety of health problems.
(Miller & Rose, 2009). The practitioner has switched between MI and other interventions (Miller & Moyers, 2006) based on the client’s needs. The use of MI has emphasized personal choice and control (Miller & Moyers, 2006). MI has provided a means for delivering person-centered interventions (Britt, Hudson, & Blampied, 2004) and was useful at any stage of recovery (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010).

Effective use of MI as an intervention stemmed from expertise and clinical intuition (Moyers et al., 2005). MI has been based on qualities of the therapeutic relationship including empathy, acceptance, genuineness, egalitarianism, and warmth (Miller, 1996; Moyers et al., 2005). The techniques involved included asking key questions and listening reflectively (Moyers et al., 2005). The client made arguments for change and the practitioner aimed to help the person realize current behaviors, which were inconsistent with his/her personal goals or values (Jackman, 2012). Goals were developed by reviewing motivational discrepancies between the person’s present behavior and his/her desired future (Moyers et al., 2005).

MI interventions have been well aligned with psychiatric nursing. The principles of MI appear to be consistent with the descriptions offered by the research participants, which suggests that this intervention was being utilized informally by expert psychiatric nurses to provide PCC. MI has been incorporated into a variety of other approaches (Miller & Moyers, 2006) based on the client’s stage of recovery (Lundahl et al., 2010). Recovery-oriented interventions involved partnerships with clients to combine the expertise and knowledge of persons in care with mental health professionals to facilitate recovery (MHCC, 2015). Although the participants specifically did not voice the use of MI in their expert practice, the principles and core constructs remained true.
Research into the quality of goal setting and the recovery of persons with mental illness is needed (Clarke et al., 2009). Further investigation into the motivation of people to strive for goals (Mann et al., 2013) and therapist attitudes and service systems that support person-centered goal planning is required (Doig et al., 2015). The therapeutic relationship has been based on mutually agreed upon goals and tasks required by all parties for achieving those goals (Green et al., 2014; Zugai et al., 2015). The health care professional may ask the client to visualize success (Mann et al., 2013) to assist with understanding the client’s perspective and foster empathy, support, and hope.

**Fostering empathy, support, and hope.**

Recovery has been discussed as an individualized journey, which varies over time, based on each unique person (Slade, Williams, Bird, Leamy, & Boutillier, 2012). A psychiatric nurse may assist in the recovery process by fostering empathy, support, and hope (MHCC, 2015; Niebieszczański, Dent, & McGowan, 2016). During data analysis each skill was coded as a distinct intervention, although when the transcripts were reviewed as a whole, the participants were noted to utilize the terms interchangeably and often in the same context. Therefore this subtheme was identified as a multifaceted intervention. The majority of the literature was focused on empathy and hope to support persons with goal achievement and recovery. The process of recovery in mental health was often based on restoring meaningfulness to one’s past experiences along with the sense of hope for the future (Schrank, Stanghellini, & Slade, 2008).

Empathy has been described as an essential component of therapy (Hunter, 2012). The process of developing empathy involved trying to sense the private world of the client (Rogers, 1992). Psychiatric nurses provided care to persons in distress (Foster et al., 2006). All interventions required empathy, patience, respect, understanding (Cleary, Horsfall, et al., 2012),
warmth, and trust to ease each person’s distress (Foster et al., 2006). Empathic listening required
the nurse to take an imaginative role to understand the persons, thoughts, feelings, perspectives,
and actions in order to explore multiple possibilities of meaning (Carper, 1979). Empathy was
communicated through listening and reflecting on the individual’s feelings (Jackman, 2012). The
ability to interact with clients in meaningful ways without appearing to be assessing or delivering
therapy was made possible by relating to clients through their stories in empathic fashions
(Cleary, Hunt, et al., 2012).

Authentic communication of empathy was associated with increased sentiments of care
(Billings, 2004). The nurse supported clients to help them feel comfortable and safe (Dziopa &
Ahern, 2008). To assist persons in care to feel safe, the psychiatric nurse responded to the
person’s dignity, preserved his/her sense of self, and protected his/her vulnerability (Benner,
1997). Nurses demonstrated respect by listening to persons stories, displaying concern, and not
imposing their beliefs or objectives on others (Chiovitti, 2008). Nurses communicated
understanding through non-judgmental and supportive responses, thereby facilitating a sense of
acceptance and safety (Hunter, 2012). Fostering hope also involved validation of the distress and
stress people experience and the challenges they face (MHCC, 2015).

Clients and mental health practitioners agreed that hope has been essential for recovery
(Hobbs & Baker, 2012; Schrank, Bird, Rudnick, & Slade, 2012; Slade et al., 2012). An aspect of
facilitating hope involved focusing on clients’ strengths to promote change (Antai-Otong, 2016b;
Coppock et al., 2010), self-esteem, self-efficacy, spirituality, well-being, and the formulation of
goals (Schrank et al., 2012). Collaborative interventions, such as guided imagery, cognitive
reframing, information seeking, education, and social relationship development, may lead to
improved levels of hope (Schrank et al., 2012). Greater emphasis has been placed on the
importance of peer support and family involvement to assist in the facilitation of hope (Casey & Long, 2003; Schrank et al., 2008).

Family members, friends, and other supports have been important contributors to the internalization of hope and should be incorporated into care whenever possible (Antai-Otong, 2016b; MHCC, 2015). Incorporation of interventions that involved maintaining contact with friends and family have assisted with the facilitation of recovery (Repper, 2000). Developing family-centered approaches to PCC should be integrated into organizational practice; additional research on client and family member’s perspectives is required to determine ways that this goal should be accomplished (Epstein & Street, 2011).

Positive feelings and thoughts about the future contributed to internalized hope (MHCC, 2015). Hope has been an essential therapeutic attitude that promoted healing and recovery (Schrank et al., 2008). Hope was co-created (Larsen, Edey, & Lemay, 2007) through a genuine, therapeutic, partnership (Slade et al., 2012). Roles of psychiatric nurses have been to instill hope, find hope, and create hope (Larsen et al., 2007) to empower clients to access their internal and external resources (Coppock et al., 2010).

Recovery-oriented systems have been based on hope and respect (Antai-Otong, 2016b). A nurse’s outlook on hope underpins his/her practice (Niebieszczanski et al., 2016). Therapists’ levels of hope indirectly affected their clients to internalize hope even during brief therapy encounters (Coppock et al., 2010). Nurses need to believe in recovery and be aware of their views on hope (Hobbs & Baker, 2012; Repper, 2000). Hope as a genuine belief may be internalized as personal and professional values (Niebieszczanski et al., 2016) of psychiatric nurses. Self-awareness has been required to monitor levels of hope (Niebieszczanski et al., 2016) to provide empathetic care (Antai-Otong, 2016a). Hope and optimism may be communicated
through body language, facial expression, and verbal messages (Niebieszczanski et al., 2016).

Health care providers should seek to understand the whole person; his/her personal identity not the diagnosis (MHCC, 2015). Positive nursing characteristics included being genuine, authentic, open, honest, and non-judgmental (Dziopa & Ahern, 2008). Persons in care reported nursing characteristics that were important to them were creativity; humor; respectful, non-judgmental attitudes; patience; and calmness (Cleary, Hunt, et al., 2012). All of these characteristics were synonymous with the suggestions provided by the participants. A health care professional should display unconditional positive regard, warmth, and acceptance of the clients experiences (Rogers, 1992).

Supportive and empathic care have been described as fundamental aspects of nursing that can be taught (Richardson, Percy, & Hughes, 2015). Educational programs may be used to develop the characters and personalities of the practitioners as well as their intellects (Rogers, 1992). All interventions required empathy, patience, respect and understanding, and these aspects need to be taught in order for the practitioners to develop skill (Cleary, Horsfall, et al., 2012). Simulation and role play were described as effective methods to increase reflection and communication skills among psychiatric nursing students (Oflaz, Meric, Yuksel, & Ozcan, 2011; Payne, 2015; Rasheed, 2015; Webster, 2014). The aims of these methods were two-fold, to increase reflection and to promote practice of nursing skill.

Simulation was used to help students safely learn nursing skills and provide an avenue for self-reflection and self-awareness (Chaffin & Adams, 2013). Simulation utilizing high fidelity manikins has been an educational strategy for psychiatric nurses (Kunst, Mitchell, & Johnston, 2016). Manikin simulation can enhance assessment and communication skill (Kunst et al. 2016). Unfortunately the mannequins display low-quality non-verbal language such as facial expression
(Kunst et al. 2016). Additional research is required to determine if skills obtained during the simulation are translated into clinical practice environments (Kunst et al., 2016).

*Hearing Voices* was an educational strategy that has been incorporated into many psychiatric nursing programs (Chaffin & Adams, 2013). A goal of *Hearing Voices* was to facilitate understanding into the experience of psychosis (Chaffin & Adams, 2013), which may help increase empathy and reduce stigma in nursing students (Sideras, McKenzie, Noone, Dieckmann, & Allen, 2015). During *Hearing Voices* simulation, the students listened to recorded audio messages aimed to mimic the experience of auditory hallucinations (Chaffin & Adams, 2013). *Hearing Voices* simulation was associated with kindness, patience, and understanding towards clients (Chaffin & Adams, 2013), and reduced negative views of psychosis (Sideras et al., 2015). In addition to strategies such as hearing voices simulations, reflective journaling helped increase empathy and decrease stigma in psychiatric nursing students (Webster, 2010).

Interventions, which will inspire hope and reduce stigma, should be developed, evaluated, and carefully investigated (Schrank et al., 2008). More research is needed to understand the direct and indirect outcomes of hope on client recovery (Coppock et al., 2010). Participatory research from clients perspective is required (Green et al., 2014). Empathy and compassion can be used as learning markers to further investigate educational resources and approaches required to develop these traits in student nurses (Richardson et al., 2015). The process of determining goals, providing support, empathy and hope often can be achieved through listening in individualized interactions.

**Listening in one-to-one interventions.**

One-to-one interventions are interpersonal interactions (Cleary, Horsfall, et al., 2012), which help construct the therapeutic relationship (Hurley, 2009). One-to-one interventions
included being present, and listening to, as well as talking with, distressed persons helped to ease their suffering (Cleary, Hunt, et al., 2012). Listening during one-to-one interactions with clients was described as an integrated intervention. Listening was portrayed as an active process of paying attention and being with individuals to help them find meaning behind their experiences.

Psychiatric nurses get to know and understand clients in-depth to provide holistic health care (Hall & Powell, 2011). Recovery-oriented professionals value the lived experiences, insights, and expertise of clients (MHCC, 2015). Awareness of persons in care may be achieved through listening to client narratives (Hall & Powell, 2011). Narratives helped people make sense of their experiences (Casey & Long, 2003) and find meaning behind their behaviors (Dziopa & Ahern, 2008). Narrative included talking about the self; one’s health, illness, life, trauma, support systems, and cultural beliefs (Hall & Powell, 2011). The use of story-telling, as a means of communication, was present in nearly all cultures (Hall & Powell, 2011).

Listening has been defined as an intellectual and emotional process (Shrivastava, 2014). Two types of listening included reflective listening and active listening. Reflective listening was accomplished through a process of making statements in an attempt to clarify the person’s perspective (Jackman, 2012). Active listening involved communicating empathy to help persons feel understood and valued (Weger, Castle, & Emmett, 2010). The purpose of active listening was to respond in a non-judgmental manner by demonstrating unconditional acceptance of the clients experiences (Weger et al., 2010).

Narratives have taken the form of clinical stories (Hall & Powell, 2011; Tanner, 2006). The clients’ senses of identity, their relationships with others, and their meanings of life experiences were shared through narratives as the individuals attempted to understand and restore a sense of order through the use of story (Foster et al., 2006). A holistic nurse assisted
persons in finding meaning behind the experience of health and illness (Mariano, 2007). Recovery involved trying to understand the experience of mental illness allowing persons to grow beyond their symptoms (Repper, 2000).

The psychiatric nurses strived to understand the person’s perspective rather than inquiring if the story was valid or true (Jackman, 2012). The story may have been told with different meaning or purpose every time it was shared (Hall & Powell, 2011). Personal recovery emerged from client narrative (Piat & Sabetti, 2012). Psychiatric nurses needed to be open to the possibility of being with clients and participating in their recovery (Delaney, 2012). Listening to narratives has helped the nurse focus on the needs of the client (Benner, 1997). The process of listening has been communicated through reflecting, clarifying, and summarizing the narrative expressed (Dziopa & Ahern, 2008).

Listening and understanding have strengthened PCC (Gaillard, Shattell, & Thomas, 2009). Reflective and active listening were higher levels of communication associated with client satisfaction (Weger et al., 2010). Clients reported that being understood was associated with feelings of empowerment, worthiness, and importance (Gaillard et al., 2009). The experience of being misunderstood was described as dehumanizing and had a negative impact on the therapeutic relationship (Gaillard et al., 2009). The participants linked increased levels of distress and aggression in clients to experiences of being unheard or misunderstood.

A psychiatric nurse should be present to listen to the concerns of family members and other supports. Family members should be included in care planning whenever possible (Jensen, 2004). Unfortunately, family members often have voiced that they were not heard and were uninformed on the care of their loved ones (Jensen, 2004). Psychiatric nurses are present with persons in care as well as family members and other support persons (MHCC, 2015). Additional
research on the family members’ perspectives of mental health care should be examined to facilitate training programs for staff (Jensen, 2004).

Listening is a skill that can be taught (Shrivastava, 2014). Active listening has been encouraged through training on the use of open-ended questioning, paraphrasing, and reflecting on feelings (Brodie, Vickery, Cannava, & Jones, 2015). Active listening can involve mimicking the speaker’s eye contact, facial expressions, and body language, to communicate understanding non-verbally (Weger et al., 2010). Simulation and role play, as previously described, were educational strategies that have assisted with increasing therapeutic communication (Ellis, Brou, King, & Tusa., 2015; Jack, Gerolamo, Fredrick, Szajna, & Muccitelli, 2014). Roles of a psychiatric nurse included listening to narrative, keeping persons safe, providing reassurance, helping with self-care, teaching, and providing information (Casey & Long, 2003; Chiovitti, 2008).

**Person-centered teaching.**

Teaching and providing education was found to be an important psychiatric nursing intervention as described by the participants. Teaching and educating were originally coded as a third theme although when the transcripts were re-examined as a whole, teaching was identified as a PCC intervention. Person-centered teaching was noted as an individualized intervention, based on the person’s stage of recovery, strengths, goals, and needs. Collaboration with persons in care has been noted as an essential component of teaching and providing education (Koivunen et al., 2012). Increased emphasis has been placed on the knowledge that individuals possess about their health conditions (Shah, Klainin-Yobas, Torres, & Kannusamy, 2014), and tailoring activities to meet the needs of persons in care has been identified as important (Koivunen et al.,
Persons in care appreciated ongoing dialogue and education from psychiatric nurses and physicians (Sebergsen, Norberg, & Talseth, 2016).

Empowering clients to make informed decisions required person-centered education and teaching (Repper, 2000). Patient education was an effective method of supporting persons’ capacity for independence, enhancing adherence to treatments, and improving insight into illness (Hätönen et al., 2008). Psychoeducation has been associated with reduced relapse, readmission, decreased length of stay in acute care settings, increased medication adherence, and improved use of coping strategies for persons living with schizophrenia (Xia, Merinder, & Belgamwar, 2010). Persons residing in acute care environments perceived information to be highly important to them (Newman, O’Reilly, Lee, & Kennedy, 2015; Hätönen et al., 2008).

Psychiatric nurses provided information in a flexible, person-centered manner based on each person’s unique needs, preferences, skills, and present health status (Koivunen et al., 2012). Interactive teaching allowed for client feedback, choice, and discussion to help the person build strengths (Chiovitti, 2008). The descriptions provided by the participants were consistent with interactive teaching. Psychiatric nursing roles in education included that of a motivator, instructor, collaborator, and teacher (Koivunen et al., 2012). Education was noted as an element of a PCC plan (Hätönen et al., 2008).

Psychoeducation, information offered to persons receiving mental health services regarding illness, treatment, and recovery, was found to help empower people and increase levels of hope (Shah et al., 2014). Teaching and providing education was associated with reduce levels of stigma (MHCC, 2015). Stigma refers to internalized negative feelings and thoughts people hold (MHCC, 2015). The participants frequently mentioned the need to address the negative impacts of stigma on mental health care and persons living with a mental illness. Persons and
their family members often reported that stigma negatively impacted almost every aspect of their lives (MHCC, 2015; Newman et al., 2015). Psychoeducation has been described as an effective method to reduce the impact of stigma (Çuhadar & Çam, 2014; MHCC, 2015). Clients should be educated and actively participate in the care planning process to combat the negative effects of stigma (Newman et al., 2015). A role of a nurse has been to inform persons of treatment options and explore the implications for alternative therapies (Mariano, 2007).

Persons living with mental illness should have access to evidence-based treatments, although this goal may not be achievable (Young, 2010). Persons and staff generally agreed that most patients were given very little information or opportunity to discuss medication, especially if this information was not specifically requested (Polluck, Grime, Baker, & Mantala, 2004). Clients and caregivers reported that they did not have enough information about medication upon discharge from hospital and little written information was provided to persons (Polluck et al., 2004). Clients reported that information provided did not take into account the person’s individuality and unique health care needs (Hätönen, Kuosmanen, Koivunen, & Välimäki, 2010).

Persons in care wanted information to be reviewed through open discussions with staff, along with written handouts and information technology from up to date, reliable sources (Hätönen et al., 2008). Barriers to providing teaching included the person’s mental status, lack of staff resources, and poor operational procedures and conditions (Hätönen et al., 2010). Staff reported a lack of time available to provide teaching (O’Donovan & Gijbels, 2006; Polluck et al., 2004), which was echoed by the reports of the participants. Staffing routines must provide nurses with time to develop connections with clients and facilitate person-centered teaching (Zugai et al., 2015).

Information technology should be adapted into health care provision to meet the
educational needs of clients (Koivunen et al., 2012). A method to address the lack of information available for mental health service users may be provision of computer access along with reliable web-based information to persons in care (Hätönen et al., 2008; Young, 2010). Software programs, such as electronic client questionnaires and videos, have shown promise to improve access to mental health education in a number of clinical settings (Green et al., 2014). Health care providers need to engage persons through innovative educational strategies to facilitate person-centered teaching (Gruman et al., 2010).

Family education and empowerment has been noted as a component of recovery-oriented services (Sowers, 2005). Health care professionals should facilitate access to information, support, and resources for family members and other carers (MHCC, 2015; Pickett-Schenk, Lippincott, Bennett, & Steigman, 2008). Key elements of family psychoeducation included illness education, crisis intervention, emotional support, self-hope groups, and enhancing coping strategies (Green et al., 2014). Family psychoeducation was associated with reduced reports of stress and distress by family members (Green et al., 2014).

More research is needed to determine if family psychoeducation strategies produce outcomes for the person living with the mental illness (Pickett-Schenk et al., 2008). In general, an increase in psychoeducation research for psychosis (Xia et al., 2010) and other mental health illnesses is required, as limited research was available regarding person-centered teaching. Quantitative and qualitative studies on education and relaxation interventions, from the perspective of persons in care, is needed (Shah et al., 2014) to improve practice and policy.

A need for an increase in non-pharmacological interventions such as stress management, relaxation exercises, and psychoeducation in mental health care has become apparent (Shah et al., 2014). Education, along with relaxation, has reduced depression symptoms in persons living
with mood disorders (Shah et al., 2014). Information technology has potential to empower persons and enhance coping strategies (Koivunen et al., 2012). PCC has been focused on enhancing people’s inner resources to strengthen recovery (Borg & Kristiansen, 2004).

**Enhancing coping strategies.**

The concept of coping has been associated with stress; stress has been described as the circumstance in which persons were required to cope and coping was a possible reaction to stress (Keil, 2004). Coping involved confronting stressors, external or internal, by persons with varying degrees of success (Keil, 2004). Coping involved methods and actions taken to deal with stress regardless of whether the efforts were successful or not (Shanley, Jubb, & Latter, 2003). Coping strategies were used on a regular basis, whether or not the person had symptoms or was in crisis (Roe, Yanos, & Lysaker, 2006). A holistic nurse may assist persons in accessing their internal resources and healing capacities (Mariano, 2007). Hope and motivation have been effective in increasing cognitive coping and can positively influence a diverse range of stressors (Moos & Holahan, 2003).

The ability of persons to cope has had an impact on nursing care and interventions (Keil, 2004). Psychiatric nurses have helped to support a persons’ self-efficacy by exploring past successes in problem areas (Jackman, 2012). Focusing on persons’ strengths may help them to tap into and utilize their internal resources (MHCC, 2015). Proactive coping involved examining and developing strategies in the present, which may assist with overcoming future obstacles (Drummond & Brough, 2016; Sohl & Moyer, 2009). Proactive coping may assist with building resources to achieve goals (Sohl & Moyer, 2009).

A helpful intervention, referred to as coping planning, has involved discussion and preparation of strategies to strengthen coping abilities and manage potential barriers to change.
(Kwasnicka, Presseau, White, & Sniehotta, 2013). During coping planning people imagined possible scenarios and barriers that may hinder them from performing behaviors needed to achieve goals or manage challenges (Schwarzer, 2016). If a person encountered a barrier and did not have the necessary resources required to overcome the barrier, the risk of relapse increased (Sniehotta et al., 2005). Preventative coping involved building internal resources to be prepared when stressors arose (Roe et al., 2006). Coping planning has helped people anticipate risk or difficulties by linking possible obstacles to effective coping strategies (Sniehotta et al., 2005). Discussion of barriers and limitations should include methods to overcome the barriers based on strengths and internal resources to facilitate hope (MHCC, 2015).

Well defined coping plans and coping systems may make goal attainment more likely (Schwarzer, 2016). Participation in peer-support and self-help groups has been noted to bolster coping skills (Moos & Holahan, 2003). In addition, exploring methods to enhance family communication and coping strategies has positively impacted the lives of people living with a mental illness (Crowe & Lyness, 2014). Social resources and supports have strengthened coping efforts by providing emotional support, guidance, assistance, and advice (Moos & Holahan, 2003).

Coping strategies have been accessed during experiences of stress and crisis (Mariano, 2007). Relaxation strategies, such as deep breathing, mindfulness mediation, guided imagery, aromatherapy and yoga, have been identified as brief interventions that may help mitigate the negative effects associated with stress (Mariano, 2007; Scotland-Coogan & Davis, 2016). Relaxation strategies combined with cognitive therapies have produced more beneficial results for anxiety than relaxation alone (Shah et al., 2014). Relaxation interventions have been incorporated into clinical practice to help persons regulate emotions (Scotland-Coogan & Davis,
Nurses’ helped people incorporate useful strategies into their lives and encouraged ongoing practice outside of treatment settings (Mariano, 2007). Continued research on coping plans and relaxation interventions is required (Scotland-Coogan & Davis, 2016). Future research is needed to investigate the relationship between coping, symptoms, and recovery for persons living with psychosis (Roe et al., 2006).

**Acute Care Psychiatric Nursing Interventions**

Psychiatric nursing interventions have been difficult to define (Repper, 2000). To understand psychiatric nursing interventions, one must first consider what psychiatric nursing interventions are not. These interventions are not tasks to be completed. Acute care psychiatric nursing interventions have been defined as meaningful interactions with persons to enhance safety, foster recovery, and develop therapeutic relationships (Newman et al., 2015). Interventions and assessment have been embedded into the caring process (Coombs et al., 2013). The ability to interact with clients in meaningful ways without appearing to be assessing or delivering therapy involved skillful delivery of multifaceted psychiatric nursing interventions (Cleary et al., 2012).

Clinical and client cues were observed through the practice of constantly scanning the environment, observing, and interacting with persons to have up to date knowledge of all individual persons in care and the unit as a whole (Sitterding et al., 2014). Expert psychiatric nurses paid attention to their intuition and used this form of knowing to guide interventions (Holm & Severinson, 2016). Psychiatric nurses recognized the importance of being aware of all persons residing in the acute care environment as well as the ward milieu (Hamilton & Manias, 2007). Awareness was more than noticing and observing; engagement was an important aspect of becoming aware and providing PCC (Manna, 2010; Stewart et al., 2009).
Key concepts associated with awareness and PCC have been identified as safety, therapeutic relationships, collaboration, engagement, and reflection (Newman et al., 2015). Therapeutic relationships served as the foundation for the delivery of structured and complex interventions (Browne et al., 2014). All interventions, including the use of boundaries, have been aimed at equalizing the power in the therapeutic relationship (Dziopia & Ahere, 2009).

PCC has been described as involving a circular process of getting to know the client, understanding his/her goals, devising and delivering a care plan, and revisiting that plan during times of change (Buchanan-Barker & Barker, 2005). In practice, psychiatric nurses met with persons in one-to-one interactions to gain awareness of the clients’ unique stories, their hopes, dreams, and goals while offering support, providing teaching, building on coping strategies, and delivering care plans through inseparable interplay of complex skills and interventions (Koivunen et al., 2012; MHCC, 2015; Parse, 2010; Piat & Sabetti, 2012; Shanley & Jubb-Shanley, 2007).

**Strengths and Limitations of Research**

Psychiatric nursing experiences were examined in-detail and in-depth to provide insight into the interventions used by these nurses; detailed knowledge that could not be gained from quantitative inquiry. Little research had been done regarding psychiatric nursing interventions in acute care settings with adult populations, therefore a descriptive qualitative study was warranted. The phenomenological themes were identified to provide insight into the essence of psychiatric nursing interventions; these research findings will have important implications for the profession of psychiatric nursing. The semi-structured interview style allowed the researcher to seek additional detail regarding each intervention. These findings may be transferable to other acute care settings.
Through semi-structured interviews, the researcher was able to gather rich data regarding the psychiatric nurse participants’ experiences. The narratives helped illuminate the complexities of their psychiatric nursing practices. To enhance trustworthiness of data analysis the researcher asked for exhaustive descriptions of each intervention stated. When elements of analysis were unclear the researcher returned to the original transcripts to verify the contexts of the conversations.

Findings of the study were used to provide detail into otherwise unspoken psychiatric nursing interventions. However, a number of features may be considered as limitations. Research quality can be influenced by the researcher's personal biases (Anderson, 2010). To reduce bias, the researcher openly questioned and reflected on assumptions and pre-understanding throughout the research procession. Researchers are never fully able to remove the self, including thoughts, feelings, preferences, inclinations, expectations, and influence, from the research process; although a concerted effort was made to be aware of and lessen the factors that would prevent understanding the participants’ lived experiences. The researcher practiced self-awareness to remain objective and genuinely open to the data. Reduction was utilized to promote with a sense of wonder and set aside preunderstanding of the phenomenon (van Manen, 1997).

Rigor is more difficult to maintain and assess when conducting qualitative research (Anderson, 2010). Auditability, rather than rigor, is a more appropriate standard of qualitative research. An extensive audit trail was maintained to establish authenticity and trustworthiness of findings. The audit trail demonstrated that the researcher clearly followed the research steps as outlined by van Manen (1997). Notes, memos, coding instructions, and categorical data assignments were available for external review by other researchers such as the thesis advisor. Great lengths were taken to remain true to the data.
All data were coded into categories. Extensive inclusion of narrative, utilizing direct quotes voiced by the participants, helped to illuminate the expert psychiatric nurses lived experiences. Data collection and review were conducted until no new themes arose; sufficient data were available to complete data analysis. Coding the meaning voiced into phenomenological themes was an enormous task, which took considerable time and care. One may argue that the background of the researcher enhanced the understanding of the experiences shared by the participants. This understanding and ongoing reflection in light of that understanding may have been instrumental in increasing the quality of the interpretation.

Purposive and snowball sampling may introduce sampling bias and reduce generalization of findings; although the research inclusion and exclusion criteria are sound. The relatively small sample size, six participants, is consistent with that of hermeneutic phenomenology. The population differed in terms of years of experiences and educational background. The participants with 40 or more years of experience were prepared with a Psychiatric Nursing Diploma, whereas the participants’ with less than 15 years of experience were prepared with a Bachelor of Science in Psychiatric Nursing. The phenomenological themes were consistent across all participants regardless of education preparation although additional research is warranted to determine ways that education preparation may affect psychiatric nursing interventions and development of expertise. All of the participants were female adding homogeneity to the sample, additional research is required to determine if the gender of the psychiatric nurse effects the interventions utilized. Attrition did not take place in this study.
Chapter 6: Conclusion

The practice of psychiatric nursing in acute care mental health settings has been undergoing change (Brookes, Murata, & Tansey, 2006). Changes to the mental health care system has impacted the practice of acute care psychiatric nurses and the care provided (Cleary, 2003). Literature on psychiatric nursing interventions has remained limited considering the changes faced by present day psychiatric nurses (White, 2014).

Hermeneutic phenomenology as outlined by van Manen (1997) was applied to gain understanding into the essence or common understanding of psychiatric nurse practice in acute care environments as much expertise, gained from clinical practice, is known to the professionals, yet goes unspoken. Six expert psychiatric nurses were interviewed and shared their experiences of providing care. Psychiatric nursing interventions were revealed through themes of awareness and PCC. Difficulty in defining the interventions may have stemmed from understanding that these interventions were not discrete; they were interconnected and harmonious in practice. The descriptions provided by the participants, and the interpretation of them, will add to the available literature on acute care psychiatric nursing interventions.

The phenomenological themes of awareness and PCC illuminated the lived experiences of psychiatric nurse practicing in acute care settings. What did these psychiatric nurses know? They were aware of the interconnectedness of the self, others, and the environment in acute care settings. What did these psychiatric nurses do? They provided PCC; these interventions were united and reciprocal manners of caring. Awareness was required to provide PCC and through the practice of PCC awareness was enhanced.

The theme of awareness was composed of self-awareness, awareness of the client, and situational awareness. All contexts of awareness were of equal importance in psychiatric nursing
practice. Increased levels of awareness have been associated with increased safety (Hirst, 2003). Reflection and clinical experience have been used to increase awareness (Epp, 2008; Jack & Miller, 2008; Rew, 2000). Self-awareness involved knowing and reflecting on oneself to deliver person-centered interventions (Eckroth-Bucher, 2010). The subtheme of self-awareness was divided into somatic feelings of intuition (McCutcheon & Pincombe, 2001) and maintaining boundaries (Malone et al., 2004). Awareness of the client took place through observation, engagement (Manna, 2010; Muralidharan & Fenton, 2006), and assessment (Bowers, 2005). An awareness of the total milieu, or situational awareness, was required and a role of a psychiatric nurse was to balance the needs to a particular individual with the needs of the unit (Delaney & Johnson, 2006). The theme of awareness provided insight into what psychiatric know in order to do what they do.

Levels of awareness in psychiatric nurses may be increased through clinical supervision (Jack & Smith, 2007), team debriefings (Peternelj-Taylor & Yonge, 2003), journaling (Eckroth-Bucher, 2010), and portfolio development (Rasheed, 2015). Reflection and self-awareness were required by all team members to reduce incidents of boundary crossings during care (Jack & Miller, 2008). Standards and policies should be reviewed and revised to guide staff on methods to maintain therapeutic boundaries (Hanna & Suplee, 2013; Peternelj-Taylor & Yonge, 2003).

PCC is recognized as a holistic approach for provision of respectful, individualized, recovery-oriented care (Morgan & Yoder, 2012). PCC was founded upon delivering PCC plans; determining goals; fostering empathy, support, and hope; listening in one-to-one interactions; teaching with a person-centered approach; and enhancing coping strategies. All aspects of PCC were connected in practice through a complex application of psychiatric nursing skills.

Clients were full, equal, and active partners in the provision and implementation of PCC
plans (Koivunen et al., 2012; RPNC, 2010). Goals were determined by each client to help him/her take ownership of his/her recovery (McGuire et al., 2015). Levels of hope and motivation increased successful goal attainment (Schrank et al., 2008). Empathy was demonstrated through reflective and active listening (Jackman, 2012). One-to-one interventions included being with and listening to persons’ narratives (Cleary, Hunt, et al., 2012) to explore meanings behind the experiences of health and of illness (Dziopa & Ahern, 2008). Person-centered teaching was based on that person’s unique needs, preferences, skills, and present health status (Koivunen et al., 2012). Psychiatric nurses helped people to access and enhance their inner healing capacities (Mariano, 2007) by exploring the coping strategies that have been effective in coping with past stressors (Jackman, 2012). All aspects of PCC are of equal importance. Barriers to providing interventions were unit acuity and time constraints. Psychiatric nurses needed organizational support and protected time to spend with persons in order to facilitate safe PCC (Mullen, Drinkwater, & Lewin, 2013).

Undergraduate education can lay the foundation of knowledge required to enhance awareness and PCC. Simulation, role play, reflection, and debriefing have been found to be effective strategies to allow student nurses to develop increased levels of awareness and therapeutic communication skills (Chaffin & Adams, 2013; Ellis et al., 2015; Jack et al., 2014; Oflaz et al., 2011). Awareness and PCC care were noted to be reciprocal in nature; education strategies that increase awareness will inherently increase PCC skills given the interconnection.

Qualitative and quantitative research to replicate and verify the findings of this hermeneutic investigation is warranted. Similar research exploring the perspectives of persons living with mental illness is imperative to gain a more inclusive and extensive understanding of this phenomenon. In general, ongoing research that addresses the changes in acute care,
including participatory research involving mental health clients, is required. Research is required on methods to sustain the use of reflective practice, following the completion of undergraduate education.

Hermeneutic phenomenology was used to gain awareness of the details of everyday psychiatric nursing practice that may be taken for granted (van Manen, 1989). Increased understanding may affect acute care psychiatric nurses’ abilities to provide holistic care to address the changes and complex demands faced in the psychiatric nursing profession. Reflection on the findings and translation of knowledge has implications for practice, policy, education, and research related to mental health care and service delivery within and beyond psychiatric nursing practice (Lopez & Willis, 2004).


London: Edward Arnold Ltd.


Appendix A

Interview Guide

[This guide is a suggested format, to be used with consistency when appropriate. Research using hermeneutic phenomenology as method entails asking participants’ broad and general questions that focus attention on gathering data to facilitate textual and structural portrayals of the participant's experiences. Data will be collected through the use of open-ended, semi-structured research questions delivered through a conversational interview. This qualitative approach relies on the premise of adjustment and flexibility in data collection based on the information gathered. Therefore adaptation of the interview format is anticipated and appropriate.]

Professional History

I would like to discuss your experience as a psychiatric nurse working with adult clients in acute care settings. In order to understand your professional history, I will begin by asking you general information about yourself and your psychiatric nursing practice.

How many years have you actively practiced as a psychiatric nurse?
How many years have you practiced in an acute care inpatient setting? How many of those years were with adult clients?
Do you practice in a rural or an urban setting?
The purpose of this research is to explore your practice in urban settings. Although the other practice environments that you are employed are valuable, for the purpose of this study please focus conversation on your acute care experiences working with adult clients in urban settings.
Briefly explain the other psychiatric nursing settings, if any, that you have practiced in?
The purpose of this research is to explore your experience working in acute care settings with adult clients. Although the other practice environments that you are employed are valuable, for the purpose of this study please focus conversation on your acute care experiences working with adult clients.
Please tell me, what is your age?
What is your highest education credential you have obtained? What is your highest education credential you have obtained in psychiatric nursing?

Acute Care Psychiatric Nursing Experience

I would like to get to know more about your experiences working with adult clients in acute care inpatient mental health settings.

How long have you been employed in this current setting?
From your perspective as a psychiatric nurse, tell me about the acute care setting in which you are currently employed?
What does it mean to you to be a psychiatric nurse practicing in acute care?
Based on your experiences in acute care settings, tell me about how you practice as a psychiatric nurse?
Psychiatric Nursing Interventions

I would like to understand your experiences in delivering psychiatric nursing interventions to adults clients in acute care inpatient mental health settings.

Tell me about your psychiatric nursing practice?
How do you view psychiatric nursing interventions?
From your perspective, what psychiatric nursing interventions do you use?
Please describe your experience in using psychiatric nursing interventions in acute care.
How do you know when you are using a psychiatric nursing intervention?
What factors have an influence on your ability to deliver these interventions?
What advice do you have for novice psychiatric nurses related to psychiatric nursing interventions and practice?

Thank you, I will send a link to my thesis once it has been completed and is in the repository for graduate student theses.
Appendix B

Letter of Invitation

Dear Psychiatric Nurse,

Psychiatric nursing interventions are integral to the health and care of mental health clients. The practice of modern day psychiatric nursing is in a process of change, especially within acute care environments. You have been identified as an expert psychiatric nurse. Your voice is required to gain insightful information about psychiatric nursing interventions in the context of acute care. Increased understanding may affect acute care psychiatric nurses ability to provide holistic care to address the challenging and complex demands faced in this profession.

You are being invited to participate in a study to explore psychiatric nursing practice and interventions with adult clients in acute care inpatient mental health settings.

I am a student in the Master of Psychiatric Nursing Program through the Faculty of Health Studies at Brandon University. My supervisor is Dr. Fran Racher. The information gathered will be published in my thesis. This information may be used to benefit the future advancement acute care psychiatric nursing practice, policy, and education. This information may also be utilized beyond the thesis to write scholarly articles and be presented at conferences and workshops for the purpose of sharing knowledge on psychiatric nursing interventions.

With your help we can meet the study goals and learn more about psychiatric nursing in acute care environments within Winnipeg, Manitoba. If you agree to participate, you will be involved in an individual interview regarding your experiences delivering psychiatric nursing interventions with adult clients in acute care settings. I would be happy to share the findings with you following the study. I will email a link to my thesis once it has been completed.

At a time and place convenient to you, I would like to meet with you to talk about your experiences delivering psychiatric nursing interventions to adult clients in acute care inpatient settings. Our conversation will be about one and a half to two hours long. The interviews will be audio-recorded and then transcribed by a transcriptionist. Your participation will be kept confidential and confidentiality will be maintained through the use of a pseudonym. Data from all participants will be aggregated and your name or any other identifying information will not be published or shared.

Participation is voluntary and you may refuse to answer any question or withdraw from the study at any time. Participating or declining to participate in this study will not affect your relationship with the researcher or Brandon University.
Should you have any questions about participating in the study, please contact me directly to further discuss this project. I may be reached at (204) 761-5843 and andreat_999@hotmail.com. You may also speak with my supervisor, Dr. Fran Racher at (204) 727-7414 and racher@brandonu.ca. For questions regarding ethics you may contact the Brandon University Research Ethics Committee (BUREC) at (204) 727-9712 and burec@brandonu.ca.

Sincerely,

Andrea Thomson RPN

Master of Psychiatric Nursing Student,
Faculty of Health Studies
Brandon University
Appendix C

Ethics Certificate

Brandon University Research Ethics Committee (BUREC)
For Research Involving Human Participants

ETHICS CERTIFICATE

The following ethics proposal has been approved by the BUREC. The approval is valid for up to five (5) years from the date approved, pending receipt of Annual Progress Reports. As per BUREC Policies and Procedures, section 6.0, "At a minimum, continuing ethics research review shall consist of an Annual Report for multi-year projects and a Final Report at the end of all projects... Failure to fulfill the continuing research ethics review requirements is considered an act of non-compliance and may result in the suspension of active ethics certification; refusal to review and approval any new research ethics submissions, and/or others as outlined in Section 10.0".

Any changes made to the protocol should be reported to the BUREC prior to implementation. See BUREC Policies and Procedures for more details.

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

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<tr>
<th>Name of Principal Investigator:</th>
<th>Ms. Andrea Thomson, Brandon University</th>
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<tr>
<td>Title of Project:</td>
<td>Acute Care Psychiatric Nursing Interventions: The Experience of Export Nurses</td>
</tr>
<tr>
<td>Co-investigator(s):</td>
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<tr>
<td>Faculty Supervisor:</td>
<td>Dr. Frnn Racher, Faculty of Health Studies (Psychiatric Nursing) Brandon University</td>
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<td>April 29, 2015</td>
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<tr>
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<td>April 29, 2020</td>
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<tr>
<td>Authorizing Signature:</td>
<td>Dr. Etsuko Yasui Co-Chair Brandon University Research Ethics Committee</td>
</tr>
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</table>
Appendix D

Consent Form

Dear Participant,

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you a basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please feel free to ask. Please take time to read this carefully and to understand any accompanying information.

The following information is provided to you to decide whether you wish to participate in the present study. You may withdraw from the study at any point in time without affecting your relationship with this researcher or Brandon University and without any prejudice to any pre-existing entitlements you hold. Consent will be discussed throughout the research process. Participation is voluntary.

The purpose of the study is to discover what psychiatric nursing interventions are being used with adult clients in acute care settings. The information gathered will be published in my thesis. I would be happy to share the findings with you following the study. I will email a link to my thesis once it has been completed. This information may also be utilized beyond the thesis to write scholarly articles and be presented at conferences and workshops for the purpose of sharing knowledge on psychiatric nursing interventions. Data from all participants will be aggregated and your name will not be associated with the research findings in anyway. It is unanticipated that any information will be collected regarding the abuse of clients in care, although the researcher has a duty to report if this is disclosed.

Your data will be collected in a private interview at a location and time of your convenience. The interview will be audio-recorded and transcribed by a transcriptionist. The transcriptionist will sign a confidentiality agreement prior to receiving any data collected from your interview. Audio recording the conversation will allow me to transfer our dialogue into notes. I may also take a small amount of handwritten notes during our interview.

The computer files and transcripts of our conversations will be kept confidential and accessed only by me, Andrea Thomson, my supervisor, Dr. Fran Racher, and the transcriptionist. The computer files will be saved on a flashdrive and stored with the notes in a locked filing cabinet. In the notes and computer files I will use pseudonyms or false names for participants. I may quote your words to illustrate a point, but I will never use your name or information that could identify you.
Please sign the consent form with full knowledge of the nature and purpose of the procedures. A copy of this consent form will be given to you to keep. You will not incur any financial costs in participating in this research. There are no known risks and/or discomforts associated with this study. The expected benefit from the study is the sharing of information about the experience of being a psychiatric nurse practicing in acute care. The research approach will be used to facilitate a deeper understanding of psychiatric nursing interventions being offered in acute care psychiatric nursing practice. Increased understanding may affect acute care psychiatric nurses ability to provide holistic care to address the challenging and complex demands faced in this profession. The knowledge may assist novice psychiatric nurses in developing skills. Practice, policy, and education may be influenced with the research results.

Your signature on this form indicates that you have understood the information regarding participation in the research project and have agreed to participate. This does not waive your legal rights nor release the researcher or the involved institution from their legal and professional responsibilities. Your continued participation should be as informed as your initial consent, so feel free to ask for clarification or new information at any time.

Do not hesitate to ask any questions about the study either before participation or during the time that you are participating. If you have any questions concerning your participation you may contact me directly at (204) 761-5843 and andreat_999@hotmail.com. You may also contact my supervisor, Dr. Fran Racher at (204) 727-4714 and racher@brandonu.ca. For questions regarding ethics you may contact the Brandon University Research Ethics Committee (BUREC) at (204) 727-9712 and burec@brandonu.ca.

______________________________________________________________________
Signature, participant         Date
______________________________________________________________________
Signature, researcher        Date