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Recovery-Oriented Care in a Psychiatric Health Setting

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Walden University
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Abstract

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MS, University of Phoenix, 2009

BSN, Carlow University, 2005

Project Submitted in Full Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Psychiatric recovery-oriented care is aimed at improving patients' quality of care while increasing the efficiency of health care providers. Despite the benefits of recovery-oriented care, this approach is often lacking in health care settings. The purpose of this project was to implement a recovery-oriented training on psychoeducational groups on a 26-bed psychiatric unit. The Iowa model of evidence-based practice and adult learning theory provided the framework for the project. The objectives were to (a) assess training needs, (b) evaluate barriers for recovery-oriented psychiatric nursing, (c) develop strategies to address barriers, (d) train staff in psychoeducational approaches, and (e) evaluate the training effectiveness. Information on knowledge, confidence, training needs and barriers in conducting psychoeducational groups was collected from 24 nursing staff. Open-ended interviews were conducted to ascertain staff perceptions on training needs and barriers. Interview responses were analyzed for common themes. Staff expressed a need for training and perceived a lack of knowledge and time as barriers in conducting psychoeducational groups. A questionnaire was used to collect data on knowledge (8 items) and confidence (5 items) pre and post training. Pre/post responses were analyzed using descriptive statistics and paired sample *t* test. Results showed a significant increase in staff knowledge, but not confidence in conducting psychoeducational groups from pre to posttest. Results may be used by psychiatric nursing staff to improve the quality of recovery-oriented care, patient satisfaction, and efficiency of the care delivery system. Recovery-oriented psychiatric care implicitly changes social norms by helping individuals with mental health problems integrate back into their communities.

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Section 1: Introduction

Background

Health care recovery efforts are vital in the last phase of case management pursuing the full restoration of a patient's normal health status. Health care recovery is conceptualized as the patient connecting with health care professionals to positively influence their care and recovery (Bennett, Breeze, & Neilson, 2014). Health care professionals play a significant role in encouraging recovery by exhibiting optimistic attitudes, applying operative interventions, and having the appropriate skills to support patients on their recovery journey (Bennett et al., 2014). Therefore, recovery is essential not only in the clinical cases but also in rehabilitative settings where nursing care focuses on prolonging life. Nurses' training in the field of patient recovery is an ongoing concern being embraced by health care providers as the most important phase in efficiency of care delivery. Contemporary nursing trainings provide education for the basics, which would be experienced later in practice but failed to provide training in specialized nursing areas, such as psychiatric nursing and how to conduct groups and provide recovery-oriented care. Many of the useful and critical aspects of nursing care are learned through best practices emanating from hands-on experiences and clinical research findings. These sources provide valuable information, advising on the process in which recovery nursing care should be approached for optimal health outcomes among patients in any setting or conditions.

Patients suffering from various disorders and diseases find recovery care to be an integral part of health care delivery, which offers an opportunity to boost the individual's

coping ability toward the illness. In addition to conditions and other cognitive, physical, or developmental problems, health facilities with psychiatric patients are in urgent need of recovery care. Mental health recovery has been acknowledged as the main objective for patients with mental illness (Substance Abuse and Mental Health Services Administration [SAMSHA], 2011). Recovery is an individualized journey that promotes healing and assists individuals with restoring their ideal level of functioning. According to Silverstein and Bellack (2008), recovery is defined as a reduction in mental health symptoms that places the individual in widespread or limited remission from their psychiatric illness. Although several definitions of recovery exist, the consensus is that recovery helps patients with mental illness cultivate the necessary resources to manage their illness efficiently. SAMSHA (2012) defined recovery from mental health and substance use disorders "as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (p. 3). The SAMSHA definition has been widely accepted in the mental health field, used extensively by the mental health advisory of Veterans Healthcare Administration (VHA), and adopted in mental health facilities. SAMSHA (2012) included 10 essential components that help guide recovery: self-directed, nonlinear, individualized, personal, empowerment, holistic, strength-based, peer support, respect, responsibility, and hope. These components have been accepted by the Veteran's Healthcare Administration as the core elements of recovery. Because recovery is multifaceted and unique to the individual, mental health professionals must have a clear understanding of recovery and the interrelated role that psychoeducational groups play in the recovery process.

The benefits of mental health recovery-focused care drive the demand for continuity of care and assist in restabilizing the patient by promoting positive coping skills to help the patient reach his or her ultimate level of functioning. Despite the important need for a phase of care delivery, many institutions, health facilities, and rehabilitative care settings inadequately promote their potential in reaching top quality care through the design and implementation of a proper recovery framework for their patients (Fitzgerald, Kantrowitz-Gordon, Katz, & Hirsch, 2012). The observed failure is attributed to numerous factors. Some scholars report that the lack of commitment by the policymakers at the institutional level led to inadequate resource allocation in investing in recovery care, resulting in adverse health outcomes (Schlegel, Woermann, Shaha, Rethans, & Vleuten, 2012). The efficiency of health institutions is also reduced. Other scholars indicated that in instances in which recovery programs are initiated, human resource limitations and inadequate approaches led to situations that hampered the full realization of goals (Pupkiewicz, Kitson, & Perry, 2015).

Most approaches to recovery care leave out essential elements such as an interdisciplinary composition of groups tackling implementation tasks of the program (A. Cleary & Dowling, 2009). Diverse teams drawn from various disciplines in health care apart from the nursing profession are effective in addressing the different logical frameworks of recovery care. However, team management occurs in a setting of psychiatric patients and other social development problems. Elements such as a positive attitude, a sense of ownership, and a feeling of possible achievement through shared goals and targets of the team engaged in recovery programs are necessary for success.

According to Denham-Vaughan and Clark (2012), recovery-oriented care in mental health includes the ability to orient the thinking and attitudes of each person involved to achieve the optimal outputs from every individual.

The efficient evolution of the process of recovery is possible with proper planning, good content, and suitable delivery methods for specific audiences and subjects. Getting all the variables right provides a predisposition to the desired health outcome at posttreatment, postdischarge, or as a part of managing chronic medical conditions such as terminal illnesses (M. Cleary, Horsfall, O'Hara-Aarons, & Hunt, 2013). Nursing and other health care professionals have to be trained and mentored in the delivery of the best proven practices in recovery-oriented nursing care in any setting. However, such training is lacking in many medical facilities, especially in mental health settings that have patients with psychiatric and addictive issues (M. Cleary et al., 2013). The quality of care remains substandard despite adequate and proper staffing in clinical treatment areas (Aebersold & Tschannen, 2013). There are underdeveloped skills and abilities among nursing and other health care professionals who support posttreatment and postdischarge patients.

The lack of adequate recovery-oriented care in many psychiatric health facilities among psychiatric nurses is blamed partly on the reduced ability of patients to fully regain their health status potential. Prepractice training of psychiatric nurses on recovery-oriented practices may not include emerging best practices. New knowledge should be integrated into practice through on-the-job nurse training. Research indicated that psychiatric nurses are given less consideration in terms of work and health equipment

than other health care professionals (Farley-Toombs, 2011). Consequential factors such as security and improving the social and cognitive development of patients depend on the implementation of recovery-based care. Among nurses and other health care workers in psychiatric settings, emotional stability and coping skills are central to helping patients recover properly (Farley-Toombs, 2011).

Focusing on nurses' training in handling the recovery of patients with mental health issues is important in improving the quality of care. Some of the applauded approaches are group education, panel discussions, and task-oriented case scenarios (Yuan, Williams, & Fang, 2012). Problem-based methods are preferred in nursing school compared to theoretical approaches. Best practices are important in the achievement of desired levels of expertise to promote recovery among patients.

Problem Statement

Psychiatric patient recovery is often slow and inefficient due to inappropriate approaches used by psychiatric nurses in delivering recovery-oriented health services (Farley-Toombs, 2011). A lengthy recovery period leads to low levels of patient satisfaction (Department of Health, 2006). General quality of life deteriorates among the affected patients. However, appropriate training in psychiatric nursing and other health professions is effective in achieving the quality and efficiency needed in psychiatric health units for optimal clinical outcomes (McKenna, Furness, Dhital, Park, & Connally, 2014). By conducting psychoeducational groups and providing recovery-oriented training of nurses and other health care professionals in psychiatric health facilities, the treatment disparity can be reduced.

Purpose

The purpose of this project was to develop and implement an educational intervention for psychiatric nurses to provide recovery-oriented care and conduct psychoeducational groups on an inpatient psychiatric unit. To accomplish this goal, I assessed barriers and deficiencies among nurses to develop the educational intervention. The Iowa model of evidence-based practice (Titler et al., 2001) guided the process of implementation and evaluation of the practice change. The project included the following objectives:

- assess the training needs of psychiatric nurses in the inpatient unit to devise the most appropriate training content and approaches that would meet their needs,
- evaluate the perceived barriers for effective recovery-oriented psychiatric nursing care,
- determine strategies in addressing perceived barriers,
- educate psychiatric nurses on group dynamics and psychoeducational groups in patient recovery, and
- evaluate the effectiveness of training on recovery-oriented nursing care for psychiatric patients, considering the lessons learned, while advising future training and nursing practice in mental patient recovery.

Project Questions

The purpose of this project and its objectives were intricately linked to the issues that the project addressed. The project's questions formed the basis of the study and were

used to design the benchmarks of the program. Success depended on the level of satisfaction with which the questions were answered. I conducted monitoring and evaluation to meet the goals of the project. The project questions were as follows:

1. What are the perceived training needs of psychiatric nurses on an acute inpatient psychiatric unit?
2. What are the perceived barriers to recovery-oriented psychiatric nursing care on an acute inpatient psychiatric unit?
3. What strategies do nurses need to break the barriers of full and efficient recovery-oriented psychiatric nursing practice?
4. Is recovery-oriented psychoeducational group training effective in increasing the staff's knowledge and confidence in conducting groups?

Evidence-Based Significance of the Project

Recovery-oriented patient care involves many factors. Most of these were not explained to psychiatric nurses during their school-based training. Despite the inadequacy of nursing curriculum on managing patient recovery in psychiatric care settings, the ability to help psychiatric nurses manage patients' recovery is crucial in improving the quality and speed of recovery (Gale & Marshall-Lucette, 2012). Many health institutions base their recovery efforts on patients (Pallaveshi, Zisman-Ilani, Roe, & Rudnick, 2013). Health care providers encourage patients to be mentally and emotionally stable to cope with changes in their health status as they strive to return to normal health. However, studies show that it is also vital for the psychiatric nursing fraternity involved in psychiatric patient care to have a significant impact on the recovery process (Pallaveshi et

al., 2013). For example, effectively working in groups to manage outpatients or those in rehabilitative facilities generated more positive health outcomes than in settings where patients were left to strive alone on the way to recovery.

In cases in which health care practitioners are actively engaged in the patient recovery process, health outcomes include higher quality of care and consumer satisfaction. These two factors determine the sustainability of health systems through increased productivity and operational efficiency (Cook et al., 2009). Other benefits of health care provider-focused recovery plans are economic and social (Cook et al., 2009). One of these is cost effectiveness. Quality health care delivered in psychiatric units reduces the length of the patient's stay, reducing the health care cost. A faster recovery process also leads to a reduction in the level of stress or depression among patients (Department of Health, 2006), thereby increasing the quality of life after recovery (Pallaveshi et al., 2013). Group work, team management, and skill acquisition during training programs promote cohesiveness at work, which encourages synergy of skills of psychiatric nurses (Farley-Toombs, 2011). Psychiatric nurses should be able to utilize themselves in a collaborative manner to promote therapeutic recovery.

Implications for Social Change in Practice

Increasing the quality of health care by increasing the rate of recovery among psychiatric patients and patients with other social problems is a method of addressing the issue of disparity in health care and its associated risks (McKenna et al., 2014). In some instances, the use of effective recovery in mental health patients leads to reduced insecurity risks (Pallaveshi et al., 2013). Mental health patients who are subjected to

planned recovery processes are less likely to have violent incidents or misbehavior related to their psychiatric conditions (Farley-Toombs, 2011). Recovery-oriented psychiatric nursing care potentially impacts society by helping individuals with mental health problems integrate back into their communities. The nursing profession is not unique in creating a social impact through effective methodologies in practice. The ability to nurse the patient both emotionally and clinically is vital to the success of nursing care. By using emotional support to reduce the adverse health outcomes that impede the recovery of mental health patients, recovery-oriented nursing care can reduce illness among the sick (Alfaro-LeFevre, 2013).

Definitions of Terms

To ensure a clear understanding of words used in this project, key terms are operationally defined. Some terms may be used differently in diverse settings or applied separately in various academic disciplines.

Evidence-based practice (EBP): The use of sound elements of practice, which are proven effective through hands-on experience or research (Fitzpatrick, 2007). Usually EBP takes place at the workplace, as opposed to class-based training, as outlined by a professional career training curriculum. Through the learned lessons, EBP is useful in improving the quality of psychiatric nursing at the facility where the project is performed, as it is a permanent practice skill among trained health providers (Fitzpatrick, 2007).

Psychoeducational groups: A type of group that incorporates information on the specific mental illness, treatment options, patient and family resources, coping skills, and management strategies (Vreeland, 2012). Psychiatric nurses play a major role in

conducting these groups on a psychiatric unit. In a recovery-oriented environment, there is a prominence on patient collaboration and a priority on promoting a partnership by providing psychoeducational groups (Vreeland, 2012). Group dynamics include occurrences and activities, both social and behavioral, affecting the general behavior of the group in a certain way. Group dynamics can be effectively managed to reduce the negative outcomes and amplify the positive outcomes, thereby leading to better team efficiency. Group dynamics refers to the interactions among individuals conversating in a group setting (Nazzaro & Strazzabosco, 2009). Group conflict, cooperation, and neutrality are elements that shape the performance of any team.

Summary

The project may lead to changes in practice among psychiatric nurses and other staff who are directly involved in the management of recovery of mental health patients. Nurses working in teams or groups leads to better patient care than only one person nursing the patient (Fitzpatrick, 2007). Nurses on duty attending to one patient and agreeing on all aspects of care can yield better outcomes than those in disagreement. Through group dynamics, team management, and teamwork, better health care decisions for patients can be achieved compared to when this kind of cooperation is missing. Culture in health care settings is reinforced by the use of proper teamwork in promoting the well-being of patients. Moreover, the potential transferability of the recovery-oriented care project may influence best practices in other psychiatric units. The recovery model includes a quality improvement framework to support competent nurses. On the surface this may seem simple, but the process is quite complex.

Section 2: Background and Context

The process of psychiatric patient recovery is slow and hampered by inappropriate approaches used by psychiatric nurses in delivering recovery-oriented health services (Farley-Toombs, 2011). A lengthy recovery period leads to low levels of patient satisfaction (Department of Health, 2006). The general quality of life deteriorates among affected patients. Appropriate training in psychiatric nursing and other health care professionals is effective in improving the quality and efficiency of patient recovery in psychiatric health units for optimal clinical outcomes (McKenna et al., 2014). Through psychoeducational groups and the provision of recovery-oriented training for psychiatric nurses and other health care professionals, patient outcomes can be improved.

Project Purpose and Objectives

The goal of this project was to develop and implement an educational intervention for psychiatric nurses on how to provide recovery-oriented care and conduct psychoeducational groups on an inpatient psychiatric unit. To accomplish the goal, I assessed barriers and deficiencies among nurses to develop the educational intervention. The Iowa model of evidence-based practice (Titler et al., 2001) was used to guide the process for implementing and evaluating the educational intervention. The project included the following objectives:

- assess the training needs of psychiatric nurses in the inpatient unit to devise the most appropriate training content and approaches that would meet their needs,

- evaluate the perceived barriers for effective recovery-oriented psychiatric nursing care,
- determine strategies in addressing perceived barriers,
- educate psychiatric nurses on group dynamics and psychoeducational groups in patient recovery, and
- evaluate the effectiveness of training on recovery-oriented nursing care for psychiatric patients, considering the lessons learned, while advising future training and nursing practice in mental patient recovery.

Project Questions

The purpose of this project and its objectives were intricately linked to the issues that the project sought to address. The project questions form the basis of the project inquiry and will help in designing the benchmarks of the program. Success will depend on the level of satisfaction to which questions are answered. Also, monitoring and evaluation was done accordingly to meet the goals of the project. The project questions were as follows:

1. What are the perceived training needs of psychiatric nurses on an acute inpatient psychiatric unit?
2. What are the perceived barriers to recovery-oriented psychiatric nursing care on an acute inpatient psychiatric unit?
3. What strategies do nurses need to break the barriers of full and efficient recovery-oriented psychiatric nursing practice?

4. Is recovery-oriented psychoeducational group training effective in increasing the staff's knowledge and confidence in conducting groups?

Concepts, Models, and Theory

EBP is a collection of best practices in nursing based on credible forms of evidence. Information on EBP is obtained through collecting evidence from primary research studies, quality improvement initiatives, and expert panels, and applying this knowledge in the clinical practice setting. This is useful for care delivery in psychiatric nursing (Koivunen, Välimäki, & Hätönen, 2010). Although there is considerable literature on best practices in psychiatric nursing care, this project focused on recovery-oriented care. EBP for inpatient recovery-oriented care is passed down from one generation of psychiatric nurses to another through on-the-job training as opposed to prepractice education. Scholars agreed that although prepractice training integrates elements of EBP into the curriculum, this approach is not as effective as on-the-job training, which is immediately put into practice and evaluated for effectiveness (Stillwell, Fineout-Overholt, Melnyk, & Williamson, 2010). Although approaches to nursing training on EBP are informed by theoretical models on education and training, the content can vary regarding the required skills and knowledge for a particular setting (Grove, Burns, & Gray, 2013).

Theoretical frameworks are used to explain the approaches to recovery-oriented care by advising implementers of such programs in achieving effectiveness among the beneficiaries. I used adult learning theory as the theoretical framework for the project because this theory differentiates the learning needs of adults and how new information is

processed. Adult learning theory was developed by Knowles (1989) and originally consisted of six assumptions regarding how adults learn and process new information. These assumptions are based on andragogy, which is a learner-focused approach that emphasizes operations and the significance of educational training instead of curriculum (Knowles, 1989). Knowles further stated that due to life experiences, adults have more preconceived notions about learning new initiatives, and they must perceive this need and be ready to learn. Curran (2014) stated that health care organizations that fail to utilize adult learning theory to guide educational development prevent the transfer of knowledge, which can negatively impact patients. Adult learning theory is self-directed and a shared learning experience (Knowles, 1989). Therefore, curricula should be centered on interactive activities in which adult learners can actively participate and acquire knowledge.

The implementation of recovery-oriented care by nurses requires that they introduce, develop, and assess evidence-based practice (Doody & Doody, 2011). The Iowa model (Tilter et al., 2001) provides a framework through which the approach is holistically outlined. The model is superior to biomedical theories of practice, which are inadequate in nursing settings especially as part of evidence-based care delivery. The Iowa model includes seven important processes to be observed when implementing EBP, and incorporates members of the organization, patients, health care systems, and other stakeholders. Additionally, the Iowa model identifies triggers that determine the points of knowledge acquisition or problems to be solved. Shifting from risk management to clinical problems is necessary for improving the practices for psychiatric care (Grove et

al., 2013). According to Grove et al. (2013), knowledge-focused triggers include EBP elements, philosophies, procedures, and organizational policies. The Iowa model guides implementation of patient recovery, thereby streamlining the process of quality improvement in helping psychiatric patients to experience a fast and accurate recovery.

Relevance to Nursing Practice

Nursing education is a prerequisite for quality patient care, including the recovery process. According to Denham-Vaughan and Clark (2012), psychiatric nursing stems from proper education and training, which determine the achievable level of quality care among psychiatric patients. I envisioned systems in which psychiatric nurses operate to be vital in predicting the course of recovery for patients with mental health problems. The main focus of this project was education and training of nursing personnel. Training plays an important role in promoting the desired patient recovery outcome, especially for psychiatric patients. Furthermore, EBP is effective in improving quality and efficiency in health care delivery for psychiatric patients (Terry, 2015). Recovery-oriented care depends on the level of training of psychiatric nurses on the best practices available for specific types of patients.

Methodologies such as psychoeducational groups and knowledge of group dynamics provided the best implementation framework for the project. Psychoeducational groups help in facilitating the training of psychiatric nurses to promote proper patient recovery. Researchers agreed that theoretical frameworks specific to nursing care settings are needed to improve the effectiveness of practices among nurses (Stillwell et al., 2010). Through an interdisciplinary approach to patient care,

recovery can be optimized. The diverse disciplines can cooperate and channel efforts toward the achievement of a shared goal of initiating and sustaining proper patient care to recovery. This element of patient care differentiates recovery-oriented care from other types of nursing care delivered to patients (Farley-Toombs, 2011).

Nursing training in recovery-oriented care needs a systematic approach and continuous monitoring to be effective. It requires a comprehensive, logical framework that includes the milestones, goals, and benchmarks for each process. It also requires the inclusion of all possible parameters of nursing care, which can have a direct or indirect influence on the elements of the logical framework (Lysaker & Buck, 2008). All activities that affect the nursing schedule must be included and planned, placing every element in its proper place and considering time and responsibility. The timing of task competition and clear goals for each activity must be established before the onset of training. Researchers agreed that there may be possible deviations between what is planned and what is experienced in the process of executing the strategy (M. Cleary et al., 2013). However, deviations may be mitigated through monitoring and evaluation, which lead to a review of the blueprint for powerful impact on the subjects. Nurses in a psychiatric unit who are to be trained in recovery-oriented care must be coordinated and assisted to adhere to every aspect of the logical framework while going through a smooth and efficient training process. Although the approach applies to nursing practice in any setting, it is modifiable for use in recovery-oriented nursing care for psychiatric nurses.

Psychiatric nurses understand the gaps in practice they are facing, which diminish the efficacy of care delivery. Some may give suggestions on the best means of

addressing problems. Although full implementation of these suggestions are often not fully carried out or successfully implemented in the workplace setting. However, the workplace setting is not the only factor in recovery (Farley-Toombs, 2011). The atmosphere includes the emotional readiness of the psychiatric nurses, as well as the skill sets owned in the domain of care delivery. Nursing education and training provide an opportunity for psychiatric nurses to improve their competencies in facing challenges in care delivery so that patient satisfaction and quality of care can be enhanced. In recovery-oriented nursing, nursing education and training should be an ongoing venture for continuous quality improvement (McKenna et al., 2014). Optimal outputs are possible from psychiatric nurses when new developments in their field are instilled in their practice. Recovery-oriented care can help in achieving the goals of preventing patient relapse, improving the pace of recovery, ensuring long-term well-being, and reducing the severity of unhealthy conditions.

Local Background and Context

Patient care involves numerous factors. Most of these are not imparted to psychiatric nurses at the time of their school-based training. Despite inadequacy in the content of nursing curriculum on managing patient recovery, especially in psychiatric care settings, the ability to help psychiatric nurses manage patients' recovery is crucial in improving the quality and speed of recovery (Gale & Marshall-Lucette, 2012). Many health institutions base most of their recovery efforts on patients (Pallaveshi et al., 2013). The health facilities allow patients to be mentally and emotionally stable and cope with changes in their health status as they strive to return to normal health. However, studies

show that it is vital for nurses involved in psychiatric patient care to significantly impact the recovery process (Pallaveshi et al., 2013). For instance, effectively working in groups to manage outpatients or those in rehabilitative facilities generated more positive health outcomes compared to settings in which patients were left to strive alone on the way to recovery.

In cases in which health practitioners are actively engaged in the patient recovery process, health outcomes include higher quality of care and consumer satisfaction. These two factors determine the sustainability of health systems through increased productivity and operational efficiency (Cook et al., 2009). Other benefits of health care provider-focused recovery plans are economic, such as cost effectiveness, or social, such as a reduction in the patient's level of stress or depression (Department of Health, 2006). Recovery-oriented care increases the quality of life after recovery (Pallaveshi et al., 2013). Psychiatric nurses should be able to approach patients in a therapeutic manner that encourages and promotes recovery.

The setting for this quality improvement (QI) project was a 26-bed inpatient psychiatric unit. This unit provides mental health treatment for adults age 21 and older. Primary admitting diagnoses include depression, bipolar, PTSD, and substance abuse. Purposeful sampling, as described by Frankfort-Nachmias and Leon-Guerrero (2014), involved the nursing staff members employed on this unit. Because of the project's nature (QI), written informed consent was not required. However, the full disclosure of the academic nature of the project was discussed with organizational leaders and project participants. The institutional policies for vetting and conducting an academic capstone

project were followed. The local institutional review board (IRB) chair classified the project as non-research operations activities on September 25, 2015 as per the facility's standard operating procedures. Walden IRB approved the project on May 27, 2016. The approval number for this study is 05-27-16-0423452. Ethical considerations were fully observed regarding confidentiality, privacy, and integrity of all participants. The above measures were initiated with the consideration that psychoeducation is a requirement for psychiatric patient recovery.

Psychoeducational groups provide a framework for achieving effective recovery-oriented care in psychiatric patients. Colom (2011) cites three attributes of psychoeducation groups in the implementation of efficient recovery-oriented psychiatric care. The first attribute is an open relationship between the patient and the caregivers, which facilitates support to psychiatric care in a proactive approach, rather than a reactive approach. The person with a mental health condition benefits from the ability to open up on self-care and improves in the capability to take personal decisions, an aspect which is detrimental for the stability or increase in the speed of recovery. The second attribute of the psychoeducation model in recovery care is an encouragement for teamwork. Working in groups is essential in bringing out the best in different workspaces, including nursing. Therefore, the psychoeducational group is based on the logic of teamwork in recovery-oriented psychiatric care. Teamwork and open-door-policy come together in affecting the third attribute of recipient-provider relationship which benefits the patient. The relationship sets up a sound social setting, in which the patient trusts the caregiver and the providers deliver the best quality of service to the recipient (Phillips & Schade, 2012). In

the mix, actual outputs are enhanced, as opposed to an environment of mistrust, which is common in authoritarian patient-provider relations. The psychoeducation group has become increasingly popular among psychiatric patient recovery programs.

The effectiveness of psychoeducational groups is highly influencing the patients. However, the staff or provider of recovery-oriented care must have the knowledge and skills to implement the methodology. According to Aho-Mustonen, Miettinen, Koivisto, Timonen, and Räty (2008), the application of the psychoeducational group methodology in psychiatric care settings not only helps long-term mental health patients to receive better and faster treatment, but also the staff and severely ill patients benefit from the additional skills and knowledge. Awareness of the illness, side effects, and coping opportunities are highlighted, offering a collective approach to controlling the prognosis of the disease. The attitude towards care is positively enhanced among the mental health patients in the application of the psychoeducation groups, as is the methodology for implementing recovery-oriented care. The ability of psychoeducational groups in affecting the change necessary for patient recovery in psychiatric patients is explained by Slade, Amering, Farkas, Hamilton, and O'Hagan (2014) as the mental transformation among the staff and the patients, using the theory that human systems only transform through cognitive development, learning, and training. According to Slade et al., changing the human system requires voluntary devotion, trust, and social harmony. Psychoeducation groups offer a concrete social setting that supports the positive mental change in the trained staff member or the patient.

Recovery-oriented patient care instills capabilities of enhanced self-determination and sense of responsibility. Nursing staff are responsible for providing the best recovery-oriented care in order to achieve healthy outcomes (Decker, Peglow, & Samples, 2014). Attitudes of both the staff and the patient are positively changed to significantly contribute towards recovery. Taking into consideration that psychoeducation is person-centered, the same implementers of recovery care meet the welcoming efforts of the patient and ensuing optimal health outcomes. As Bore, Hendricks, and Womack (2013) discovered by using psychoeducational groups in schools, understanding the context of the patient, such as lifestyle and culture, adds value to the enhancement of positive health outcomes. The patients benefit from quality health care, as the provider gains the skills and ability of effective care delivery. The use of psychoeducation groups is patient recovery-oriented care. Recovery has a huge body of knowledge on the capabilities of impacting positive health outcomes in the psychiatric setting upon both the mental health patients and their caregivers.

Role of the DNP Student

As a Psychiatric Nurse Manager, DNP student, and advocate for mental health, I play a significant role in ensuring that the highest quality of care is delivered to the patients on the inpatient unit that I manage. In this role, I am responsible for staffing the unit with competent and knowledgeable nursing staff, including nursing assistants and registered nurses. This entails fostering a practice milieu that is conducive to learning and securing resources for ongoing nursing staff development. Furthermore, I am responsible for implementing best practices in mental health treatment and recovery-oriented care.

The motivation for this project comes from a commitment to the mission of the VA, a commitment to our veterans, and a commitment to our nursing staff. Numerous studies indicate that recovery-oriented care is a standard of quality care for mental health. Therefore, producing an environmental milieu, structured to meet the multifaceted needs of psychiatric patients, consists of establishing evidence informed recovery-oriented care. Recovery-oriented care is often lacking on inpatient psychiatric units. The nursing staff I work with appeared to lack fundamental confidence in delivering comprehensive recovery-oriented care. The nursing staff verbalized several needs and barriers related to recovery-oriented care, including lack of knowledge and confidence, precluding recovery-oriented psychoeducational groups from being conducted. I embraced the opportunity to utilize my doctoral education and training to create and engage staff in a 1-hour educational session on recovery-oriented care, the goal of which was to increase knowledge and the nurses' level of confidence in conducting psychoeducational groups.

Because a formal project team approach was not utilized for this capstone, one bias that I had to address was the potential conflict of having supervisory authority over the nursing staff who participated in the learning needs and barriers assessment and the subsequent training with evaluation. To address this issue, I relied on the facility's ICARE (integrity, commitment, advocacy, respect, and excellence) values to guide the open staff discussions. I listened to all staff, respected their views, and developed the action plan and training based on their input. I provided the staff with full project disclosure, complied with the facility's policies on conducting quality improvement projects, and conducted the pre- and post-testing evaluation with no identifiers.

Summary

Recovery-oriented care has become a general guiding principle of many mental health care organizations (McKenna et al., 2014). Recovery care restores patients to their optimal level of functioning and promotes effective coping methods to manage crisis situations. Although recovery is a standard of care, nurses may not be familiar with the concepts and lack the competency and confidence in applying the recovery model in practice. It is important for nurses to enhance their knowledge towards recovery-oriented care approaches and improve their level of reliance and confidence. A systemic approach to applying recovery-oriented frameworks is considered fundamental for the improvement of services and to bridge the disparity gap to recovery for mental health patients (Carpenter-Sing, Hipolito, & Whitely, 2012).

Recovery-oriented care views patients holistically, while promoting shared decision making and social inclusion (Carpenter-Sing et al., 2012). A psychiatric environment enriched with recovery-oriented care allows nurses to engage therapeutically with patients and embolden shared decision making by encouraging patients to participate in their care (Carpenter-Sing et al., 2012). Achieving such a milieu requires that nurses be fully informed on the concepts of the recovery model. This QI project was conducted as a first critical step towards developing a recovery milieu in one local setting. What follows is a detailed description of the methods utilized to conduct the project.

Section 3: Collection and Analysis of Evidence

Recovery-oriented care is well recognized as an evidence-based approach to enhance mental health and quality of life among those with mental illness or addiction. The focus of recovery-oriented care is to engage patients in mental health or addiction issues that put the person at the center of the care, rather than the diagnosis. Recovery refers to the manner in which the person experiences and manages the mental illness or addiction as they live in the community. Therefore, providing training to staff is essential for increasing staff level of knowledge, confidence, and development on recovery-oriented concepts (Le Boutillier et al., 2011).

There are multiple strategies incorporated in recovery-oriented care. One effective strategy is nurse-led psychoeducational groups. Despite the recognized success of this approach, many treatment programs have failed to implement high-quality, comprehensive recovery programming for their patients (Fitzgerald et al., 2012). The observed failure is attributed to numerous factors. The expressed lack of knowledge and confidence among psychiatric nurses in planning and delivering psychoeducational groups was identified as a modifiable barrier in implementing recovery programming (McKenna et al., 2014). The purpose of the current project was to develop and implement educational training for psychiatric nursing staff on recovery-oriented care, while also focusing on how to conduct psychoeducational groups on an inpatient psychiatric unit. A summary of the specific practice questions and the sources of evidence used to address these issues is presented in the following section.

Practice-Focused Questions

The project was implemented within an inpatient psychiatric unit for adult patients. Patients in this unit are primarily admitted for the treatment of anxiety and mood disorders such as PTSD or substance abuse. Implementation of a comprehensive recovery-oriented program was identified as a strategic goal of the local organization. Based on internal organizational benchmarks, this unit identified a need to increase the number and types of nurse-led psychoeducational groups offered to patients. Informal discussions among nursing staff and nursing leaders suggested that a lack of knowledge and confidence in providing psychoeducational groups was a concern. To address the local problem and achieve the organizational strategic goals, the project was conducted to answer the following four questions:

1. What are the perceived training needs of psychiatric nurses on an acute inpatient psychiatric unit?
2. What are the perceived barriers to recovery-oriented psychiatric nursing care on an acute inpatient psychiatric unit?
3. What strategies do nurses need to break the barriers of full and efficient recovery-oriented psychiatric nursing practice?
4. Is recovery-oriented psychoeducational group training effective in increasing the staff's knowledge and confidence in conducting groups?

Sources of Evidence

Two primary sources of data (internal and external) were included in the capstone project. Internal facility-level evidence was collected from the pre and post knowledge

and confidence test, along with the staff's opinions, which were elicited to develop the action plan. External evidence from published literature also guided the project. Published research indicated that patient recovery-oriented care involves numerous factors, most of which are not imparted to psychiatric nurses during school-based training. Despite inadequacy in the content of nursing curriculum on managing patient recovery, especially in psychiatric care settings, the ability to help psychiatric nurses manage patients' recovery is crucial in the quality and the speed of recovery (Gale & Marshall-Lucette, 2012).

Many health institutions base their recovery efforts on patients (Pallaveshi et al., 2013). The health facilities allow patients to be mentally and emotionally stable to cope with changes in their health status as they strive to return to normal health. Nevertheless, studies indicated that it is vital for psychiatric nurses involved in psychiatric patient care to impact the recovery process (Pallaveshi et al., 2013). Working in groups to manage outpatients or those in rehabilitative facilities resulted in more positive health outcomes compared to settings in which patients were left to strive alone on the way to recovery.

Published Outcomes and Research

A systematic review (SR) is used to answer a specific clinical question based on a thorough analysis and synthesis of the complete body of relevant research evidence. The data included in an SR is based on preestablished inclusion criteria and follow a well-defined, rigorous methodology. Although this project was guided by a narrative review of the literature, the purpose and scope of the project did not warrant a formal systematic review.

Archival and Operational Data

Although the scope of the project did not include a secondary analysis of archival or prospective operational data, local benchmark information on the number of psychoeducational groups was considered in designing the scope and focus of this project. Based on benchmark analyses conducted by the staff (according to organizational standards and procedures for collecting data, conducting benchmark analysis, and communicating the outcomes to shared stakeholders), the local organization recognized the need to increase the number and types of nurse-led psychoeducational groups. Leaders and key organizational stakeholders worked closely in guiding this project and were invested in the successful implementation of the project plan.

Evidence Generated From the Doctoral Project

The Iowa model of EBP (Titler et al., 2001) was used as a framework in implementing this QI project. I followed the six steps outlined for piloting a change in practice. These included selecting the targeted outcomes, collecting baseline data, designing the intervention, implementing the intervention on the targeted unit, evaluating processes and results, and modifying the intervention as required.

The setting for this QI project was a 26-bed inpatient psychiatric unit. This unit provides mental health treatment for adults age 21 and older. Primary admitting diagnoses include depression, bipolar, post-traumatic stress disorder (PTSD), and substance abuse. Purposeful sampling approaches, as described by Frankfort-Nachmias and Leon-Guerrero (2014), were used by inviting all of the nursing staff employed on the

targeted unit to participate in the open-ended staff discussions and formal educational training.

I used both qualitative and quantitative methods and procedures for the evaluation. Qualitative methods include open-ended interviews/discussions to acquire perceptions from participants regarding experiences. Open discussions with nursing staff were used to identify learning needs and perceived barriers to implementation of recovery-oriented care within the context of an acute inpatient psychiatric unit. Discussions were conducted with the interdisciplinary team with the intent of gaining insight into their thoughts on recovery-oriented care and barriers preventing recovery-oriented care from being implemented. Following the qualitative approach, I documented (through handwritten notes) the information obtained from these discussions and examined the data for common themes (see Frankfort-Nachmias & Leon-Guerrero, 2014). This approach provided valuable information regarding the knowledge that the nursing staff possess on conducting recovery-oriented groups and the barriers that these nurses encounter. Engaging the nursing staff in these types of discussions allowed their input and experience to be incorporated into an action plan for the unit, thereby encouraging ownership and buy-in from the staff. A focused barrier-reduction implementation action plan was developed based on the thoughts and beliefs presented in these discussions.

Assessing and evaluating practices represent a key to quality psychiatric nursing and help in developing interventions to promote a practice change. According to M. Cleary et al. (2013), there is a need for education programs with an evaluation to address

the gaps in the knowledge of staff and ensure that clinical practices and philosophies are recovery focused. As a second primary emphasis, I developed and implemented an educational intervention aimed at improving the knowledge and confidence of nursing staff in conducting psychoeducational groups. The educational intervention was delivered in a face-to-face group session and covered key principles of recovery-oriented care and psychoeducational groups. The instructional delivery strategies were based on adult-learning principles and included didactic PowerPoint slides and guided group discussion to achieve the objective of the teaching session. The educational intervention was designed using the best available evidence on recovery-oriented psychoeducational groups, as well as identified learning needs of the participants. The educational intervention was delivered on site and included acceptable teaching strategies based on adult learning principles.

According to Step 5 of the Iowa model of EBP, staff knowledge and confidence were evaluated after their participation in the educational session. Baseline knowledge and confidence data were collected before the implementation of the educational intervention, using a Likert-type scale. A Likert-type pretest and posttest containing the same 10 assessment questions was developed to evaluate the educational intervention (five questions assessing knowledge and five questions assessing perceived confidence). The following steps were implemented in the development of this test: Knowledge questions were generated based on the content of the educational training, while confidence questions were designed based on other confidence questions used in previous local organizational training. Because the pretest/posttest was not a standardized tool

from the literature, information about its validity and reliability is not available. The potential limitation and resulting bias from using such a tool is also recognized. However, to help establish preliminary validity, I enlisted a nurse researcher, a nurse educator, and a psychiatric clinical nurse specialist within the local organization to assess face validity. Changes to the pretest/posttest first draft were made based on their comments and expertise. Participants completed the pretest/posttest before and immediately after the educational session.

Because this was a QI project, written informed consent was not required. However, the academic nature of the project was discussed with organizational leaders and project participants. The institutional policy for vetting and conducting an academic capstone project was followed. The proposed QI project was submitted to the local institutional review board (IRB) chair for a formal "non-research operations activities" determination as required by standard operations and policies. Based on this review, the project was deemed to meet the definition of quality improvement on September 25, 2015. The project was submitted to Walden IRB for review, and received final approval on May 27, 2016 (IRB approval number 05-27-16-0423452).

Ethical considerations were fully observed regarding confidentiality, privacy, and integrity of all participants. Participants' pretests and posttests were labeled with a de-identified code, and hard copies were stored in locked files according to the local organization's protocols. Electronic scores were recorded in an Excel file and stored in SharePoint on a password-protected computer owned by the facility. The Excel data file was transferred to SPSS 24 by a research nurse associated with the institution's research

and development program. According to local policies, no data were removed from the facility or stored on a personal computer. Furthermore, destruction of hard and electronic data is in compliance with the local organization's record-keeping policies. Open-ended discussion notes were documented as per the organization's standard process for keeping minutes. Also, these notes were recorded without names to protect the participants' identities.

Analysis and Synthesis

Internal data (evidence) specific to this project were collected using qualitative and quantitative strategies as planned for each question. Open-ended staff discussions were employed to collect information for Questions 1, 2, and 3. A pretest/posttest was used to collect data for Question 4. Demographic information and experience level were collected on the pretest questionnaire (Appendix A). The systems used to record, track, organize and evaluate the data (internal evidence) were provided by the local organization in which this project was conducted. All local policies and requirements for collecting, storing, analyzing, and reporting on data and outcomes were followed. Qualitative responses from the open-ended staff discussions were documented in consonance with local policies for recording minutes.

Hard copies of the pretest/posttest responses were stored in a locked file cabinet in a locked room pursuant to local policies. Item response data were transferred to an Excel file by two individuals to ensure the quality of the database. Specifically, one person read each response by question, while the other person recorded the responses in the Excel database. A research nurse transferred the Excel file into the SPSS 24 statistical

program. A data dictionary was created for the purposes of coding and interpreting responses for the SPSS data analysis. To ensure the data were transferred accurately, a random check of items was conducted and it was found that all items were correctly coded and entered per the data dictionary. Finally, a descriptive summary for each pretest/posttest item was generated using SPSS 24. All data were consistent within the range of the coded responses for each item; no erroneous data or outliers were identified.

Because the educational intervention was not classified as a mandated training per local operating procedures, a requirement for all participants to complete the pretest/posttest was not imposed. Nevertheless, all participants (24) completed the pretest/posttest evaluation. To minimize missing information and data, participants were asked to check their pretest and posttest for completion before turning them in. Even with this prompt, there were a couple of items with missing information. Items with missing data were included in the analysis.

This QI project incorporated both qualitative and quantitative analytic procedures based on the focus of each project question. Further details linking project questions, data collection strategies, and the evaluation plan are illustrated in Table 1.

Table 1

Project Analytic Plan and Procedures

Project question	Data collection strategies	Evaluation plan
1. What are the training needs of psychiatric nurses on an acute psychiatric unit?	Open-ended discussion with staff – qualitative.	Learning needs were identified and shared with the local leaders and the nursing staff. Also, concurrence was elicited from local leaders and nursing staff.
2. What are the perceived barriers to recovery-oriented psychiatric nursing care on the acute psychiatric unit?	Open-ended discussion with staff – qualitative.	Common barriers were identified and shared with the local leaders and nursing staff. Consensus was elicited from local leaders and nursing staff.
3. What are the perceived strategies to implement in order to address the barriers to full and efficient recovery-oriented psychiatric nursing practice?	Open-ended discussions with staff – qualitative. An action plan was developed based on staff input of perceived training needs, barriers, and strategies to address barriers.	Common needs were identified and shared with local leaders and nursing staff. Consensus was elicited from local leaders and nursing staff. The completion of an Action Plan was evaluated by a simple Yes / No completion benchmark. The action plan was shared with local leaders and nursing staff.
4. Is the "Recovery-Oriented Psychoeducational Group" training session effective in increasing nurses' knowledge and confidence in conducting psychoeducation groups?	Deliver face-to-face training on group dynamics and principles of psychoeducation groups.	Quantitative methods were used to evaluate pretest and posttest knowledge and confidence. A posttest score of 80% was used as the benchmark goal, as per the standard operating procedures of the local organization. The percentage of participants that obtained the 80% posttest benchmark was calculated in SPSS 24. Pretest/posttest change scores were calculated. *T*test was used to estimate differences between pretest and posttest scores. SPSS 24 was used to generate change scores and to conduct the t-test.

Summary

The aim of this project was to enhance recovery-oriented psychoeducational group programming on an adult psychiatric inpatient unit. This was accomplished through two key tactics. A practical action plan was developed for leaders and staff to help address the perceived barriers and needs of local staff in implementing recovery care and psychoeducational groups. A focused educational training on recovery care and psychoeducational groups was implemented to increase the nursing staff's knowledge and confidence in providing rehabilitation care and psychoeducation groups. The findings and recommendations of the project are presented in next section.

Section 4: Findings and Recommendations

Recovery-oriented care is an essential, evidence-based approach to enhance mental wellness and quality of life among those with psychiatric disorders or dependency. Kane (2015) indicated that recovery-oriented care promotes mutual respect and instills hope, empowerment, and compassion, while focusing on the patient's needs. The focal point of recovery-oriented care is to engage patients in mental health and/or addiction treatment modalities that place the individual at the heart of the illness rather than the diagnosis. Recovery refers to how the person experiences and manages the mental disease or addiction as he or she lives in the community. Developing an interpersonal relationship is considered a patient-centered care aspect and is the foundation of providing recovery-oriented care (Kane, 2015). Recovery-oriented care consists of several interrelated approaches used by health practitioners to assist patients on their personal and individualized recovery journey. One strategy is the inclusion of psychoeducational group programming for patients on inpatient psychiatric mental health units. Despite the recognized success of the recovery-oriented approach to care, comprehensive recovery-oriented programming is lacking for many patients seeking mental health treatment (Fitzgerald et al., 2012). Given this background, the specific aims for this project were threefold: (a) to identify the perceived training needs and barriers to recovery-oriented psychiatric nursing care, (b) to identify strategies to address these needs and barriers, and (c) to develop and conduct an educational training on recovery-oriented psychoeducational group programming for nursing staff on an inpatient

psychiatric mental health unit. In this section, I provide a summary of the specific practice questions and the sources of evidence used to answer these questions.

Research evidence and best practice guidelines provide guidance and insight into the multiple strategies incorporated in recovery-oriented care. One effective strategy is nurse-led psychoeducational groups. Despite the recognized success of this approach, many treatment programs fail to implement high-quality, comprehensive recovering programming for their patients (Fitzgerald et al., 2012). This is attributed to numerous modifiable factors. The expressed lack of knowledge and confidence among psychiatric nurses in preparing and delivering psychoeducational groups is considered a modifiable barrier in implementing recovery programming (McKenna et al., 2014).

This QI project was implemented in an inpatient psychiatric unit for adult patients. Patients on this unit are primarily admitted for the treatment of mood disorders, anxiety disorders including PTSD), and substance abuse. Most patients are diagnosed with a dual psychiatric disorder, which necessitates recovery-oriented programming and care. Implementation of a comprehensive recovery-oriented program was identified as a strategic goal of the local organization. Based on evidence from internal organizational benchmarks, this unit highlighted the need to increase the number and types of nurse-led psychoeducational groups offered to patients, as patients voiced concerns about the lack of teamwork and activity on the unit. Informal discussions among nursing staff and nursing leaders indicated that lack of knowledge and confidence in providing psychoeducational groups was a concern. To address this local problem and achieve the organizational strategic goals, the project addressed the following four questions:

1. What are the perceived training needs of psychiatric nurses in acute psychiatric units?
2. What are the perceived barriers to recovery-oriented psychiatric nursing care on an acute inpatient psychiatric unit?
3. What strategies do nurses need to implement to break the barriers of full and efficient recovery-oriented psychiatric nursing practice?
4. Is recovery-oriented psychoeducational group training effective in increasing the staff's knowledge and confidence in conducting groups?

Internal data (evidence) specific to this project were collected using qualitative and quantitative strategies as planned for each question. Open-ended staff discussions were used to answer Questions 1, 2, and 3. Question 4 was answered using a questionnaire for data collection. Demographic information and perceived level of experience were collected on the pretest questionnaire. The pretest and posttest contained the same 10 assessment questions: Five questions assessed knowledge and five questions assessed perceived confidence. To accurately match pretest and posttest responses, each pretest/posttest paired set were numerically identified with matching numbers and paper clipped together. To assist the participant in completing the correct test, the pretest was printed on blue paper and the posttest was printed on white paper. Participants completed the pretest (blue) questionnaire immediately prior to the educational training and turned it in. Participants completed the posttest (white) immediately after the training and turned it in. Participants were informed that the questionnaire responses would be anonymous, and the numbering system was used for matching pretest and posttest scores. SPSS Version

24 was used to analyze the data related to the effectiveness of the educational session in increasing knowledge and confidence in conducting recovery-oriented psychoeducation groups (Question 4).

Findings and Implications

A total of 24 nursing staff members working on an acute inpatient psychiatric unit participated in this QI project. Participants consisted of 8 men and 16 women, nine of which were registered nurses (RNs) and 15 were nursing assistants (NAs). Most staff (83.3%) reported that they had moderate to extensive experience working with psychiatric patients. Although 50% indicated that they had moderate to extensive training in recovery-oriented care, more than half (58.3%) reported that they had none to minimal training in conducting psychoeducational groups. These findings were consistent with the informal staff discussions on perceived training needs in conducting psychoeducational groups. The reported levels of experience and training are presented in Table 2.

Table 2

Level of Experience and Training

	Level of experience working with psychiatric patients *n* (%)	Training in recovery-oriented care *n* (%)	Training in conducting psychoeducational groups *n* (%)
Did not answer	1 (4.2)	1 (4.2)	0 (0)
None	0 (0)	2 (8.3)	2 (8.3)
Minimal	3 (12.5)	9 (37.5)	12 (50.)
Moderate	9 (37.5)	8 (33.3)	8 (33.3)
Extensive	11 (45.8)	4 (16.7)	2 (8.3)

Project Question 1 Findings: Perceived Training Needs

Results from the open-ended staff discussions revealed that most staff indicated they had no formal training on how to conduct psychoeducational groups. They felt like the organization was pushing them to perform groups without providing the appropriate training. Although some staff voiced that they feared speaking in public during groups, others stressed an overall lack of confidence in managing group dynamics. A few of the staff expressed a lack of knowledge regarding group topics and the actual content to be included during the groups. Finally, some staff voiced confusion over the various types of psychoeducational groups. Several staff-led psychoeducational groups were observed and noted to be poorly facilitated, further indicating that staff lacked knowledge and confidence in managing the dynamics of the groups.

Project Question 2 Findings: Perceived Barriers

In addition to identifying a perceived lack of training and knowledge, staff voiced frustration over, the numerous unit admissions and discharges, changes in patient acuity, and the amount of documentation that made conducting groups a low priority. Staff perceived these issues as barriers preventing them from conducting psychoeducational groups and implementing recovery-oriented care.

Project Question 3 Findings: Strategies to Overcome Barriers

Staff asked for more education and learning opportunities related to recovery programming and skill building in conducting psychoeducational groups. Staff also asked for protected time to attend training sessions.

Project Question 4 Findings: Effectiveness of Recovery-Oriented Psychoeducational Training

Per the standard operations procedures of the local organization, a posttest knowledge score of 80% was used as the benchmark goal for the participants. The knowledge test consisted of 8 questions with a possible total score of 0-8 points. A correct response was scored as 1 point. The 80% benchmark was calculated as 6.4/8 correct responses. Because scores were limited to whole numbers, a score of 7 (87.5%) was required to meet the 80% benchmark for individual participants. As indicated in Table 3, findings showed an increase in knowledge scores from pretest to posttest. Pretest scores ranged from 3 to 8, with 10 (50%) participants meeting the 80% benchmark for passing. Posttest scores ranged from 5 to 8, with 12 (58.3%) meeting the benchmark. Although the number of individuals who reached the benchmark increased from pretest to posttest, 10 (41.7%) individuals did not reach the posttest benchmark set by the organization.

Table 3

Pretest and Posttest Knowledge

Knowledge Score	Pretest		Posttest	
	Frequency	%	Frequency	%
0	0	0	0	0
1	0	0	0	0
2	0	0	0	0
3	1	4.2	0	0
4	2	8.3	0	0
5	4	16.7	4	16.7
6	5	20.8	6	25.0
7	10	41.7	5	20.8
8	2	8.3	9	37.5
Total	24	100	24	100

As displayed in Table 4, the mean (average) score for knowledge increased on the posttest immediately after participating in the educational session. The paired pretest and posttest difference was statistically significant for knowledge at the .05 significance level (Table 5). Additionally, a paired *t* test was conducted to compare pretest and posttest confidence. As shown in Tables 4 and 5, there was a slight decrease in posttest confidence scores, but this difference did not reach statistical significance. The confidence result was not anticipated; however, on further reflection, the result makes sense as increasing confidence is more likely achievable with tangible hands-on experience, which the classroom setting did not provide.

Table 4

Descriptive Results for Knowledge and Confidence

		Pretest		Posttest	
Outcome	*N*	Mean	*SD*	Mean	*SD*
Knowledge	24	6.125	1.296	6.792	1.141
Confidence	24	18.875	2.365	18.250	4.589

Table 5

Paired Sample t Test Results for Knowledge and Confidence

	Paired differences							
				95% Confidence Interval				
Outcome	Mean	*SD*	Std. error mean	Lower	Upper	*t*	*df*	Sig. (2-tailed)
Knowledge	-.667	1.435	.293	-1.272	-.061	-2.277	23	.032*
Confidence	.625	4.189	.855	-1.144	2.394	.731	23	.472

*Statistically significant at 0.05.

The recovery-oriented care project has substantial implications for positive social change for individuals, communities, and institutions/systems. Project findings indicated

staff discomfort and lack of knowledge with recovery-oriented concepts. Findings also confirmed staff reports, patients' complaints, and the agency's position that recovery-oriented care is lacking on the inpatient psychiatric units. Educating staff and providing ongoing training on recovery-oriented care and psychoeducational groups will benefit patients, staff, and the agency. Vreeland (2012) stated that psychoeducational groups help patients make behavioral changes that can contribute to improving compliance with treatment. A team that is knowledgeable and competent in conducting recovery-oriented psychoeducational groups is more likely to provide a safe and structured patient-centered inpatient environment. The agency's strategic goals of providing the highest quality care are realized by improving patient outcomes and decreasing recidivism rates. Implementing recovery-oriented care has the potential to benefit the other two inpatient units, while also improving the therapeutic relationships and the care that patients receive on those units by providing an environment enriched by psychoeducation. According to Vreeland, staff facilitating psychoeducational groups must possess the skills to guide the team and provide a strong educational element. Having a competent staff is critical to conducting psychoeducational groups and implementing recovery-oriented care.

Recommendations

For staff to achieve and sustain knowledge and confidence in recovery-oriented care and conducting psychoeducational groups, a solid action plan for continued learning is required. The recommendations are as follows:

1. Provide ongoing and mandated trainings for all nursing staff. Provide staff with protected time to attend trainings.

2. In addition to immediate posttraining evaluations, incorporate longitudinal program evaluations to inform sustained learning and confidence in conducting recovery-oriented psychoeducational groups.
3. Implement future projects involving education for recovery-oriented care and psychoeducational groups on all three inpatient psychiatric units.
4. Integrate classroom and experiential learning opportunities based on adult learning theory.

These recommendations along with plans for dissemination will be shared with the key stakeholders within the organization along with the Action Plan and Competency Sheet (Appendices B and C).

Contributions of the Doctoral Project Team

While a formal project team was not utilized to conduct this capstone, key stakeholders (including the service area Associate Chief Nurse, Clinical Nurse Specialist, members of the psychiatric interdisciplinary team, and the Associate Chief Nurse for Research) were fully engaged from the inception of the project. The cumulated experience working with numerous key stakeholders with varying levels of buy-in was a revelation for me. The organization attempted to implement recovery-oriented care in 2013, which was unsuccessful. Staff working on the acute inpatient psychiatric units had limited knowledge of how recovery-oriented care relates to mental illness. The key stakeholders collaborated throughout the early planning stages and the duration of this project. Key stakeholders conducted a gap analysis and concluded that the absence of a recovery model and lack of psychoeducational groups was an area for QI efforts. The

stakeholders were engaged from the very beginning by assisting, providing guidance, and working in collaboration, to develop a solidified plan to help educate the staff on the inpatient psychiatric unit. The next step was to share the outcomes with other stakeholders and discuss expanding the project to the other inpatient units. Because this project resulted in an increase in nursing staff knowledge, key stakeholders agreed to extend the project to the other two psychiatric inpatient units. Furthermore, because confidence overall did not have a significant improvement, experiential learning opportunities will be built into the training for all three units. Future directions include having nursing staff observe psychoeducational groups conducted by a psychologist prior to conducting groups on their own. The nursing staff conducting the group will receive honest and constructive feedback to help them improve their group facilitation skills.

The team members were very helpful and identified the gap in practice and the need to improve care delivered to psychiatric patients by implementing recovery-oriented care. All members worked hard and fully participated in discussing the project's implementation. The group decided that future recovery-oriented training will utilize adult learning principles and include experiential learning. A one-time training is not sufficient for improving the nursing staff's level of confidence in conducting psychoeducational groups.

Strengths and Limitations of the Project

The main strength of the project was utilizing adult learning theory in designing and delivering the educational training. The use of focused discussion using real life

situations to reinforce principles enabled the staff to self-direct the conversation and openly discuss their concerns and fears while understanding the concept of recovery-oriented care and psychoeducation groups. Staff commented that they felt comfortable having the roundtable discussion. The atmosphere was conducive to learning and the staff actively participated.

A limitation of the project was that the training was only offered to staff on one inpatient psychiatric unit and not all staff members were able to participate. Protected time was given to unit nursing staff to attend the training; however, 10 staff members were on extended leave and were not able to participate in the educational session. Future educational trainings focused on recovery-oriented care and psychoeducational groups should be implemented with all nursing staff on all three inpatient psychiatric units using the adult learning theory.

A second limitation was that the intervention was delivered as a single educational session in a classroom setting. While the teaching approach was grounded in adult learning principles and resulted in improved staff knowledge, it is recognized that confidence is more likely to improve with experiential learning. Benner (1984) states that there are five levels of skill acquisition that a nurse transitions through to achieve expertise. All nurses begin as novices and gain expertise through clinical experience and knowledge acquisition. Currently, a little over half (58.3%) of the nursing staff self-identify as having none to minimal experience (i.e., are novices) in conducting psychoeducational groups. While not everyone reaches the expert level (Benner, 1984), it is anticipated that the more groups staff facilitate, the more likely their skill level and

confidence will improve. Future education should include hands-on experiential training in conducting psychoeducation groups.

A final limitation is the timing of the pretesting and posttesting. A stronger design is to evaluate sustainability of learning and confidence over time. Given the scope of the project, longitudinal data collection was not incorporated. Recovery programming is an ongoing quality improvement initiative and linked to the organization's strategic plan; as such, learning opportunities (both in the classroom setting and hands on experience in conducting groups) and longitudinal program evaluation are recommended and included in the action plan developed as a part of this project.

Section 5: Dissemination Plan

The outcome of this recovery-oriented care training will be shared with the key stakeholders within the institution. The key stakeholders will be informed that the nursing staff members who received the training were able to score better on the knowledge posttest. The results of this project proved useful in adding quality improvement evidence to the field of nursing, especially on matters of recovery-oriented care in mental health. Per stakeholder buy-in and commitment, the recommendations from this project will be applied to all three inpatient mental health units in the organization to improve nurses' training regarding recovery-oriented care of mentally ill patients. The findings and recommendations from this study will be disseminated through additional internal facility trainings, workshops, and seminars to provide ongoing education to train nurses on recovery-oriented care and psychoeducational groups.

There are opportunities to share the results of this project to the local and national community beyond facility level dissemination. I plan to submit an abstract to the Greater Pittsburgh Nursing Research Conference held annually in the region's area. Additionally, I plan to share the findings at the national Veterans Administration (VA) level with the VA Office of Nursing Services mental health clinical advisor.

Analysis of Self

Developing, implementing, and analyzing the results of this recovery-oriented care project was a challenging process that has elevated my ability to implement an evidence-based project to change practice and improve patient outcomes. I was a novice starting out, unaware of the rigor of the process. However, as my knowledge expanded, I

gained a greater understanding of the importance of the institutional review board and the cumbersome but necessary process for attaining approval. My passion for psychiatric nursing and advocating for patients with mental health kept me motivated and engaged in this project as I realized how beneficial this project would be for mental health patients and staff. On the other hand, I was disappointed by my lack of knowledge of recovery-oriented care and my failure in leading the staff toward recovery-oriented care beforehand. My extensive research, my work with other disciplines, and my preceptor helped strengthen my leadership and management skills. I am now able to recognize the value of a recovery-oriented environment and the positive impact it has on the well-being of psychiatric patients and staff. The knowledge and insight I have gained through this experience have equipped me for my future role as a DNP nurse, my work as a lifelong learner, and the responsibilities that come with that title, such as helping to change clinical practice and implementing evidence-based projects to improve patient outcomes and provide educational opportunities for staff.

Summary

Mental health patients face numerous daily challenges such as dealing with stigma and other inadequacies as they strive to manage their mental illness. When confronted with a mental health crisis, this vulnerable population requires quality care with a patient-focused approach. This occurs through developing trusting partnerships with the staff to help them obtain the necessary tools and resources to handle crisis situations and to assist patients in returning to their optimal stage of performance. Recovery-oriented care is a holistic approach that embraces several interrelated pieces

that create the foundation of patient-centered care. Psychoeducational groups are a major component of recovery and are the driving force for educating psychiatric patients on a variety of health and related social issues. According to Vreeland (2012), psychoeducational groups decrease relapse and recidivism rates while improving medication compliance and patient satisfaction by allowing shared decision-making. Providing quality care for psychiatric patients requires a staff that is knowledgeable, comfortable, and confident with conducting psychoeducational groups. Recovery-oriented care and psychoeducational groups improve patients' comprehension and level of understanding regarding their mental illness (Vreeland, 2012). However, when staff members lack knowledge and confidence in implementing recovery-oriented care, the potential exists to negatively impact patients participating in noneffective groups. A lack of knowledge and confidence among staff can be modified with proper training. Ongoing training is the key for helping staff increase their level of confidence in conducting psychoeducational groups with a vulnerable mental health population. This training offered in this project proved to be a successful strategy in the ongoing goal for implementing recovery-oriented care for the psychiatric patients in this facility.

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Appendix A: Questionnaire

Demographic Information: (Please circle the following questions about yourself).

1. Gender: Male Female
2. Current Position: RN LPN NA

Level of Experience (Please circle the level that best describes your training or experience).

3. Level of formal training in conducting psychoeducational groups:

   None Minimal Moderate Extensive

4. Level of experience working with psychiatric patients:

   None Minimal Moderate Extensive

5. Level of formal training in Recovery-oriented Care:

   None Minimal Moderate Extensive

Clinical Knowledge and Intervention Skills Assessment: (Answer the following questions based on your current knowledge regarding the topics presented. Even if you are unsure please provide an answer for each question asked).

6. Which is recovery-oriented care?
   a) Provides continuity of care
   b) Assist patients with returning to their optimal level of functioning
   c) Help patients learn positive coping strategies
   d) All of the above
7. How do you manage a disruptive patient in a group setting?
   a) Allow the patient to continue to be disruptive

b) Remove the patient from the group

c) Redirect the patient

d) None of the above

8. What is the purpose of recovery-oriented care?

a) Decrease readmission rate

b) Improve patient satisfaction

c) Promote a therapeutic environment

d) All the above.

9. What are the components of group dynamics?

a) Structure

b) Process

c) Function

d) All of the above

10. What is the purpose of psychoeducation al groups?

a) Increase knowledge about a particular topic

b) Provide information

c) Conduct therapy with the patient

d) A and B

e) None of the above

11. How many people are considered a group?

a) One

b) Two

c) Three

12. What are the barriers preventing recovery-oriented care?

a) Multiple admissions/discharges

b) Lack of teamwork

c) Lack of knowledge regarding recovery-oriented care

d) Lack of staff

e) All of the above

13. What are four basic therapeutic skills?

a) Reflective Listening, Open-ended Questions, Affirming, Summarizing

b) Reflective Listening, judgmental, sympathetic, confirming

c) Open-ended Questions, subjective questions, acknowledging

d) A and B

e) All of the above

Table A1

Provider Confidence (Please Check the Level That Best Describes Your Confidence at This Time)

Question	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I am confident in my ability to successfully implement recovery-oriented care.	☐	☐	☐	☐	☐
I am confident in my ability to successfully conduct psychoeducational groups.	☐	☐	☐	☐	☐
I need more education on how to conduct psychoeducational groups.	☐	☐	☐	☐	☐
I am confident that my current environment is conductive for implementing recovery-oriented care.	☐	☐	☐	☐	☐
I am confident that my peers will support a recovery-oriented environment.	☐	☐	☐	☐	☐

Appendix B: Psychoeducational Group Competency

	Assessment Method				Remediation			
COMPETENCY	Observation of Practice (Initial and Date)	Demonstrates or verbalizes knowledge (Initial and Date)	Mock event, drill or simulation (Initial and Date)	Test/Quiz (Initial and Date)	Competency Level	Training Method	Competency Level	Initials of rater (preceptor, supervisor, or expert) and Date
Psychoeducational Group COMPETENCY								
Staff able to identify appropriate material for psychoeducational groups.								
Staff describe process for conducting psychoeducational groups?								
Did the staff member announce the group topic/time and location to the patients?								
Were ground rules discussed at the beginning of the group?								
Was the staff member able to facilitate the group and manage any disruptive behavior?								
Did the staff member have all group participants sign in?								
Did the staff member document the group correctly, including type of group, participation and any relevant information in the computerized patient record?								

Appendix C: Recovery-Oriented Care Action Plan

Recommendation	Plan of action	Responsible person(s)	Target date(s)	Status of actions
Provide ongoing training on recovery-oriented care utilizing the adult theory approach.	Every six months a recovery-oriented training will be conducted for staff on all three inpatient psychiatric units.	Managers, assistant managers and nurse educator	6/1/2017	Plan was reviewed with the major stakeholders within the organization.
All psychiatric staff will observe a psychoeducational group conducted by the psychologist, manager or the clinical nurse specialist. Staff will complete 3 return groups and be evaluated as competent or incompetent with conducting groups. Remedial training is to be provided for staff considered to be incompetent in group facilitation.	All staff will observe and conduct three psychoeducational groups. Unit champions will be identified and will help provide additional training to staff and new employees. Staff will be observed conducting three groups on three different days. During the observation staff will be evaluated on their capability of managing and facilitating group dynamics. Competency will be determined after three successful groups.	Psychologist, unit managers and clinical nurse specialist	3/10/2017	Plan was reviewed with the major stakeholders within the organization.
Managers will continue to monitor the number of psychoeducational groups being conducted every month	Each unit will have a programming schedule and will have groups assigned by all level of staff every shift.	Unit managers and assistant managers	1/10/2017	Plan was reviewed with the major stakeholders within the organization.