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Towards evidence-based nursing in psychiatric inpatient care

Attitudes and experiences among patients and staff

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Abstract
Salberg, J. 2022. Towards evidence-based nursing in psychiatric inpatient care. Attitudes and experiences among patients and staff. *Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine* 1811. 58 pp. Uppsala: Acta Universitatis Upsaliensis. ISBN 978-91-513-1414-3.

Nursing in psychiatric inpatient care is shadowed by a strong medical perspective and roles and responsibilities within nursing are unclear. Implementation of nursing research and theories through evidence-based practice (EBP) is crucial to high-quality nursing. Steps Towards Recovery (STR) is a nursing programme focusing on the individual recovery process, a key theoretical basis for nursing in psychiatric and mental health care. The overall aim of this thesis was to explore aspects of nursing in connection to implementation of STR in psychiatric inpatient wards. A descriptive, comparative study (Study I) of patients' and staff members' experiences of STR and implementation of the programme was conducted in Dalarna, where STR was initially implemented. According to the results, patients were mostly positive and experienced that STR contributed positively to their care. Staff members were also positive towards STR and considered the programme to contribute to positive development of nursing care. Study II explored staff members' understandings of nursing in psychiatric inpatient care. Results showed that nursing was understood in qualitatively different ways, with varying degrees of connection to the theoretical basis of nursing. Staff members' experiences of stress, quality of care and satisfaction with nursing care and work were explored in a quasi-experimental study (Study III) comparing ratings between reference wards and STR wards, before and after STR implementation. Higher ratings in two dimensions of quality of care were found in the STR group after implementation. Positive experiences of the programme were reported from staff at the STR wards. Attitudes towards and experiences of EBP and STR were explored in a mixed method study (Study IV), with results indicating that although attitudes were positive, EBP was insufficiently implemented in clinical nursing care and the responsibility for EBP was unclear. In summary, nursing in psychiatric inpatient care can be understood in a variety of ways. Even so, attitudes towards EBP in nursing were positive, but EBP implementation in clinical nursing work was considered to be lacking. STR is an example of EBP in nursing and the programme was positively received by patients, staff and nurse managers.

Keywords: Nursing, Psychiatric inpatient care, Evidence-based practice, Recovery, Recovery-oriented practices

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To Felicia and Elliot
- follow your dreams

List of Papers

This thesis is based on the following papers, which are referred to in the text as Studies I–IV.

I. Salberg, J., Folke, F., Ekselius, L. and Öster, C. (2018) Nursing staff-led behavioural group intervention in psychiatric in-patient care: Patient and staff experiences. *International Journal of Mental Health Nursing, 27*, 1401-1410.

II. Salberg, J., Bäckström, J., Röing, M. and Öster, C. (2019) Ways of understanding nursing in psychiatric in-patient care – A phenomenographic study. *Journal of Nursing Management 27*:8, 1826-1834.

III. Salberg, J., Ekselius, L., Hursti, T. and Öster, C. Staff experiences related to implementation of a recovery-oriented nursing programme in psychiatric inpatient care (under review).

IV. Salberg, J., Ekselius, L., Hursti, T. and Öster, C. Evidence-based practice in psychiatric in-patient care – attitudes and experiences from a nursing perspective (submitted).

Contents

Abbreviations

BA	Behavioural Activation
EB	Evidence-based
EBP	Evidence-based practice
EBPAS	Evidence-Based Practice Attitudes Scale
MBI	Maslach Burnout Inventory
NA	Nursing assistant
QPC	Quality of Psychiatric Care
QPC-IPS	Quality of Psychiatric Care – In-Patient Staff
RN	Registered nurse
ROP	Recovery-oriented practices
SMÅ	Steg Mot Återhämtning
SN	Specialised nurse
SNCW	Satisfaction with Nursing Care and Work scale
STR	Steps Towards Recovery
WHO	World Health Organization

Introduction

Psychiatric care

The World Health Organization (WHO) emphasises mental health as a fundamental component within the definition of health (World Health Organization, 2013). In Sweden, mental ill health is widespread and impacts society in a negative way. The most vulnerable persons and those with the greatest difficulties are cared for in specialised psychiatric care settings (Mission Mental Health, 2021). Within the WHO member states, mental health services are delivered in a variety of settings, including outpatient facilities, day care facilities, community-based facilities for residential care, psychiatric hospitals and psychiatric wards in general hospitals (Lora, Hanna, & Chisholm, 2017; World Health Organization, 2021). Community care is considered the most effective form of care for persons with chronic mental disorders in terms of cost-effectiveness, outcome, quality of life and reduction of stigma. However, such care facilities are not suitable for all patients; for persons suffering from acute mental illness, psychiatric inpatient facilities are essential components in the care process (Jacob et al., 2007). Psychiatric care in Sweden is provided by primary care and in hospitals. Persons with severe mental ill health are cared for in general hospitals, where psychiatric inpatient care and outpatient services are delivered. In 2020, 57,787 individuals in Sweden were admitted and cared for in psychiatric inpatient care. The total number of care days during that year was 890,907 (Mission Mental Health, 2021).

Psychiatric inpatient care

Patients admitted to psychiatric inpatient units are given medical treatment and nursing care. However, the interventions provided vary considerably between different care facilities (Mullen, 2009). Previous research shows that patients experience a long waiting period when receiving care in psychiatric inpatient units, where they spend a good deal of time in social disengagement (Lindgren, Aminoff, & Graneheim, 2015; Molin, Graneheim, & Lindgren, 2016; Radcliffe & Smith, 2007; Sharac et al., 2010). Being cared for by others in a mental health facility can be experienced as alienating and confusing, which can create difficulties for a patient to understand the content and

meaning of care (Johansson & Eklund, 2003; Lilja & Hellzén, 2008; Molin et al., 2016). The patient-staff interaction is important. However, a disease-oriented focus, limited time and the insecurity and inability of staff members to master their own feelings are considered to be factors preventing positive interactions (Lilja & Hellzén, 2008; Molin et al., 2016). Paternalism and feelings of being exposed to a power structure are evident (Bladon, 2017; Molin et al., 2016). Nursing in psychiatric inpatient care is often associated with a care culture promoting safety through rules and routines (Salzmann-Erikson, 2017). This care context has been described as a setting where activities such as observation, reactive action and risk management are preferred to person-centred planning and interaction (Mullen, 2009). Hence, care can be experienced as an alleviation from suffering but also a trap, based on feelings of being controlled and a lack of choice and involvement (Johansson, Skärsäter, & Danielson, 2009). Low levels of involvement and activity for patients have been reported from a nursing staff perspective as well (Tuvesson & Eklund, 2017). Even so, patient involvement and nursing interventions that support patients are underlined as important factors in the patients' recovery process (Pitkänen, Hätönen, Kuosmanen, & Välimäki, 2008; Shattell, Andes, & Thomas, 2008). Higher levels of interaction between patients and nursing staff and higher levels of social and therapeutic activities improve clinical results and wellbeing for patients who suffer from psychiatric diseases (Sharac et al., 2010). According to patients, a supporting nursing intervention involves empowering conversations (a powerful medium to engage and influence others), where the nursing staff members show a genuine interest, empower and give patients the possibility to strengthen their own autonomy. These conversations can, according to patients, be held individually or in a group setting (Pitkänen et al., 2008). Some explanations are commonly put forward as to why certain interventions (e.g., psychosocial interventions) are not being provided. They include lack of knowledge, skills and time, shortage of resources, the complexity of the setting and the individual status of patients (Mullen, 2009). However, these explanations do not change the fact that involvement and contact between patient and staff are important components of recovery and high-quality care (Pitkänen et al., 2008; Schröder, Ahlström, & Larsson, 2006). Despite these difficulties, several attempts have been made to implement and evaluate nursing interventions in psychiatric inpatient care and have shown promising results for both patients and staff members. The studies have involved a broad variety of nursing interventions, such as psychosocial interventions (Molin, Lindgren, Graneheim, & Ringnér, 2018; Sharp, Gulati, Barker, & Barnicot, 2018), psychological or psychotherapeutic skills (Berry et al., 2016; Kelly, Jayaram, Bhar, Jesto, & George, 2019), measures to reduce conflict, violence and escalating situations (Aremu et al., 2018; Björkdahl, Hansebo, & Palmstierna, 2013; Bowers et al., 2015) and the use of sensory rooms (Björkdahl, Perseius, Samuelsson, & Lindberg, 2016).

Health care staff in psychiatric inpatient care

A number of different kinds of professionals, e.g., nurses, physicians, psychologists and social workers, contribute with their specific knowledge to inpatient care for persons in need of specialised psychiatric care. However, health care staff on psychiatric inpatient wards for the most part consists of nursing staff. Often, more high school-educated nursing assistants (NAs) than registered nurses (RNs) are employed at such wards. In Sweden, RNs hold a bachelor's degree in nursing. Clinically experienced RNs can complete a post-graduate, post-registration programme in specialist nursing to gain the title specialist nurse (SN; for instance in psychiatric/mental health nursing), a graduate diploma and/or a one-year master's degree (Swedish Council for Higher Education, 1993). Registered nurses without specialist education make up the majority of nurses employed in Swedish psychiatric inpatient care (Mission Mental Health, 2021). Registered nurses are responsible for nursing care and all parts of the nursing process, although nursing actions can be carried out by other employees with relevant education and knowledge, such as NAs (Gabrielsson, Salberg, & Bäckström, 2021; Holmberg, Caro, & Sobis, 2018). Both recruitment and retention of RNs in psychiatric care have been shown to be challenging (Harrison, Hauck, & Ashby, 2017). Important aspects that have been identified as potentially increasing RNs' interest in this specialist field include reduced stigmatisation of nursing in psychiatric care and clarification of the professional role (Harrison et al., 2017). Clarification of the professional role has recently been shown to be particularly important, as not even employers seem to know what they are looking for when recruiting (Gabrielsson et al., 2021).

Nursing as a profession in psychiatric care

Psychiatric care is a specialty dominated by a medical perspective in which nursing has been described as having a marginalised status (Bladon, 2017). Theories and models of psychiatric nursing have been difficult to implement because of the tendency of nurses to try to fit into the system (Barker, 2001; Bladon, 2017). Nursing in the context of psychiatric care has even been described as a 'zombie category', at risk of losing its conceptual and explanatory power (Lakeman & Molloy, 2017). According to Barker (2003), there is uncertainty in where the line between medical treatment and nursing should be drawn. However, there are also factors within the nursing profession which have been identified as contributing to this process, such as lack of leadership and failure of the nursing practice (Lakeman & Molloy, 2017). According to previous research, nursing care and the different roles and responsibilities for members of the nursing staff lack definition. This can lead to uncertainties and difficulties for RNs in handling their professional role

(Berg & Hallberg, 2000; Holmberg et al., 2018) and leading nursing care in accordance with the nursing process as intended (Swedish Association of Psychiatric and Mental Health Nurses, 2014; The Swedish Society of Nursing, 2017).

Evidence-based practice in nursing

Evidence-based practice (EBP) is a term used to describe the use of nursing research in clinical nursing practice (Ingersoll, 2000). Research and theory within the area of psychiatric and mental health nursing contributes substantially to delivery and development of health care (Gabrielsson, Tuvesson, Wiklund Gustin, & Jormfeldt, 2020). Registered nurses are usually educated in and positive towards EBP (Saunders, Stevens, & Vehviläinen-Julkunen, 2016; Warren et al., 2016) and should be active in developing evidence-based (EB) nursing (International Council of Nurses, 2012). However, they consider their ability to implement EBP as extremely low (Warren et al., 2016) and rarely use EB data in their decision-making (Stokke, Olsen, Espehaug, & Nortvedt, 2014). A phenomenographic study of nurses' understandings of working with EBP in a surgical setting has further illuminated this, as the results showed three widely varying understandings: from it being difficult to understand and use, to it being the nurses' responsibility to lead (Karlsson, Gunningberg, & Jangland, 2019). Leadership plays a key role in health care organisations and the importance of nurse managers' leadership in relation to EBP in nursing has been identified in previous research (Kueny, Shever, Lehan Mackin, & Titler, 2015; Sandström, Borglin, Nilsoon, & Willman, 2011), indicating that empowerment, support, being accessible and striving towards shared governance for RNs are important aspects.

The concept of recovery

Recovery is a central concept within psychiatric inpatient care, though it has been conceptualised in a number of ways over the years (Collier, 2010). Two overarching perspectives can be seen: medical recovery or recovery as a personal process of change (Collier, 2010; Noordsy et al., 2002; Schrank & Slade, 2007; Tuffour, 2017). A widely accepted definition of personal recovery was proposed by Anthony (1993), where recovery is seen as a unique and personal process involving change and development. This comprises changes of attitudes, feelings, values, goals and skills. These changes are crucial to reclaim oneself and to live a satisfying life, even when illness is causing limitations in everyday life. One theoretical model for nursing in psychiatric care, focusing on recovery, is the Tidal Model, which emerged

from a study of the need for psychiatric nursing. This recovery model for the promotion of mental health focuses on person-centredness and empowerment (Barker, 2001), in which interactions and interpersonal relations (Peplau, 1991) are central. The individuals' lived experiences are respected and the reason for admission to psychiatric inpatient care is seen as a consequence of difficulties that the individual and those close to that person have encountered in life, not solely the result of a disease. Buchanan-Barker and Barker (2008) emphasised that the focus of the model was on enabling living a constructive life even under difficult circumstances. The authors stated that nursing staff members should help patients use their capacity for change, with the patients being in control of the process. Engagement is fundamental to the process and should be achieved in ways that mirror the individual's needs. The concept of personal recovery and various aspects of the process are regarded as relevant in several psychiatric contexts, such as forensic care settings (Pollak, Palmstierna, Kald, & Ekstrand, 2018) and inpatient wards caring for persons with a variety of different symptoms and diagnoses (Leamy, Bird, Boutillier, Williams, & Slade, 2011). It is important that the theoretical concept of recovery is adopted into clinical nursing work. One way of getting there is through education. Possible areas for educational development in advanced level mental health nursing have been identified (Stickley et al., 2016). If it were included in education curricula, the likelihood of this view of recovery being adopted in clinical nursing might increase.

Recovery-oriented practices in nursing

Recovery-oriented practices (ROP) are an example of EBP in psychiatric and mental health nursing (Coffey, Hannigan, & Barlow, 2019; De Ruysscher, Vandevelde, Tomlinson, & Vanheule, 2020; Waldemar, Arnfred, Petersen, & Korsbek, 2016). In psychiatric inpatient care, ROP have become a more integrated part of nursing in recent years. They differ from medical models of care by a distinct focus on each individual patient's recovery, rather than focusing only on mental illness and symptoms (Chester et al., 2016). Implementation of ROP and recovery-oriented models and programmes in psychiatric inpatient care is being performed worldwide. It has been reported to be feasible, although somewhat challenging (Lorien, Blunden, & Madsen, 2020; McKenna et al., 2014; Waldemar et al., 2016). For example, an observational study in the context of psychiatric inpatient care explored ROP in interactions between patients and staff members. The results were described in the theme 'as-if collaboration', which included subthemes of negotiation, demands, guidance, decisions, control and condescending communication. It was concluded that ROP are reflected rhetorically, but at risk of being ignored due to competing demands in a firm organisation (Waldemar, Esbensen, Korsbek, Petersen, & Arnfred, 2018).

Steps Towards Recovery

Steps Towards Recovery (STR) is a manual-based nursing programme initially developed in Dalarna, Sweden (Folke et al., 2015). It was adapted from principles of behavioural activation (BA), a form of cognitive behavioural therapy (Kanter et al., 2010; Martell, Dimidjian, & Herman-Dunn, 2013). Behavioural activation is a psychological intervention with the goal to increase participation in activities that promote positive reinforcement and decrease avoidance and ruminating behaviour (Kanter et al., 2010). Based on empirical research, BA is a promising intervention in psychiatric inpatient care. It can be used in the treatment of patients with a variety of diagnoses (Banducci, Lejuez, & MacPherson, 2013; Clignet, van Meijel, van Straten, & Cuijpers, 2012; Clignet, van Meijel, van Straten, Lampe, & Cuijpers, 2012; Folke et al., 2015; Folke et al., 2015; Gollan, Hoxha, Hanson, & Perkins, 2014; Snarski et al., 2011). Interventions based on BA can be practiced by nurses and other staff members (Clignet, van Meijel, van Straten, & Cuijpers, 2012; Clignet, van Meijel, van Straten, Lampe, et al., 2012; Cuijpers et al., 2011; Ekers et al., 2014; Folke et al., 2015).

The specific objectives of STR are to support the patient in the process of recovery and in taking responsibility for their own recovery. This is achieved by raising awareness and engagement, and by enabling behavioural change. The method is also to be used as an overall approach in nursing at psychiatric inpatient wards. The structure of the programme rests on a weekly schedule, with daily group sessions on weekdays. Each session has a specific theme (Figure 1), with associated work sheets for the patients. The group sessions are open for all admitted patients who, depending on their situation, can choose to participate occasionally or more frequently. The atmosphere during the sessions is a crucial part of the treatment process and is therefore discussed at the start of each session.

Figure 1: The fives themes included in Steps Towards Recovery.

Implementation of STR

Prior to implementation at the psychiatric clinic at Uppsala University Hospital, the STR material was further developed regarding feasibility, wording and comprehensiveness, together with a user representative employed at the hospital clinic. An STR education was designed, covering theoretical and practical activities: the theory of recovery as a personal process, the themes, the material and how to lead STR activities. The education was divided into four two-hour blocks and led by two experienced nurses specialised in psychiatric care. The implementation of STR was designed in several steps. First, one or two staff members at each intervention ward were given the role as STR coach, underwent the education and then guided and supported fellow staff members in their work with STR, as group leaders or auxiliaries. Second, all staff members at the five wards took part in the education, Third, all coaches shared reflections, tips and strategies at joint meetings, twice a month, and ward managers met once a month. The project leader and a user representative attended all these meetings. Lastly, to promote commitment to the programme, a web-based education was designed to be used as a resource and introduction for new employees.

Rationale

Psychiatric inpatient care is an important care setting for persons suffering from severe mental ill health. The status and quality of nursing in psychiatric inpatient care have been reported to be low, with an evident lack of nursing research and theory linked to the clinical nursing work. Experiences from both patients and staff informs us that this care context can be confusing and may lack content that creates meaningful care. Taken together, this indicates that something has to be done. Hence, STR saw the light of the day and initial evaluations in Dalarna were promising (e.g., Study I in this thesis). These positive results and the identified importance of development within nursing care raised an interest to explore STR as a nursing programme in psychiatric inpatient care further. A decision was made to implement STR at the psychiatric clinic in Uppsala. A scientific evaluation of different aspects of nursing in connection to the implementation was needed.

Aims

The aim of this thesis was to explore aspects of nursing care in connection to implementation of a recovery-oriented nursing programme on psychiatric inpatient wards. The main focus was on staff members' understandings of nursing, their attitudes towards the nursing programme and towards EBP and their experiences of stress, quality of care and job satisfaction. Patients' experiences of the nursing programme were also a part of this thesis.

The specific aims of each study are listed below.

- The aim of Study I was to evaluate patients' and staff members' experiences of a nursing staff-led behavioural group intervention, based on BA, in mental health inpatient care. Specific aims were to investigate (i) patients' experience of the intervention and how the intervention affected their care, (ii) staff members' experiences of the implementation and how the intervention affected the nursing care, and (iii) comparisons between subgroups of both patients and staff and their experiences.

- Study II aimed to describe the various ways that nursing staff in psychiatric inpatient care understand nursing.

- The aim of Study III was to explore the experiences of the recovery-oriented nursing programme STR among nursing staff, as well as their ratings of stress, quality of care and satisfaction with nursing care and work, before and after implementation. A second aim was to compare these results with the ratings of nursing staff on wards where the nursing programme was not implemented.

- Study IV aimed to describe attitudes towards and experiences of EBP in nursing in general and in conjunction with implementation of a recovery-oriented nursing programme in psychiatric inpatient care. Three different perspectives were explored: nursing staff members' attitudes towards EBP before and after implementation of STR, nurses' experiences of working with EBP in nursing in general and of STR and nurse managers' experiences of EBP in general and of STR.

Methods

Design

Various research designs and methodologies have been used in the studies in this thesis. Both quantitative, qualitative and mixed-method research are represented. Study I had a descriptive and comparative design, with a quantitative research approach. Study II was a descriptive study with a qualitative research approach. Study III was quasi-experimental, using a prospective, pretest-posttest design. Study IV was a mixed method study with a convergent parallel design, including both qualitative and quantitative research. An overview of the four studies is presented in Table 1.

Table 1: *Overview of the studies included in the thesis.*

Study	Design	Participants	Data collection	Analysis
I	Descriptive, comparative design	Patients n = 84 Staff members n = 34	Self-administrated questionnaires	Statistical analyses
II	Descriptive design	SNs n = 3 RNs n = 3 NAs n = 10	Individual, semi-structured interviews	Phenomenographic analysis
III	Quasi-experimental, prospective, pretest-posttest design	STR wards: Pre n = 49 Post n = 40 Reference wards: Pre n = 26 Post n = 30	Questionnaires (MBI) (QPC-IPS) (SNCW)	Statistical analyses
IV	Mixed method, convergent parallel design	Questionnaire: Pre n = 49 Post n = 40 Focus group Interviews: n = 5 Individual interviews: n = 3	Questionnaire (EBPAS) Focus group interviews Individual semi-structured interviews	Statistical analyses Focus group analysis Qualitative content analysis

Note. SN: Specialised nurse; RN: Registered nurse; NA: Nursing assistant; STR: Steps Towards Recovery; MBI: Maslach Burnout Inventory; QPC-IPS: Quality in Psychiatric Care – In-Patient Staff; SNCW: Satisfaction with Nursing Care and Work scale; EBPAS: Evidence-Based Practice Attitudes Scale.

Procedures

Study I

A recovery-oriented nursing programme, STR, was implemented in a public hospital setting in Dalarna, Sweden. Implementation was conducted at three acute general psychiatric inpatient wards where both male and female adult patients were cared for. Voluntary and compulsory admissions were accepted. Data collection started when staff members on the wards had been responsible for STR during a period of at least six months.

The starting point for Studies II–IV was a decision made by the head of the psychiatric department at Uppsala University Hospital, Sweden. The department's clinic comprised eight psychiatric inpatient wards for adults at baseline and seven at follow-up. Wards were sub-specialised in psychotic disorders, mood disorders, substance use disorders linked to pain-related conditions, substance use disorders or forensic care. The wards accepted both voluntary and compulsory admissions. Both males and females over the age of 18 years were cared for in all of the wards. Nursing staff at the wards include SNs, RNs and NAs. The decision was made to implement STR at five of the university hospital's eight psychiatric inpatient wards, starting in August 2017.

Study II

The study was conducted at all eight psychiatric inpatient wards. Data collection was conducted before implementation of STR. Information and invitation to participate in the interview study were given in connection to the gathering of baseline data for Studies III and IV.

Study III

Both baseline and follow-up data were gathered at all wards. Eight wards at baseline and seven at follow-up, due to organisational changes. The wards where STR was not implemented were used as a reference for clinic-wide changes over time.

Study IV

The study was conducted at the five STR wards. Wards were sub-specialised in psychotic disorders, mood disorders or substance use disorders linked to pain-related conditions. Data for the quantitative part of the study were collected before and after implementation. Focus group interviews and

individual interviews were conducted after implementation of STR. Information and invitations to participate in focus group interviews were sent out along with the questionnaires for follow-up data used in Studies III and IV. Nurse managers were contacted and informed separately.

Participants

Study I

All patients discharged from the wards and all nursing staff working on the wards during the time of data collection were invited to participate. A total of 118 persons (84 patients and 34 staff members) completed the questionnaires. Patients from two of the included wards participated. All three wards were represented among participating staff members (8 nurses (not specified), 26 NAs).

Study II

Nursing staff members from eight psychiatric inpatient wards were invited to participate in Study II. Thirty-four staff members showed initial interest. Within this group, participants were chosen by purposive sampling to ensure a distribution in professional role, sex and age. Sixteen nursing staff members participated (three SNs, three RNs and 10 NAs).

Study III

All nursing staff members at the wards: SNs, RNs and NAs, were invited to participate in Study III. Eligible participants included 130 nursing staff members at baseline and 128 at follow-up. Due to organisational changes, one of the reference wards had been closed at the time for follow-up. A total of 145 booklets with questionnaires were submitted (75 pre and 70 post), with 89 from the STR wards (49 pre and 40 post) and 56 from the reference wards (26 pre and 30 post).

Study IV

For Study IV, all nursing staff members at the wards, SNs, RNs and NAs, were invited to respond to a questionnaire about attitudes towards EBP. Eligible participants included 83 nursing staff members at baseline and 78 at follow-up. A total of 49 staff members returned the questionnaires at baseline and 40 at follow-up. The possibility to participate in focus group interviews was presented to all RNs and SNs (in the study collectively referred to as ‘nurses’) working at any of the five wards. Nurses who provided written consent to participate were contacted personally by the researchers for further

administrative planning of the focus groups. Based on a decision made by the head of the clinic, all enrolled participants could participate in focus group interviews during paid working hours. Nurse managers at the five wards were presented with the opportunity to participate in individual interviews. Three managers accepted participation, they were all SNs with active employment and experience as nurse managers. If participation was accepted, they provided written consent.

Data collection

Study I

The study was based on data gathered over a three-month period in 2016. A self-administered questionnaire was designed specifically for Study I (one version for patients and one for nursing staff). The questionnaires were available in both pen-and-paper format and web-based format. The patient version consisted of background questions and questions on participation in group sessions, session contents and self-reported effects of participating in the sessions. It contained 16 questions. The staff version contained a total of 35 questions, encompassing background questions and questions on the experience of leading group sessions and whether the intervention had any impact on four areas: collaboration, professional development, the content of nursing and the atmosphere at the ward. A seven-point Likert scale was used to capture the respondents' responses regarding their experiences. An invitation to comment followed each scaled question.

Study II

Study II was based on data collected in individual semi-structured interviews conducted from 14 June to 26 September 2017. The interviews were led by one of the study authors who was a SN and PhD, not employed at the clinic. An interview protocol, which had been tested previously, was used. The protocol consisted of background questions and three open-ended questions designed to capture participants' understandings of nursing in psychiatric care. Probing questions were applied to encourage the participants to give detailed and exhaustive descriptions. The duration of the interviews ranged up to 50 minutes. Interviews were coded, audio-recorded and transcribed verbatim.

Study III

Baseline and follow-up data for Study III were collected from 18 April to 31 May 2017 and from 3 February to 17 April 2020, respectively. Booklets with questionnaires were distributed to all nursing staff members at the wards and

staff members who chose to participate provided written consent, filled out the questionnaires, placed them in unmarked envelopes and left them in a box which was emptied by the researchers.

Experiences of working with the nursing programme were assessed through a total of nine questions designed for the study. Questions assessed staff members' earlier experiences of being a group leader, their use of STR and overall experiences of the nursing programme. Staff members were also asked to rate their experiences of the contents of the programme, the material, their experiences of integrating the intervention into nursing care and its contribution to a positive development of nursing care at the wards. Three of the questions were multiple choice and six were answered on a six-point Likert scale (1–6), ranging from 'very bad/negative' to 'very good/positive'. This questionnaire was filled out only by staff members at the intervention wards. *Stress* was assessed using the Maslach Burnout Inventory (MBI). It is a 22-item instrument divided into three sub-scales, each assessing one dimension of burnout: Emotional exhaustion, Depersonalisation and Personal accomplishment (Maslach & Jackson, 1981). The questions are answered on a seven-point Likert scale, ranging from 'never' (0) to 'daily' (6). Higher ratings on Emotional exhaustion and Depersonalisation indicate higher levels of burnout, whereas lower ratings on Personal accomplishment indicate higher levels of burnout. *Quality of care* was assessed with the Quality of Psychiatric Care – In-Patient Staff (QPC-IPS) scale. It is part of a family of instruments originating from QPC (Schröder, Larsson, Ahlström, & Lundqvist, 2010) and comprises 30 items divided into six dimensions: Encounter, Participation, Support, Secluded environment, Secure environment and Discharge. Items are answered on a four-point Likert scale ranging from 'disagree' (1) to 'fully agree' (4). *Satisfaction with nursing care and work* was assessed using the Satisfaction with Nursing Care and Work (SNCW) scale, which comprises 34 statements. Responses are given on a five-point Likert scale ranging from 'fully disagree' (1) to 'fully agree' (5). The responses result in a total score between 34 and 170 (Hallberg, Welander, & Axelsson, 1994).

Study IV

Questionnaire

In Study IV, staff members' attitudes towards EBP were measured using the Evidence-Based Practice Attitudes Scale (EBPAS). This is a standardised questionnaire developed to assess mental health providers' attitudes towards adoption of innovation and EBP (Aarons, 2004). It contains 15 questions answered on a 5-point Likert scale ranging from 0 ('not at all') to 4 ('to a very great extent'), exploring participants' views on EBP and what they need to adopt EBP. The EBPAS contains four dimensions of attitudes: Openness, Divergence, Requirements and Appeal.

Focus group interviews

Two focus group interviews were conducted during May and June 2020, led by a nurse specialised in psychiatric care and observed by a RN, both experienced in psychiatric inpatient care. The first interview included three nurses and the second two nurses. An interview protocol with open-ended questions was used. Questions corresponded to the study aim, and encouraged nurses to discuss their experiences of working with EB nursing and more specifically STR. Probing questions were used to promote greater depth in the discussions. The interviews, lasting 33 and 69 minutes, were audio-recorded and transcribed verbatim. Observational data were collected; the observer was present during the entirety of the focus group interviews, carefully observing and capturing data on interaction and atmosphere during discussions.

Individual interviews

The individual interviews were conducted in January 2021, led by an experienced researcher and guided by an interview protocol with open-ended questions. Due to the coronavirus pandemic, interviews were held by telephone. Questions corresponded to the study aim, and served to encourage nurse managers to describe their experiences of EB nursing and more specifically STR in nursing practice and their role as managers of the nursing staff. The interviews, lasting between 21 and 37 minutes, were audio-recorded and transcribed verbatim. Interviews were coded, audio-recorded and transcribed verbatim.

Analyses

Statistical analyses

Due to small groups and skewed distributions, descriptive statistics with non-parametric analyses were used for Studies I, III and IV. Differences within as well as between groups were assessed with the Mann-Whitney U-test for continuous variables, the Chi-squared test or Fischer's exact test were applied for categorial variables. Statistical significance was accepted as $p < 0.05$.

The subgroups in Study I were formed based on participant characteristics: age, sex, attendance at group sessions and satisfaction with care. Nursing staff subgroups were based on age, sex, experience in psychiatric care and attendance as group leader. The questionnaire presented participants with the opportunity to leave comments after each question. These comments were compiled and presented alongside the quantitative results for a more comprehensive presentation of the data. The two groups in Study III consisted of staff members at the STR wards and at the reference wards, respectively. In addition to differences within and between the groups at baseline and follow-up, effect sizes were calculated. Effect sizes for changes in the respective groups were calculated using Rosenthal's r (Rosenthal & Rubin,

2003). Limits for effect sizes for non-parametric tests were set as follows: small (0.1), medium (0.3) and large (0.5) effect (Cohen, 1988). In Study IV, differences between pre- and post-measurements were assessed. All analyses were performed using the statistical package IBM SPSS 21.0 (IBM-SPSS Inc. Chicago, Illinois, USA), version 21.0 for analyses in Study I and version 27.0 in Studies III and IV.

Qualitative analyses

The aim of Study II was to describe nursing staff members' understandings of nursing in psychiatric inpatient care. Hence, a phenomenographic approach to analysis was chosen. The process of analysing the data was inspired by Dahlgren and Fallsberg (1991) and followed seven steps: *Familiarisation, Condensation, Comparison, Grouping, Articulating, Labelling* and *Contrasting. Familiarisation* refers to reading through the interviews carefully to gain a sense of the whole. *Condensation* is the process in which the most significant statements on the participants' feelings and thoughts about nursing in psychiatric inpatient care are identified, shortened and summarised. This process results in preliminary descriptions of each individual's understanding of nursing, what he or she focused on, and what it meant for him or her. *Comparison* means that the preliminary understandings are compared with each other and that similarities and differences identified. *Grouping* entails grouping understandings with similar focus and meaning in descriptive categories. *Articulating* concerns description of qualitatively different ways of understanding nursing in psychiatric inpatient care. *Labelling* alludes to classifying the descriptive categories to emphasise the essence of the different understandings. *Contrasting* involves forming an outcome space to mirror the internal relationship between the descriptive categories.

Focus group interviews in Study IV were analysed in accordance with the description of Krueger and Casey (2015), a commonly used method for analysis of such data. This method considers group interactions during interviews. Thus, data included both transcripts and observational data. Analysis of the data was purpose-driven and conducted in a step-wise matter. All data were read and reread to get a sense of the whole. The text was then coded and opinions with similar meaning were be grouped together. Grouping in this stage was based on similarities and differences, which resulted in subcategories. Comparisons between the subcategories and the text as a whole were made during the entire process. Lastly, the subcategories were collapsed into four categories. Field notes on the observation schemes were used to describe the interactions in the groups.

Data from individual interviews in Study IV were analysed through qualitative content analysis, as described by Elo and Kyngäs (2008). Analyses were performed in a number of steps; First, the entire text was read in order to get a sense of the whole. Next, parts of the text related to the study aim were

highlighted through open coding, and preliminary headings were noted in the margin. The headings were then abstracted into codes which were grouped into categories and subcategories. After discussion and consensus, the coding sheets contained three categories.

Mixed method analysis

For Study IV, both qualitative and quantitative results were merged through a convergent analysis in the final step of the analysis. The convergent analysis consists of merging and comparing qualitative and quantitative results in the same phase of the research process (Creswell & Plano Clark, 2018; Kettles, Creswell, & Zhang, 2011).

Ethical considerations

All research that this thesis is based on has been conducted in accordance with the Declaration of Helsinki. Approval by the Regional Ethical Review Board in Uppsala has been obtained for all studies (2014/542/1, 2016/414, 2019-04315, 2020-06328). Specific ethical considerations related to the studies are presented below.

Quantitative research

Consideration was taken to ensure participants' anonymity: all data were coded and therefore anonymous throughout the process.

Participants' informed consent was handled differently in the studies. Study I gave participants the opportunity to choose between pen-and-paper or web-based questionnaires. Staff members and patients ready for discharge were informed about the study, both verbally and in text. They were also informed that completion and return of the survey were considered to constitute informal consent and, therefore, no written consent was obtained.

In Studies III and IV, questionnaires were anonymously administered in pen-and-paper format only. Information about the study was given to all staff members. It was explicitly stated that results would only be presented at the group level, to ensure that staff members felt able to rate their experiences freely. Written consent was obtained from all participating staff members.

Qualitative research

For all interviews, eligible participants were informed that participation was anonymous and voluntary. They were also informed that they could withdraw at any time without explanation or consequences. The staff members received written and verbal information and all of them provided written consent.

Data collection through interviews may put the participant at risk. Anonymity, loyalties towards the employer and fear of punishment if speaking freely are examples of risks created. When conducting focus group interviews, ethical considerations are necessary because of the group setting and group dynamics. A number of considerations were taken in account to minimise risks to the participants and create a space where staff members could speak freely without feeling obligated to answer in a certain way. Interviews were conducted at the clinic, to enable performance during working hours, but in rooms that were separated from the wards. All interviews were led and observed by persons without any professional connection to the wards where the participants were employed. Data, both audio recordings and transcripts, were coded and participants were presented anonymously. Code numbers were used with the quotations presented in the results.

Results

Study I

Both patients and members of the nursing staff reported that nursing care and the care environment were important factors in the process of recovery.

Patients' experiences of the group sessions

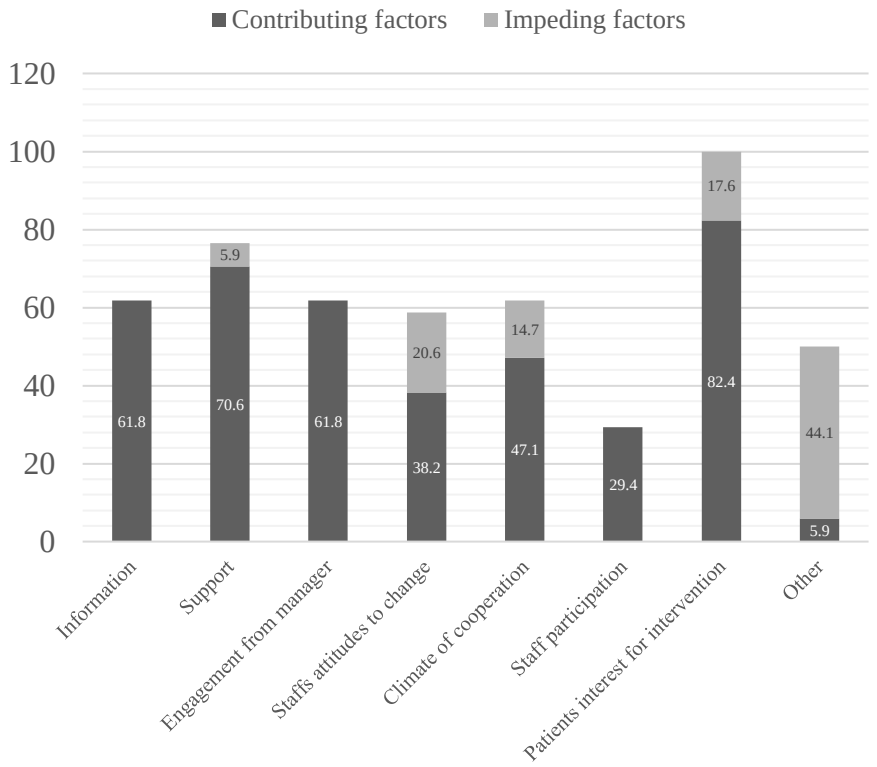
Nearly three-quarters of the patients (74%) reported positive or very positive experiences of participating in group sessions. Positive aspects of participating included a feeling of recognition and not being alone. The opportunity to develop 'tools' to use in the process of recovery was also seen as positive. Negative aspects of the group sessions included varying attitudes and performances among staff members, as well as time constraints. The most frequent reasons patients gave for not participating were mental ill health (n=19) or being busy with other care actions (n=14). Some of the patients (n=14) found the group sessions unpleasant and uncomfortable and therefore chose not to participate.

Staff members' experiences of the group sessions

A majority of staff members considered STR to be a contributing factor to positive development of the care process on the wards (79%) and reported predominantly positive effects (77%). The positive effects were described in terms of patient participation in care, enhanced contact between patients and staff, better atmosphere on the wards and reduced inactivity.

A small proportion (24%) of staff members reported negative aspects of the group sessions. These included other staff members' negative attitudes towards the intervention and difficulties during the group sessions (e.g., interaction and conversation).

Staff members reported both contributing and impeding factors during the implementation process. Interest from patients, support, information and engagement from the manager were the most contributing factors. Apart from 'other' factors (e.g., workload and staffing), negative attitudes to change among staff members were reported to be the most impeding factor. All factors are presented in Figure 2.



Note. Participants' comments to the predefined alternative "Other" included aspects of workload, staffing, negative attitudes towards the intervention and insecurity in leading groups.

Figure 2: Staff members' experiences of contributing and impeding factors during implementation (%).

Comparisons between subgroups' experiences

More positive experiences of participation, group content, impact on care and the importance of continuing with the group sessions were found in the subgroup of patients with a higher frequency of attendance in the group sessions. The experience of participation and the contents of the group sessions were also rated more positively in the subgroup of patients who were satisfied with overall care. Differences in experiences in subgroups of staff members were only found for attendance as group leaders. More specifically, staff members who had led groups > 10 times reported a more positive experience of being a group leader than those who had led groups < 10 times.

Study II

The phenomenographic analysis resulted in five categories of descriptions that reflected qualitatively different ways of understanding nursing in psychiatric inpatient care. The five descriptive categories were: *Nursing is to respond to symptoms and behaviours*, *Nursing is to plan and treat*, *Nursing is to support vulnerable human beings*, *Nursing is to motivate patients* and *Nursing is to have a holistic perspective on the treatment of mental illness.* The descriptive categories and the relationships between them are presented in the outcome space (Figure 3). The categories of descriptions are related to each other based on partially shared descriptions of the patient, the nursing interventions and the goal of nursing. The most comprehensive category included three of the other categories. However, the first category is only partially incorporated in the more comprehensive category, due to the descriptions being limited compared with those for the other four categories.

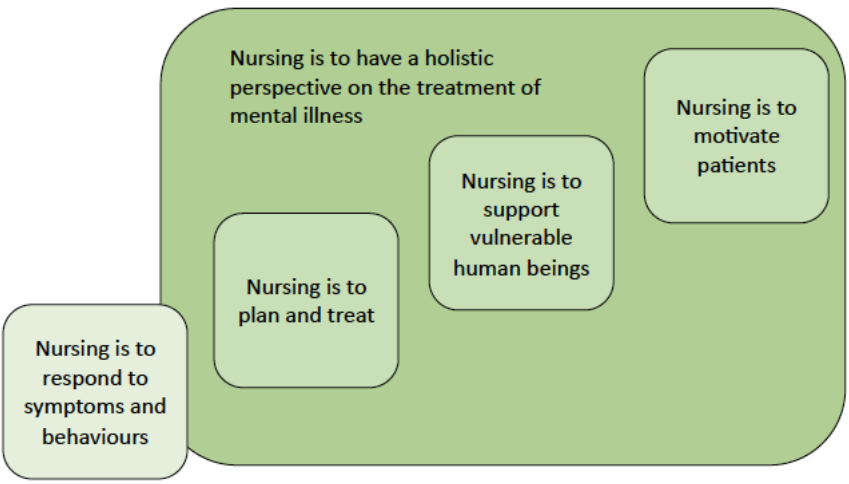


Figure 3: The outcome space, illustrating the five categories of description and the relationships between the categories.

Study III

There were no differences in demographic variables between the STR group and the reference group, except at baseline, with staff at the reference wards reporting longer experience in their profession and in psychiatric care than staff at the STR wards. Staff at the reference wards reported longer experience in their profession and in psychiatric care at baseline compared with at follow-up.

Experiences of the nursing programme at the STR wards

Over half of the nursing staff members at the STR wards had been involved in the programme (n=24/40). Their overall experience of the intervention was rated mostly positive (Md 5.0, range 1–6).

All nursing staff at the STR wards (n=40), even those not directly involved in the programme, rated their experiences of the nursing programme on a scale from 1 to 6 (1 = 'very negative', 6 = 'very positive'). See Figure 4.

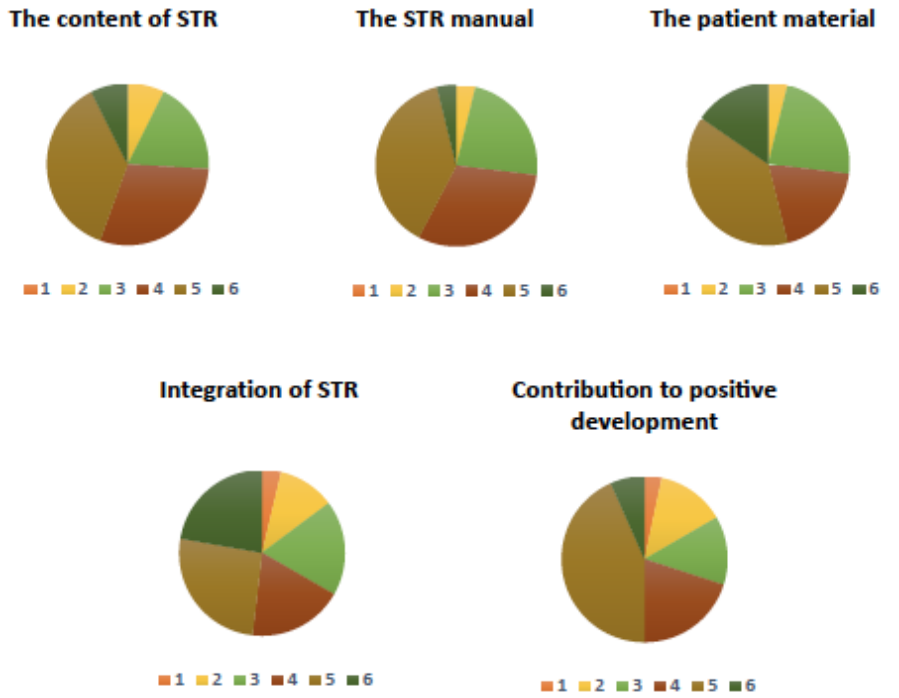


Figure 4: Results of staff members' ratings of their experiences of Steps Towards Recovery.

Stress, quality of care and satisfaction with nursing care and work

There were no statistically significant differences in staff members' ratings of *stress* (MBI), *quality of care* (QPC-IPS) or *satisfaction with nursing care and work* (SNCW) between STR and reference wards, either at baseline or at follow-up. However, staff members' ratings for many of the domains of *quality of care* (QPC-IPS) where higher at the reference wards compared with

at the STR wards, before and after implementation, although the differences were not statistically significant.

At the STR wards, no changes were evident regarding *stress* (MBI). In two of the dimensions of *quality of care* (QPC-IPS), Participation and Secure environment, higher ratings were found at follow-up, with small (0.21) and medium (0.39) effect sizes, respectively. There were no changes regarding *satisfaction with nursing care and work* (SNCW).

At the reference wards, a decrease in one dimension of *stress* (MBI), Emotional exhaustion, was evident, with a large effect size of 0.50. A decrease in the dimension Depersonalisation, not statistically significant, with a small effect size of 0.24, was also found. No changes were evident in this group regarding *quality of care* (QPC-IPS). In ratings of *satisfaction with nursing care and work* (SNCW), a small decrease, not statistically significant, with a small effect size of 0.23, was found.

Study IV

Analyses of questionnaire data and transcripts from two different types of interviews resulted in multi-perspective information about attitudes towards and use of EBP in nursing in psychiatric inpatient care.

Findings from the quantitative data indicated overall positive attitudes towards EBP (total score and dimensions). However, a tendency of resistance was reported from certain staff members on a number of items, evident in the range of ratings. Significant increases in the dimension of Openness were evident, and likewise in two of the individual items in that dimension. This indicated that nursing staff members' attitudes were more positive and that they were more open to the use of new interventions after implementation.

Analyses of transcripts from focus group interviews with nurses resulted in four categories: *Nurses' experiences of EB nursing, Steps towards Recovery as an EB programme in clinical nursing work, Responsibility for EBP in nursing, Prerequisites to working with EBP in nursing* (Figure 5). Discussions focused mainly on EBP, nurses' professional responsibility and the importance of integrating EBP in clinical nursing. Steps Towards Recovery, as an example of EBP, was discussed with positive wordings, but challenges and needs in relation to working with the programme were mentioned. Observational data from the focus group interviews showed that all participants were active in the discussions and that there was a good atmosphere during interviews. Turn-taking and no interrupting of others enabled dynamic discussions, although participants focused on different aspects and dominated discussions to varying degrees.

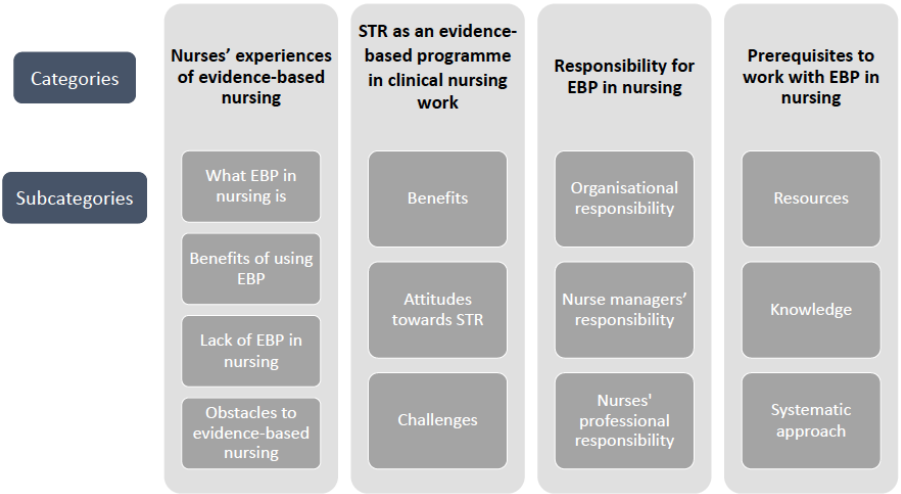


Figure 5: Results of the focus group interviews, categories and subcategories.

Analysis of data from individual interviews with nurse managers resulted in three categories: Nurse managers' experiences of EB nursing, Steps Towards Recovery as an EB programme for nursing and Nurse managers as facilitators for STR (Figure 6). Nurse managers mentioned experiences which focused mainly on STR and their role in relation to the use of the nursing programme, with less focus on EBP in a broader perspective.

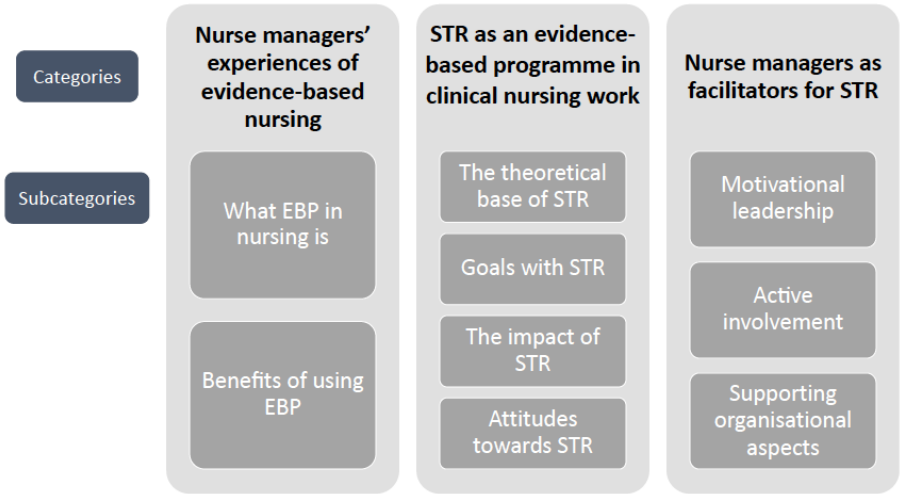


Figure 6: Results of the individual interviews, categories and subcategories.

Taken together, a convergent analysis of results from the method triangulation in this study shows that NAs, nurses and nurse managers viewed EBP in positive terms. Although attitudes were positive, difficulties in implementing EBP were identified and the results also suggests that EBP was not sufficiently implemented in nursing care.

Discussion

Methodological considerations

Quantitative research

Limited populations and response rates around 50% resulted in small sample sizes in collection of questionnaire data in Studies I, III and IV. This limits the potential to draw any conclusions on generalisation of the results. Another weakness rendered by the small samples and the fact that staff members at baseline and follow-up in Studies III and IV were not the exact same individuals was the limited options for statistical analyses of data. For example, independent analyses were conducted when comparing data from baseline and follow-up in Studies III and IV, even if data were retrieved from the same wards. This decision was made due to staff turnover and organisational changes during the time between the two measurements. A specific limitation in Study I was that patient data were only retrieved from two of the three eligible wards and that analyses to explore differences between nurses and NAs were not possible because of skewed distributions. A specific limitation in Study III was that the small number of participants made intragroup analyses impossible, though that might have led to more distinct results. For the same reason, differences between the wards, which were all sub-specialised, were not explored further in this study.

The questionnaire designed for Study I and the specific questions regarding STR in Study III were not tested for validity and reliability. The other questionnaires in Studies III and IV were standardised and had previously been used in various settings. Reliability and validity for the 22-item MBI version have been established in several languages, in both psychiatric and other professional settings (Maslach & Jackson, 1996; Paris & Hoge, 2010; Poghosyan, Aiken, & Sloane, 2009). Psychometric tests of QPC-IPS are ongoing; some results have already been published, indicating that it is a valid and useful instrument (Lundqvist, Suryani., Hermita, Sutini, & Schröder, 2019). Satisfactory reliability and validity estimates have also been reported for SNCW (Brodaty, Draper, & Low, 2003). The EBPAS has been used in several countries and settings and good reliability has been reported for the Swedish version (Skavberg Roaldsen & Halvarsson, 2019).

Clinical research requires many methodological considerations to ensure research of high quality. The naturalistic context of the research also places high demands on researchers to control for potentially influencing factors.

Due to the designs of the studies included in this thesis, the possible measures to control for these factors were limited. For example, the risk of bias has not been addressed. That could have been interesting to explore, since staff members' experiences of aspects of their work was sought: for example, were those who chose to participate pleased with their employment or not? This is a particularly interesting consideration given the previously mentioned staff turnover at the clinic.

Qualitative research

Regarding the qualitative research in this thesis, measures were taken to ensure rigour through considerations to enhance trustworthiness (Lincoln & Guba, 1985) and in overarching decisions regarding performance of Studies II and IV. This has been of importance since trustworthiness strengthens the outcome and impact of the research (Collier-Reed, Ingerman, & Berglund, 2009). In each of the studies, the authors' preunderstandings and potential risks related to their professional affiliations to the clinic were taken into consideration. As a result, the authors were not considered eligible to moderate or observe interviews. Hence, interviews in both studies were led and observed by highly qualified nurses employed outside the clinic.

Theoretical reasoning about design and methodology, as well as having the study aim as the guide for decisions throughout the study, strengthens the credibility of qualitative research (Lincoln & Guba, 1985). These aspects have been applied and the steps of the methodology are transparently described in each of the studies. Qualitative analyses involved all authors, in different aspects. Such triangulation of investigators strengthens dependability (Patton, 2015). Dependability was further strengthened by the fact that all interviews in Study II were conducted by the same moderator, as were the focus group interviews (moderator and observer) and the individual interviews, respectively, in Study IV. Measures were also taken to ensure stability over the time of data collection (Lincoln & Guba, 1985). To further ensure dependability, the analysis process of each study has been carefully described (Patton, 2015). To make it easier for the reader to decide whether the results of the studies are transferable to other contexts (Lincoln & Guba, 1985), the settings and participants of each study have been thoroughly described. As regards Study IV, a description of STR is also available. Measures to make results confirmable (Patton, 2015) have also been taken. Each step of the respective studies, as well as 'who did what', have been clearly presented. Quotations have been used when appropriate in presenting the results.

The choice of phenomenography as the method for analysis in Study II was based on the study aim and that the method is seen as a resource to enhance awareness in the context of nursing (Sjöström & Dahlgren, 2002). As the results were based on interviews with nursing staff members from a single clinic, it is important to bear in mind that they may be affected by the local

working culture and organisational factors. Both NAs and RNs were invited to participate in the interviews, which can make comparison of the results with other studies problematic, if their samples are more homogenous.

The recommended number of participants in interview studies varies depending on the approach chosen. Only three individual interviews were performed with nurse managers in Study IV, which may be considered too few (Patton, 2015). However, the naturalistic context of the research and number of eligible nurse managers could not be altered. The recommended numbers of interviews and participants in each focus group would be higher than they were in Study IV (Krueger & Casey, 2015). The recommendations were intended to be followed, to facilitate deepened discussions during interviews. However, lack of staffing resources and time, late cancellations and no-shows made that impossible. As seen in the results of Study IV, the focus in the different types of interviews differed: nurses focused on EBP broadly, whereas nurse managers focused on STR to a greater extent. The choice of methods for data collection may have contributed to this – a focus group interview with nurse managers might have resulted in discussions on EBP in a broader perspective, as this type of data collection aims to deepen discussions.

Because of the character of qualitative research and methods in each of the studies, generalisation of the results to other contexts should be cautious (Larsson, 2009). However, by considering all relevant aspects to ensure trustworthiness, researchers can enhance the transferability of their results (Lincoln & Guba, 1985).

Mixed method research

The use of mixed method research in the field of nursing in psychiatric care has expanded. However, it has been shown that a lot of research claiming to be 'mixed method' is not (Kettles et al., 2011). Therefore, measures have been taken to clearly describe the methodology of Study IV. The choice of adopting the convergent parallel design (Kettles et al., 2011) in this mixed method study was made to enable comparison between the three different parts of the study. As described in the Methods section of this thesis, the quantitative and qualitative results were merged in the final step of the analysis. The convergent analysis enables merging and comparing of both qualitative and quantitative results (Creswell & Plano Clark, 2018).

Due to the design of each study in this thesis, statements on the effects of STR are difficult to make. A randomised controlled trial or a controlled implementation study might have provided more explicit results with regard to the effects of the nursing programme. However, the naturalistic context in which this research took place made this difficult. Instead, different perspectives on nursing, EBP in nursing, and STR in particular, were

illuminated to describe experiences and create understanding for nursing and clinical use of evidence in nursing care.

Impact of the coronavirus pandemic

The coronavirus pandemic has affected parts of the work included in this thesis. Initially, observations to explore compliance to the STR manual were planned in Study III. However, those observations were not possible to perform due to restrictions in force at the time. If they had been performed, the results of those observations might have informed us about staff members' adherence to the STR manual. Data collection was also affected in Study IV, where participation in focus groups was very limited. It is possible that the number of completed questionnaires at follow-up (Studies III and IV) was limited by the pandemic, as the situation at the wards was strained which might have limited time available to fill out questionnaires. Further, the strained working situations might have affected the ability to work in accordance with STR and therefore limited staff members' experiences of STR.

Main results

As described in the introduction of this thesis, nursing in psychiatric inpatient care is viewed as unclear, with low status and a lack of structure. The implementation of a structured nursing programme focusing on core values for nursing was an excellent opportunity to explore different aspects of nursing in this context.

The main results of Study I were that both patients and nursing staff reported positive experiences of STR. Patients also reported what they gained from participating in STR and their reasons for not participating in group sessions. Staff members identified factors that were conducive or impeding to implementation. Based on comparisons of subgroups of patients and staff members, respectively, experiences from patients and staff members with a higher frequency of attendance in STR were more positive than those of participants with low attendance.

In Study II, five different understandings of nursing in psychiatric inpatient care were described. This made it evident that nursing can be understood in qualitatively different ways by staff in the same organisation. The understandings varied from limited to more comprehensive in relation to theoretical underpinnings of nursing.

Predominately positive experiences of STR were reported by staff members in Study III. Patient participation and a secure environment – both

important aspects of quality of care and the individual recovery process – were rated higher after implementation by staff members at the STR wards.

Positive attitudes towards EBP in nursing were found in all three parts of Study IV. Nursing staff members' openness to EBP was significantly higher after implementation of STR. The incorporation of EBP into nursing practice was perceived as a joint concern for nurses and nurse managers.

To summarise, the results of Studies I, III and IV give support to STR as a nursing programme enabling patients' recovery process in psychiatric inpatient care. From a staff perspective, it seemed to be well-accepted and feasible to incorporate into daily work. However, differing views on nursing in this context were presented in Study II, which is interesting to consider given that Study IV indicated staff members had positive attitudes towards EBP in nursing.

Nursing as an area of expertise

Nursing in psychiatric care has been described as a 'zombie category', at risk of losing conceptual and explanatory power (Lakeman & Molloy, 2017). Nursing has a marginalised status and is, as an area of expertise, struggling to implement relevant theories and models in a health care setting dominated by a strong medical perspective (Barker, 2001; Bladon, 2017). The results of Study II showed that there are qualitatively different ways in which nursing in psychiatric inpatient care is understood. The results also illuminated uncertainties and lack of definition in regard to nursing as an area of expertise (Berg & Hallberg, 2000; Holmberg et al., 2018). This can lead to uncertainties and difficulties for RNs in handling the autonomous professional role and in leading nursing care as intended (Swedish Association of Psychiatric and Mental Health Nurses, 2014; The Swedish Society of Nursing, 2017).

Study II revealed a spectrum of different understandings of nursing in psychiatric inpatient care. When assessed in relation to existing standards for nursing (European Federation of Nurses Associations, 2015; International Council of Nurses, 2012; Swedish Association of Psychiatric and Mental Health Nurses, 2014; The Swedish Society of Nursing, 2017), the spectrum of understandings ranged from limited to more comprehensive, based on the perceptions of the patient, nursing interventions and the goal of nursing. These results further illuminate challenges in the important work of creating a shared vision and direction for nursing (Gabrielsson, Sävenstedt, & Olsson, 2016), and of defining the roles and responsibilities in nursing (Holmberg et al., 2018).

Good leadership is imperative to secure the values of nursing and clinical competence and to improve nursing practice (Cleary, Horsfall, Deacon, & Jackson, 2011). Nurse managers need to recognise the importance of this work

and it has to be given precedence, even though circumstances in the clinical context can be impeding because more acute duties must be prioritised. As described, health care staff in psychiatric inpatient care consists of individuals with different positions in nursing, based on their education and competence, though their commitments are somewhat overlapping (Holmberg et al., 2018). With that in mind, it is important that the shared vision for nursing includes clear roles, mutual values and goals as a basis for high quality nursing care (Gabrielsson et al., 2016; Hylén, Kjellin, Pelto-Piri, & Warg, 2018; Martin, McCormack, Fitzsimons, & Spirig, 2014). It is also known that care quality and patient outcome are affected by educational levels, staffing, organisational factors and satisfaction with work within nursing (Aiken et al., 2017; Aiken et al., 2014). Creating sustainable conditions for nurses to work with high quality nursing is therefor, crucial.

Evidence-based practice in clinical nursing care

The findings of Study IV indicated generally positive attitudes towards EBP and showed that nursing staff members' openness to EBP increased significantly after implementation of STR. Based on the results of qualitative analyses in the study, EBP is seen as important, yet insufficiently used in clinical nursing. These results are in line with previous research stating that RNs are positive to EBP (Saunders et al., 2016; Warren et al., 2016), although they hardly ever use EB data in their decision-making (Stokke et al., 2014) and consider their ability to implement EBP to be extremely low (Warren et al., 2016).

It is well-known that leadership plays a key role in health care organisations and nurse managers' leadership has been identified as a key aspect in relation to EBP in nursing (Kueny et al., 2015; Sandström et al., 2011). In light of this, it is interesting to reflect on the fact that nurse managers predominantly focused on STR in their interviews, whereas nurses focused on EBP in general. Is it possible that a lack of knowledge regarding nursing competence, which has been discussed with regard to recruitment of nurses (Gabrielsson et al., 2021), is also reflected in the management of EBP in clinical nursing? This has to be considered, as nurses themselves have differing understandings of what working with EBP in their own area of expertise means (Karlsson et al., 2019). Even so, agreement between nurse managers' and nurses' experiences of EBP was evident in many of the categories identified in the different interview settings. This gives some hope when considering the need for shared vision in nursing, as discussed in Study II. The previously identified lack of EBP in nursing practice calls for consideration of obstacles, facilitators and thorough planning when implementing EBP. Implementation is described as a challenging component of EBP (McNett, Tucker, Thomas, Gorsuch, & Gallagher-Ford, 2021). Still, there are ways to connect research and practice

to increase the chances of successful implementation of EBP in clinical practice. Collaborations between nursing researchers and clinical professionals through action research may create a clearer connection between evidence and clinical practice, which could create the conditions needed to successfully implement EBP in nursing (Bjurling-Sjöberg, Pöder, Jansson, Wadensten, & Nordgren, 2021; Salzmann-Erikson, 2017). Using strategies based on knowledge from implementation research is another example of how research may be used as a facilitator in the implementation of EBP (McNett et al., 2021). These approaches could help meet the needs regarding implementation of EBP described in this thesis.

Steps Towards Recovery as an EB programme for recovery-oriented nursing

Recovery is a central concept within nursing (Barker, 2001), adopted in a variety of different settings of psychiatric care (Leamy et al., 2011; Pollak et al., 2018). From a nursing perspective, recovery is defined as a process of change (Barker, 2001; Gabrielsson et al., 2020) with regard to attitudes, feelings, values, goals and skills in reclaiming a satisfying life despite difficulties and limitations in everyday life (Anthony, 1993).

Steps Towards Recovery is a nursing programme focusing on the individual's personal process of recovery with specific objectives to support the process by helping the individual expand their own engagement in and responsibility for recovery. This is achieved by raising awareness and engagement, and by enabling behavioural change through health promotion. The programme rests on core concepts for nursing in psychiatric care, as described in the Tidal Model (Barker, 2001). Steps Towards Recovery involves daily group sessions on weekdays. The method is also to be used as an overall approach in providing nursing care to each individual patient. Starting from the individual's resources and needs, exploration and understanding of their situation through engagement is the basis for development of strategies that can be used to regain control over life and health.

Steps Towards Recovery was initially implemented at three inpatient wards at a psychiatric clinic in Dalarna, Sweden. Results from Study I showed that both patients and nursing staff had positive experiences of STR in that setting. Predominately positive experiences of STR were also reported by staff members in Study III. Patient participation and a secure environment, which are both important aspects of the individual recovery process (Barker, 2001), were rated higher after implementation. Both nurse managers and nurses described positive experiences of STR and stated that the programme contributed to nursing in psychiatric inpatient care. It was indicated that there

was potential for further exploration of STR as a recovery-oriented programme in psychiatric inpatient care. The programme focuses on the individual recovery process while taking advantage of the benefits of a group format, as presented in Study I, and has previously been described as feasible in this context (Pitkänen et al., 2008). The format of STR enables patient-staff interaction, which has been reported to be an important aspect of nursing care (Lilja & Hellzén, 2008; Molin et al., 2016). It also enables interaction between patients, which is important, as support from fellow patients contributes to positive experiences of care on psychiatric inpatient wards (I. M. Johansson et al., 2009). Based on the results of Study I, the possibility of sharing experiences with others in the STR group was appreciated.

Challenges regarding time and responsibility when working with STR in clinical nursing were described by nurses in Study IV. This ties back to the previously described uncertainties regarding responsibilities in the nursing organisation (Holmberg et al., 2018) and further emphasises the importance of leadership to improve nursing practice (Cleary et al., 2011). Clear parallels can be drawn to the results of the individual interviews in Study IV, where nurse managers identified themselves as facilitators of STR as a part of nursing care. These results are important knowledge for future implementation and development of STR.

Recovery-oriented practices have become a more integrated part of nursing in psychiatric inpatient care in recent years (Chester et al., 2016). However, research indicates that implementation can be challenging (Lorien et al., 2020; McKenna et al., 2014; Waldemar et al., 2016) and at risk of only being rhetorically reflected and overruled by competing demands in the clinical context (Waldemar et al., 2018). Hence, the conducive and impeding implementation factors identified in Study I should be considered in further research on how to implement STR as an integrated part of nursing in psychiatric inpatient care.

Conclusions

The aim of this thesis was to explore aspects of nursing care in connection to implementation of a recovery-oriented nursing programme in psychiatric inpatient wards. The main conclusions from each study are presented here.

Both patients and nursing staff reported positive experiences of STR. Based on the results, patients were generally positive towards STR and felt that it contributed positively to their care. Patients reported what they found to be negative aspects, which were related to staff engagement and time. Staff members were also positive towards STR and considered the programme to be a contributor to positive development of nursing care. Patients and staff members with a high frequency of attendance in STR were more positive than those with lower attendance frequency. These findings, along with results describing barriers to participation as well as aspects important to implementation, provided crucial knowledge for further implementation and evaluation of STR.

Nursing staff members' understandings of nursing in psychiatric inpatient care varied, ranging from limited to more comprehensive, and depended on perceptions of patients, nursing interventions and the goal of nursing. These results further illuminated challenges for nurse managers in creating a shared vision and direction, as well as defining the roles and responsibilities in nursing.

Predominately positive experiences of STR were reported by staff members. Patient participation and a secure environment – both important aspects of quality of care and of the individual recovery process – were rated higher by staff members after STR implementation. These results are promising and indicate that there is potential for further exploration of STR as a recovery-oriented programme in psychiatric inpatient care, focusing on the individual recovery process while taking advantage of the benefits of a group format.

Positive attitudes towards EBP in nursing were found in all three parts of the study. Nursing staff members' openness to EBP was significantly higher after implementation of STR. The importance of incorporating EBP into nursing practice was perceived as a joint concern for nurses and nurse managers. However, there was a lack of EBP in nursing practice and considerations of obstacles, facilitators and planning when implementing EBP was needed. Steps Towards Recovery seems to be an example of a EB nursing

programme that is well-accepted by nurses and managers in psychiatric inpatient care.

Clinical implications and future directions

This thesis provides results, derived from a clinical setting, that can be translated into knowledge of use for clinical nursing in psychiatric inpatient care.

As seen from the results of Studies I and III, implementation of a structured, recovery-oriented nursing programme can contribute to the quality of nursing care from multiple perspectives. The programme, STR, was well-accepted and seen as positive by both patients and staff. It has now been explored in two different clinics and from several perspectives. Taken together, the results indicate that STR is usable and ready to be implemented elsewhere to facilitate recovery for persons being cared for in psychiatric inpatient care. Based on the results of Study IV, there is a need for translation of research into professional nursing practice, which NAs and nurses at various levels in the organisation have reported being positive towards. Nurse managers were identified as having a crucial role in implementation of EBP and they need to take active measures to make use of staff members' positive attitudes in order to increase the use of EBP in nursing. Another area where results from this thesis can be of use for clinical nursing is in the much-needed discussions about nursing as a profession. Results from Study II further highlight the lack of definition and clarity regarding nursing. Nurse managers need to recognise the importance of a shared vision for nursing; the understandings of nursing identified could be used as a starting point for these discussions. In addition, a working climate where reflections and discussions regarding roles, values and goals for nursing are assigned high priority is needed. As highlighted in this thesis, research alone is not the way forward. It also has to be implemented and integrated into nursing practice to create a shared vision of nursing and to make EBP a self-evident part of the clinical practice of nursing. This should be considered in future efforts to improve nursing in psychiatric inpatient care. Even though results so far indicate that STR is well-accepted and improves important aspects of quality of care, future research to explore other aspects could contribute to further development and use of the programme. For instance, further qualitative exploration of patients' experiences of STR would be an important contribution.

Svensk sammanfattning

Bakgrund

Inom psykiatrisk heldygnsvård vårdas människor som på grund av svåra psykiatriska tillstånd och svårt lidande har behov av psykiatrisk vård under dygnets alla timmar. Vården vid psykiatriska vårdavdelningar omfattar både medicinsk vård och omvårdnad, men innehållet i vården varierar stort beroende på var personen vårdas. Det medicinska perspektivet är ofta starkt och omvårdnad har en perifer roll. Vård i denna kontext har beskrivits som en lång väntan i en förvirrande vårdmiljö. Även för personalen kan det vara svårt att förstå arbetet eftersom roller och ansvar för omvårdanden ofta är otydligt definierade. Sjuksköterskans professionsområde är omvårdnad och det är sjuksköterskan som har ansvar för att leda omvårdnaden, även om andra yrkeskategorier, som undersköterskor, utför ordinerade omvårdnadsåtgärder. Omvårdnad ska vara evidensbaserad, vilket betyder att den ska bygga på vetenskaplig grund och beprövad erfarenhet och att evidensbaserade metoder för omvårdnad ska implementeras i omvårdnadsarbetet. Sjuksköterskor upplever att det är viktigt att arbeta evidensbaserat, men att det är svårt att implementera omvårdnad som är evidensbaserad. Återhämtning, i betydelsen av en personlig förändringsprocess, är ett centralt begrepp och en teoretisk grund för omvårdnad inom psykiatrisk vård. Som ett steg mot omvårdnad av hög kvalitet med fokus på individens återhämtning skapades Steg Mot Återhämtning (SMÅ). Steg Mot Återhämtning är ett omvårdnadsprogram som syftar till att stärka individen i dennas återhämtningsprocess. Basen i SMÅ består av dagliga gruppträffar som utgår ifrån fem olika teman; *engagera dig, undersök, ohälsa och stress, vanliga hinder och funderingar,* samt *planera små steg*. Som ett stöd för arbetet finns arbetsmaterial kopplat till samtliga teman.

Syfte

Det övergripande syftet med denna avhandling var att undersöka olika aspekter av omvårdnad i samband med implementering av SMÅ. De olika delstudierna syftade till att undersöka: I) patienters och personalens upplevelser av SMÅ, samt hur programmet påverkade vården och arbetet, II) personalens uppfattningar om vad omvårdnad i psykiatrisk heldygnsvård

innebär, III) personalens erfarenheter av SMÅ, samt upplevd stress, vårdkvalitet och arbetstillfredsställelse före och efter införandet av SMÅ, samt IV) attityder och erfarenheter av evidensbaserad omvårdnad och SMÅ utifrån tre olika perspektiv.

Metoder och resultat

Avhandlingen baseras på fyra delstudier. Den första studien (Studie I) byggde på data insamlade vid den psykiatriska kliniken i Dalarna och de tre efterföljande studierna (Studierna II–IV) baserades på data som samlats in vid den psykiatriska kliniken i Uppsala. Studie I undersökte både patienters och personalens upplevelser av SMÅ genom att besvarade enkäter analyserades med beskrivande och jämförande statistiska analyser. Resultaten visade att de personer som hade deltagit i SMÅ under vårdtiden hade positiva erfarenheter av metoden och upplevde den som ett positivt bidrag till deras vård. Även personalen var positiva till SMÅ och upplevde att den bidrog till positiv utveckling av omvårdnaden. De personer, både patienter och personal, som hade deltagit i SMÅ vid flera tillfällen var mer positiva än de som hade deltagit i lägre utsträckning. Studie I gav även viktig information om vad som gjorde att personer valde att inte delta, samt vad personalen upplevde vara hindrande och stödjande faktorer vid implementering. I Studie II undersöktes personalens uppfattningar av omvårdnad i psykiatrisk heldygnsvård genom att individuella intervjuer analyserades med en fenomenografisk metod. Resultaten visade att uppfattningar om omvårdnad i den här kontexten varierade stort, med mer eller mindre tydlig anknytning till den teoretiska grunden för omvårdnad. I Studie III undersöktes personalens upplevelser av SMÅ och deras skattningar avseende stress, vårdkvalitet och arbetstillfredsställelse genom frågeformulär. Resultaten visade att personalen på SMÅ-avdelningarna var övervägande positiv till SMÅ som arbetsmetod, och skattade två aspekter av vårdkvalitet – delaktighet och säker miljö – högre efter implementeringen. Några säkerställda förändringar i skattningar bland personalen på de avdelningar som inte arbetade med SMÅ fanns inte. Studie IV var en mixed-method-studie, där attityder till och erfarenheter av att arbeta evidensbaserat och med SMÅ undersöktes genom enkäter, fokusgruppintervjuer och individuella intervjuer. Attityder till evidensbaserade metoder var generellt positiva och öppenhet inför nya forskningsbaserade metoder visade sig vara högre efter implementering. Erfarenheterna av att arbeta evidensbaserat och med SMÅ var positiva, men upplevelsen var att evidensbaserad omvårdnad i alltför liten utsträckning användes i det kliniska omvårdnadsarbetet.

Slutsatser

Omvårdnad i psykiatrisk heldygnsvård kan uppfattas på kvalitativt olika sätt, vilket ställer höga krav på arbetet med att skapa en gemensam grund och riktning för omvårdnaden. Oavsett dessa olika uppfattningar var personal med olika roller inom omvårdnaden positiva till att arbeta evidensbaserat, även om de upplevde en brist på evidensbaserad omvårdnad i det kliniska arbetet. SMÅ är ett exempel på hur evidensbaserad omvårdnad kan implementeras i den kliniska omvårdnaden och resultaten visar att omvårdnadsprogrammet mottogs väl, med positiva erfarenheter av både medverkan och arbetet med programmet. SMÅ kan bidra till ett meningsfullt innehåll i omvårdanden för den person som vårdas, men programmet kan också bidra till struktur i arbetet och tydliggörande av omvårdnaden. För att omvårdnad av hög kvalitet ska kunna gagna de personer som är i behov av den måste forskning och teorier av relevans för omvårdnad integreras i det kliniska arbetet. Den här avhandlingen bidrar med kunskap som kan användas i processen att skapa evidensbaserad omvårdnad.

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