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Developing an Evidence-Based Practice for Psychiatric Nursing

Robin Buccheri

University of San Francisco, buccherir@usfca.edu

L Trygstad

M Buffum

A Gerlock

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DEVELOPING AN EVIDENCE-BASED PRACTICE (EBP) FOR PSYCHIATRIC NURSING

Wouldn't we psychiatric nurses like to have people who don't understand our skills spend just one shift with us on a psychiatric unit watching us constantly monitor the entire milieu and each patient for danger to self and others - trying to ensure the safety of both patients and staff! They could watch us intervene with a bipolar patient trying to get them to participate in unit activities not by confronting but by engaging and distracting, work with a severely depressed patient as we encourage their oral intake while simultaneously assessing their suicide level, assess someone who is tormented by voices to determine if they are hearing commands to harm and whether they plan to act on those commands and assess and intervene with someone who may have akathisia or life threatening symptoms of Neuroleptic Malignant Syndrome.

We want others to know the complexity of our skills as expert psychiatric nurses and the effect of our interventions on patient outcomes. One way we can better communicate our expertise is to develop more evidence-based psychiatric nursing practices. While there are many models for creating and using evidence-based practice, we began our construction using four very basic elements:

Psychiatric nursing clinical expertise helps us decide which clinical issues need addressing, which theories are the most accurate in describing our practice and what research evidence might best improve practice.

Theories/models guide the development of research studies and instruments and put research findings into context so they can be useful to practicing nurses.

Objective measurements are essential to measuring changes in patient improvement. Some reasons why objective measurements are essential include the following.

1) They improve our ability to communicate with the treatment team. It is more effective to tell the treatment team that a patient's score on the Beck Depression Inventory (BDI) has increased from x to x than to say "the patient looks more depressed".

2) They can explain what psychiatric nurses do, defining our role and contribution to the treatment team as we describe how we assess, monitor and treat psychiatric symptoms and illness.

3) They can demonstrate the effect of our work on patient outcomes. When we can provide objective data that a nursing intervention has improved patients' symptoms or illness, our credibility and value are more evident to the treatment team.

4) They can guide our nursing interventions. Research has repeatedly demonstrated that we cannot assume what a patient is experiencing.

5) They can provide a standardized method for consistently tracking changes in patients' symptoms and/or illness over time.

Research evidence guides us in finding the answers to our clinical questions. A clinical practice question may arise in the process of daily care delivery. Why does a particular practice continue? Is there evidence to support it? After a literature search, the psychiatric nurse may see what evidence actually supports or refutes that practice. Perhaps staff can select a particular article about the practice and discuss the evidence in a journal club context. If the unit does not have a journal club, why not create one or

a venue for a discussion? Multiple nursing articles describe starting and sustaining varying types of journal clubs (Luby, Riley, & Towne, 2006; Rich, 2006; St. Pierre, 2005; Valente, 2003). Quality of evidence from articles reviewed in journal clubs can be graded with a standardized method (McInyk & Fineout-Overholt, 2005).

We describe below how our research team achieved an evidence-based practice (EBP) for the treatment of auditory hallucinations and commands to harm in patients who have schizophrenia.

Clinical Expertise: Our research team members are expert psychiatric nursing clinicians experienced in working with people with schizophrenia who hear auditory hallucinations. When we began our research in 1992, interventions for auditory hallucinations were limited to psychiatric medication and reality orientation (“I know you hear voices but I don’t”). We evaluated the evidence and decided more research-based interventions were needed for auditory hallucinations.

Theory/models: We selected two guides for our work: 1) the symptom management model (USCF, 1995), and 2) self-control of psychotic symptoms model (Brier & Strauss, 1983). These models provide a powerful patient-centered framework for assessments, interventions and evaluation of patient outcomes related to hearing voices. We include patients as partners in their care and assume they are experts about both their symptoms and the management of their symptoms. Focusing as partners increases patient empowerment and contributes to the recovery movement.

Objective measurements: Keeping patients safe is the highest priority. In this issue of JPN, our research team (Gerlock, et al, in press) describes 2 tools we developed to

provide objective measurement of auditory hallucinations. The Unpleasant Voices Scale (UVS) assesses intensity of auditory hallucinations, presence of commands to harm and intent to act on those commands. The Commands to Harm Safety Protocol provides steps for assessing dangerousness of commands to harm for those patients who respond “yes” to intent to harm. These are examples of unique tools designed for a particular purpose, context and population.

Research Evidence: We incorporated interventions with the strongest evidence into a 10-session course, Behavioral Management of Persistent Auditory Hallucinations (Buccheri et al., 1996). We measure course outcomes using objective measures and we continue to use research evidence in every modification of the course. The addition of the Safety Protocol came from research evidence about commands to harm self and others and factors closely associated with acting on those commands.

We hope our work on auditory hallucinations will encourage other psychiatric nurses to keep asking clinical questions from their experience, inquisitiveness and patient concern. The answers to those important questions can often be found from existing evidence in the research literature, clinical expertise, and theoretical exploration. Additionally, nurses can evaluate patient outcomes specific to their interventions by using objective measures of patient illness and symptom status. Answers can be tested in practice, thereby providing evidence for keeping or discontinuing a practice. From our experience, developing and implementing an evidence-based practice is an ongoing process that strengthens psychiatric nursing and improves the quality of life for patients suffering from mental illness.

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