2018

Improving Therapeutic Relationships among Psychiatric Nursing Staff and Adolescent Patients

Carla Kay Cozart

Improving Therapeutic Relationships among Psychiatric Nursing Staff and Adolescent Patients

by

Carla Cozart

A capstone project submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the degree of
Doctorate of Nursing Practice

Boiling Springs, NC

2018

Submitted by:	Approved by:
_____	_____
Carla Cozart, MSN, RN, ONC	Yvonne Smith, DNP, RN, NCSN
_____	_____
Date	Date

Approval Page

This capstone project has been approved by the following committee members:

Approved by:

_____	_____
Diana Holmes CNO (retired) RN, MBA, SSBB Committee Member	Date
_____	_____
Terrance Adams, BSN Committee Member	Date
_____	_____
Dr. Frankie Ballard, PhD, RN-BC Committee Member	Date
_____	_____
Candice Rome, DNP, RN Chair, Digital Learning Programs	Date

Abstract

This Doctor of Nursing Practice Project examined the effect of an evidence-based staff development education program on the attitudes and knowledge levels of nursing staff regarding the mentally ill adolescent patient population, for which they provide treatment and supervision. A convenience sample of 61 nursing staff members participated in the Improving Therapeutic Relationships among Psychiatric Nursing Staff and Patients project, with 74% of the available sample completing all project surveys. Descriptive statistics were used to compare the scores for the responses of participants to the Community Attitudes toward Mentally Ill (CAMI) pre and post-surveys. Concepts scored by this survey included: benevolence, social restrictiveness, authoritarianism, and community mental health ideology. Bar graphs and tables were used to present the results of the pre and post-surveys, which demonstrated a significant change for some concepts while others remained the constant. Benevolence was the concept most strongly scored but only had two statements that were scored differently when comparing the pre and post-survey scores. The changes indicate nursing staff had a greater understanding of their roles as part of the mental health care team and the responsibility of working together to address the problems of the mentally ill. Social restrictiveness had three statements with significant changes which reflects an increase in the number of nursing staff who strongly agree or agree mentally ill people should have a right to live life as normally as possible. Community Mental Health Ideology concept had two statements with significant changes from pre-intervention to post-intervention indicating most staff strongly agree or agree mentally ill people should live in a community setting. When comparing pre-intervention and post-intervention results, authoritarianism only had one statement with a significant increase in the number of staff who strongly agree or agree it

is difficult to identify the problems of a person who is mentally ill. These results demonstrate this evidence-based, targeted education and training program improved and expanded the perspectives and ideas of the nursing staff. This change in thought processes, knowledge, and attitudes can potentially have a direct impact on the development of therapeutic relationships among psychiatric nursing staff and patients.

Keywords: therapeutic relationships, communication, interpersonal relationships, nursing staff, children, and adolescents.

Acknowledgements

I would like to acknowledge and express my appreciation to the many individuals who supported and encouraged me throughout this educational and personal journey. I would like to thank Dr. Yvonne Smith who served as my DNP Project Advisor. She provided encouragement, support, and patience. She was sincerely concerned with my personal success in the program, work, and life. I would also like to thank Diana Holmes, for inspiring me to be a nursing leader with a positive outlook on the future of mental health nursing. Also, thank you Dr. Frankie Ballard and Terrance Adams who have been beyond supportive with frequent conversations and assistance to ensure the success of the project. The administrative team at the project facility were supportive and appreciative of the project and were instrumental in making the project meaningful and relevant for the nursing staff.

To my family who have sacrificed family time so that I could concentrate on the completion of my work, I am most grateful to you all. My beautiful and intelligent daughters (Michaela and Kayla), your patience and understanding will always be remembered. You have always been my inspiration for all my accomplishments in life and in nursing. To my loving Mom and Dad (Patty and James), your support through this journey is greatly appreciated. You taught me to never give up, always do your best, and to always finish what you start. To my grandson (Colton Rhys), I love you so much and I can only hope that my success will serve as an inspiration to you as you grow and become the wonderful person you are destined to be. To my best friend (Sonja), as a fellow nursing professional, you were able to sit and have conversations with me about the project, the progress, delays, achievements, and you always expressed how proud you

were of me. You made sure I got some breaks in along the journey and helped me stay focused. To all my other family, friends, and coworkers you have provided me with so much support and encouragement over the past two years. You guys are the best. I am blessed to have you all in my life. Everything I have accomplished in my life has been with you all in my heart and on my mind.

Nursing and caring for others is my passion, whether it is family and friends, patients in the facilities which I have worked, the staff I have worked with over the years, or the nursing students I have taught. The success and positive outcomes of others is my success.

Table of Contents

List of Figures

List of Tables

SECTION I

PROBLEM RECOGNITION

Identified Need

One of the main issues of the mental health care system in the southeastern United States is being able to recruit quality skilled providers to provide better clinical management for the patients (Smith, 2012). This has caused an increased need to train and prepare nursing staff to care for mental health patients. A high quality of care for both the voluntary and involuntarily committed mental health patient should help stabilize and prepare them to re-enter the community. Nursing leaders in the mental health care profession are charged with the challenge of identifying innovative and effective training programs to assist nursing staff in providing the best care to mental health patients (Goldsmith, 2017). The single largest group of employed persons in the nursing profession is nurse aides, accounting for 43% of the nursing workforce (Quinterno, 2014). The current minimal preparation for nurse aides involves a high school diploma/GED, and completion of nurse aide training (Quinterno, 2014). It is important that ongoing staff education be provided, especially when the area of expertise is a specialty area such as mental health care for children and adolescent patients.

Problem Statement

Direct care nursing staff employed in acute care in-patient psychiatric settings who work with adolescent psychiatric patients, often lack training in mental health diagnoses, therapeutic communication, relationship building, and awareness of their attitudes and bias toward their patient population. Inadequately trained and prepared staff can potentially lead to more negative patient outcomes as well as poorer employment

satisfaction and job performance. Research has demonstrated improved therapeutic communication and increased positive attitudes after participation in evidence-based staff educational programs. An evidence-based staff education program that encompasses content of diagnostic knowledge, treatment, reflection of attitudes, and staff educational learning activities tailored to the project facility needs, will positively impact the knowledge base and attitudinal changes in the project facility direct care nursing staff after completing the project staff education program.

Purpose

A facility that focuses on the mental health care of children with all and any combination of mental health disorders requires skilled providers. This formal training plan was designed and focused to prepare staff to perform in their roles more efficiently. The purpose of the project was to assist nursing staff in identifying where adolescent psychiatric patients lacked skills and building therapeutic relationships. Having more therapeutic relationships could potentially reduce the number of restrictive interventions, decrease staff and patient injuries related to restrictive interventions, and decrease the use of as needed or stat psychotropic medications to help decrease agitation and aggression. This project resulted in a model that could be duplicated to provide guidance for training in additional mental health facilities.

Setting

The project setting, a state-supported acute care mental health facility in the southeastern United States, provides services for children and adolescents with mental health care needs. The facility currently has two open units, one unit for children ages five to 11 and an adolescent unit serving ages 12 to 17. Both units were coed, consistently

serving more males than females. The focus of this project was on the adolescent unit nursing staff. The year prior to project implementation the nursing staff provided care to over 100 adolescent children. Each child admitted to the facility is assigned to a group of multidisciplinary team members who provide individualized care. The team includes: psychiatrist, psychologist, social worker, behavioral health specialist, psychosocial staff, and nursing staff. The adolescent patients meet with members of the multidisciplinary team individually throughout the day. Nursing staff provide constant observation and interaction with the adolescents 24 hours a day. These children have a variety of diagnoses. The most common diagnoses being Attention Deficit Hyperactivity Disorder (ADHD), Post Traumatic Stress Disorder, Autism Spectrum, Intellectual and Developmental Disabilities, and other additional mental illness.

Gaps in Practice

Psychiatric staff at times consider some patients beyond help and potentially overlook their needs and may not provide efficient care (Dawson, Kingsley, and Pereira, 2005). It is critical that staff view all patients as being capable and useful to engage them in a therapeutic relationship. Understanding traumatic histories contribute to patient behaviors is essential in nursing care for the mentally ill (Dawson et al., 2005). The relationship and interactions need to be positive and help the patient find skillful adaptive approaches to life situations (Dawson et al., 2005). A comprehensive review and audit of all restrictive interventions over 10 months was conducted at the project facility to discover and identify patterns of contributing factors, successful therapeutic interventions that appeared to prevent restrictive interventions, patterns in contributing factors, therapeutic interventions used to successfully prevent restrictive interventions, and

patterns in patient and staff injuries related to restrictive interventions. It was revealed there was a need to provide training to nursing, and especially nurse aide staff, targeted at developing therapeutic relationships with patients. The nurse aide staff are always with patients, observing and documenting their ability to cope and interact with their environments. The nurse aide staff are typically the first responders when a child or adolescent patient is struggling. Improving therapeutic relationships could assist with de-escalating patients who are potentially harmful to themselves or others. Ability to recognize lagging skills and understand behaviors of patients are performance expectations of nursing staff, but there is a gap in their education and preparation to consistently provide this expectation.

SECTION II

NEEDS ASSESSMENT

The care team for children in the mental health settings is a multidisciplinary team that comprises a variety of approaches when the children are first encountered. It is important for all providers to understand the importance of the initial assessment. It is the beginning of the therapeutic relationship and therefore influences future engagement with the child (O'Reilly, Karim, Stafford, & Hutchby, 2015). Patients in the acute care mental health settings have potential to be violent or aggressive towards themselves or others. Acute care mental health patients present to staff with therapeutic and emotional challenges that fall under four main themes. These themes include choice, power, problem solving, or enjoyment (Dawson et al., 2005). Often the aggressive behavior is the result of the patient striving to have a choice in their care (Dawson et al., 2005). This can be a conscious or unconscious desire to control their actions. When the child perceives they have power over the situation and that their behaviors have helped them solve a problem in their favor, the result reinforces the behaviors that are acceptable (Dawson et al., 2005). The fourth theme considers the fact that the child may simply get pleasure from behaving in a way that others feel is aggressive and not welcomed (Dawson et al., 2005). For staff to manage the patients with aggression related to choices, power, problem solving, or enjoyment, they need training and the ability to apply practical approaches. These approaches need to be therapeutically implemented to ensure the child learns to use adaptive skills to manage the situation (Dawson et al., 2005). For some children, this power struggle to problem solve can often cause them to recall the trauma they may have experienced in the past. Staff need training to improve their

interpersonal skills, humanistic approach, knowledge, communication skills, and personal and teamwork qualities (Dawson et al., 2005).

In the initial stages of project development, a comprehensive review and audit of all restrictive interventions over 10 months was conducted to discover and identify patterns of contributing factors, successful therapeutic interventions that appeared to prevent restrictive interventions, patterns in contributing factors, therapeutic interventions used to successfully prevent restrictive interventions, and patterns in patient and staff injuries related to restrictive interventions. It was revealed there was a need to provide training to nursing, and especially nurse aide staff, targeted at developing therapeutic relationships with patients. Current orientation and staff education offerings were also reviewed and reinforced the need for implementation of this DNP project as there was a notable gap in staff training at the entry of employment and in continuing education offerings.

Literature Review

Staff must be sure to understand the patients' problem and their potential to improve. Viewing the child as just being ill or beyond help may contribute to further trauma attributed to neglect. The staff must believe that each child has the potential to be better and use a humanistic approach to help them improve (Dawson et al., 2005).

The nursing leader in the mental health setting must allow for the expression of nursing staff feelings and thoughts about the care needed and provided to the patients. The leader is charged with the duty to provide further education and training to help nursing staff alleviate any anxiety, fears, or concerns they may have about engaging patients in a therapeutic way (Martin & Chanda, 2016). Ongoing strategic

communication is the glue that brings the team together. All nursing staff feel supported and educated when communication about common goals and efforts are used (Levine, 2015). Nursing staff who are not prepared, educated, and supported frequently feel anxious and afraid to engage the patient in therapeutic communication. They may find themselves unapproachable or withdrawn from patient access. They can struggle with using silence as a communication technique that allows listening and identifying patient needs. They may not wait long enough for the patient to answer pertinent questions. This may prevent the patient from being involved in their care. Smiling, laughing, and looking away from the patient at inappropriate times can hinder the development of a trusting relationship. The patient does not feel secure and safe when the actions of the nursing staff are inappropriate (Martin & Chanda, 2016).

Support for Therapeutic Relationship Training

Zarea, Maghsoudi, Dashtebozorgi, Hghighizadeh, and Javadi (2014) established that simple therapeutic communication between the nurse and the patient can decrease anxiety for both parties. Anxiety can occur for a short period of time or may last a long time depending on the psychological disease process. Depression is another psychological disorder that can be addressed using therapeutic communication. Zarea et al. (2014) used Peplau's model including the four stages of therapeutic relationships: orientation, identification, working, and termination for the nurse to interact with the patients. The interactions began in the first encounter with the patients. They were given a pre and post-test to measure the effectiveness of the framework. The Hospital Anxiety and Depression Scale was also used to collect data. The results demonstrated a decrease in anxiety and depression when using Peplau's framework. The patients reported hope,

positive attitudes, and motivation to cope. The nurses and patients could better identify diagnosis and process questions and concerns which lead to more therapeutic relationships (Zarea et al., 2014).

Therapeutic Relationships in the Facility Setting

Therapeutic relationships begin with the relationships amongst the providers. It is the responsibility of the organizational leaders to evaluate how teams are working together to develop therapeutic relationships, and to identify any breakdowns in communication. This can help prevent poor outcomes and mistakes in care (Levine, 2015). Another aspect that can prove to be helpful is improving communication between the primary care provider and the mental health care providers to ensure the needed services are provided sooner rather than later (Wong & Talmi, 2015). Quality therapeutic care requires professionals to spend quality time with patients to encourage them to participate in their own care. Some facilities have accomplished positive practices through the work of the employed staff. The National Mental Health Institute of England (2007) studied seven best practices units to determine the themes that support best practices. The themes included: respecting and empowering patients, staff being available, and engagement focused observation, good multidisciplinary team working, therapeutic work, services for discharged patients, and embracing change (Pereira & Woollaston, 2007). The culture of the units focused on empathy for the patients and support for the staff. Respecting and empowering patients meant treating them normally and involving them in the weekly care planning process (Pereira & Woollaston, 2007). The nurses on the units studied spent three working sessions with the patients a week. These working sessions were varied and included the example of one-to-one situations such as short

walks together. This allowed the nurse to engage them in activity for observation rather than the traditional formal observation of the patient (Pereira & Woollaston, 2007). The multidisciplinary teams had a shared vision and agreed to follow the plans to present as a cohesive team and prevent staff splitting. This team dynamic helped the nurses feel valued and supported which contributed to a more pleasant ward environment (Pereira & Woollaston, 2007). All team members participated in the therapeutic group sessions to prevent the patients from becoming bored, stressed, or aggressive. The nurses found facilitating groups to be enjoyable and rewarding (Pereira & Woollaston, 2007). Services to discharged patients included allowing discharged patients to return and attend groups to aid in the transition back to the community (Pereira & Woollaston, 2007). Lastly, embracing change can be frustrating and hard to participate in, but these staff members thought change was a good thing and needed to improve the services provided (Pereira & Woollaston, 2007). The overall theme was staff need to feel valued, empowered, and supported. Staff also requested flexibility in their work hours, engagement in suggestions for change, and regular training and supervision (Pereira & Woollaston, 2007).

Therapeutic Relationships amongst Individuals

Farrelly and Lester (2014) conducted a literature review to help provide better understanding of the benefits of therapeutic relationships in the care of individuals with mental health diagnosis. Three key components were identified: mutual trust, mutual respect, and shared decision making. Lack of clarity in the goals was an identified barrier to developing therapeutic relationships. Consumer surveys revealed satisfaction with the nurse/patient relationship but dissatisfaction with the over-reliance on medications, lack of autonomy, and medical power struggles. Nurses can use the relationship they build

with the patient to help ensure their involvement in care and advocate for the concerns of the patient (Browne, Hurley, & Lakeman, 2014).

Stenhouse (2011) implemented a qualitative study of patients in the acute care setting which provided insight on patient expectations regarding communication with unit nursing staff. These patients expected help from nurses who initially said they could come and talk. What the patients perceived was nursing staff who were too busy to talk due to completing non-nursing task. This did not promote a sense of safety and contributed to the loss of confidence in the care they would receive. This prevented patients from asking for the help they needed. The patients then began to turn to other patients on the ward for support and encouragement. This can lead to the development of unhealthy relationships with patients who also have mental health problems. Nurses need to learn techniques that can help them approach patients and provide meaningful interactions that meet the patients' expectations which are based on initial interactions with the nurse (Stenhouse, 2011). Verbal communication is essential to forming the therapeutic relationship. This communication should be evaluated to ensure information is provided and open-ended questions are used to obtain information (Ruiz-Sancho, Froján-Parga, & Galván-Domínguez, 2015). The physical environment also plays a role on the ability for nurses to build therapeutic relationships with patients. Both nurses and patients need to have a sense of freedom in the care environment. An environment free from pressure and chaos of searching for charts, online documentation, managing the schedule and location of patients, and looking for private places to talk on the ward/unit allows the nurse to prepare for more meaningful group sessions which engage patients in activity with the staff (Shattell, Andes, & Thomas, 2008). This promotes a sense of well-

being and decreases anxiety. Empowering the nursing staff to be more focused on patient care and providing individualized and group activities using friendly and reassuring interactions can improve the satisfaction of the patients and staff. Nursing staff must work together as a team to ensure all are practicing to best meet the needs of the patients (Shattell et al., 2008).

Barriers to Therapeutic Relationships

Barriers to developing therapeutic relationships need to be identified and addressed. Some of the barriers are provider-based and some are patient-based. The patient barriers include feelings of fear of being judged or labeled, shame, guilt, and anxiety (MacDonald, 2014). The provider can at times become persecutory, rejecting, or blaming (MacDonald, 2014). The provider must be aware of their tone of voice, context of their conversations, and consider whether their message can be perceived as being friendly, hostile, or controlling (MacDonald, 2014). The provider should be open to the patient, ask open-ended questions, understand how the questioning might contribute to the patients suffering, and be aware of how the relationship is progressing (MacDonald, 2014). Patients will often feel pressure to perform in the relationships and the provider needs to not place any demands on the patient to improve or be better (MacDonald, 2014). When caring for younger mental health patients, the nursing staff should recognize the background information that leads to the mental health issues. This will allow for better understanding of the power struggles they encounter (Harper, Dickson, & Bramwell, 2014). The children frequently have issues related to parental involvement, may suffer from developmental delays, problems with self-expression, and difficulty with continuity or loss of relationships. They need consistent and trusting relationships with

providers to prevent re-traumatization and increasing stress related to retelling their story to multiple care providers (Harper et al., 2014). The life experiences of children include the following: violence, unpredictability, and disregard for their needs. This may leave children with lack of identity and an inability to form effective relationships, and limited hope (McCormack & Thomson, 2017). Traumatized children are vulnerable and have a negative sense of self which results in poor relational attachments related to low self-esteem, distress, and post-traumatic stress later in life (McCormack & Thomson, 2017). Therefore, it is important for nursing staff to build relationships with children that include well-defined boundaries, roles, and expectations (McCloughen, Gillies, & O'Brien, 2011). These relationships need to be focused on goals of the patient, honesty, trust, and respect. Validating the beliefs and feelings of the child through listening and discussion are important (McCloughen et al., 2011). Open and truthful communication can help work through challenging situations and focus on solutions that help the child return to the community (McCloughen et al., 2011). The nurses must recognize the knowledge and contribution of the patient to prevent power struggles. This can assist the child to participate in problem solving which can build skills needed to function more independently and effectively in society (McCloughen et al., 2011). The therapeutic relationship between the patient and the nursing staff should be goal focused and incorporate trust and honesty. The staff need to be available and caring. The staff's ability to meet the needs of the patient is how the trust is developed. Many times, these needs relate to accomplishing tasks out in the community and helping the patient gain insight and awareness of themselves (Easter, Pollock, Pope, Wisdom, & Smith, 2016). The

ability to build successful relationships in the facility is a direct correlation to developing meaningful relationships in the community (Easter et al., 2016).

Therapeutic Relationship Education and Training

It is important to be emotionally intelligent when building therapeutic relationships (Fitzpatrick, 2016). Emotional intelligence involves self-awareness, self-regulation, and self-motivation (Fitzpatrick, 2016). One must be aware of their own emotions and confidence level, be in control of their ability to be adaptable and innovative in their approach to care and be motivated and optimistic about providing excellent care that meets the goals of the patient (Fitzpatrick, 2016). In this project literature review, most of the research discovered regarding staff education of therapeutic relationships involved simulation with standardized patient experiences in a lab setting and less frequent use of clinical experiences. All nursing staff should have the clinical skills to work with mental health patients, as they are cared for in all settings. After experiencing simulated practice and clinical practice, most students reported the simulated experienced helped them be more confident in their skills in the clinical practice setting (Eade & Winter, 2017). Approaching patients, especially those with mental health problems can be anxiety provoking. Simulation is a tool that can help nursing professionals in training learn to communicate and provide holistic care that addresses the physiological, psychological, environmental, and spiritual needs of the patients. Simulation can assist in the establishment of a trusting and meaningful relationship with the patient. The simulation experience is meaningful to the learner if there is a debriefing that identifies safety concerns. The learner should be mindful of safety concerns in the practice setting such as being too close to the patient, avoiding eye

contact, or having their hands in their pockets. This is also a good time to remind the learner that the use of silence in communication is a useful tool (Martin & Chanda, 2016). Role playing and the evaluation of interpersonal communication recordings help the nursing staff learn to focus on the patient, show empathy, and respond appropriately. It is important to always summarize the patient's concerns at the end of a communication session and provide some information on what the patient should expect next (Webster, 2014). A framework that can be used to help nursing staff provide effective communication is Solution-focused brief therapy. This framework helps the nursing staff focus on what the patient wants to happen, what they are doing to make it happen, and how they know change is possible (Smith & Kirkpatrick, 2013). It focuses on the patients' strengths and how they can use their strengths to help themselves (Smith & Kirkpatrick, 2013). Research studies on this framework demonstrate that it does provide structure for communication, focuses on goals, and reflects on the issues in the lives of the patients (MacInnes et al., 2016).

Nesset, Rossberg, Almvik, & Friis (2009) provided three weeks of training to the nursing staff to determine if training and education would improve the quality of milieu therapy. This education focused on involvement, support, orientation, anger and aggressive behavior, and order and organization. The results of the study demonstrated the education provided did improve the milieu and atmosphere of the care area and relationships between the staff and patients (Nesset et al., 2009). Safewards© model also provides education to staff and focuses on 10 interventions staff can use to decrease conflict and limit actions that might threaten the safety of the milieu. The Safewards© Model suggest the following: standard behaviors which are posted on the unit, advisory

statements for nursing staff that change every few days, individualized de-escalation techniques of patients to be shared with other staff, the requirement to verbalize positive statements to patients daily, be cognizant of upsetting news patients may be receiving, assist staff and patients to know each other better, patient meetings, distraction and sensory tools easily available for patients who become agitated, reassurance of other patients after an incident occurs, and positive messages from discharged patients posted in milieu. The Safewards© Model also focuses on the physical health of the staff, realizing the potential effects of burnout on care provided. This model also encourages providing exercise and healthy snacks for staff (Bowers et al., 2009).

Mindfulness training has been proven to help staff respond to challenging behaviors in a less reactive way (Brooker et al., 2014). Without intervention, challenging behaviors may continue. Restrictive interventions do not address the cause of the behaviors and does not teach the patient more adaptive ways to communicate their needs during times of struggle. Mindfulness training helps staff and patients learn to be more accepting and calm when circumstances are difficult to manage (Brooker et al., 2014). Other basic personal qualities that make for an excellent staff person capable of building therapeutic relationships include: being dependable, compassionate, reliable, knowledgeable, kind, warm, and empathetic (Sweeney et al., 2014). Without basic training and personal characteristics staff are at risk for retreating from stressful situations and burnout (Sweeney et al., 2014).

Use of Restrictive Interventions

Training on physical restraint is a necessity to ensure the safety of the nursing staff and the patients. There is concern that nursing staff participating in the therapeutic

role and safety roles are incompatible. The main concern with using physical restraint is it can reinforce the inequality of power in the staff-patient relationship (Knowles, Hearne, & Smith, 2015). The physical incident could be considered abusive, degrading, or traumatic for the patient involved (Knowles et al., 2015). There is also the question of whether the physical restraint is justified (Knowles et al., 2015). This question of justification could be related to negative attributes and motives of the staff (Knowles et al., 2015). Physical restraint also contributes to the feelings of helplessness and powerlessness of the patients involved (Knowles et al., 2015). It is important for staff to receive training that will help identify more therapeutic ways for patients to express their emotions to prevent the use of physical interventions (Knowles et al., 2015). It is important for nursing staff to remember that patients, including children and adolescents are admitted to mental health facilities because they have been determined to be a danger to themselves or others. Children and adolescents with developmental problems are at an increased risk for being exposed to restrictive interventions (Duke, Scott, & Dean, 2014). This danger may compromise the therapeutic milieu. Staff are responsible for using the least restrictive intervention to manage incidents and maintain the safety of all persons involved. The least restrictive intervention is verbal de-escalation. Other restrictive interventions include seclusion, physical restraint, and use of sedative medications on an as needed basis. The use of seclusion is a performance indicator and best practice requires minimal use of such interventions because they are considered traumatic for both the staff and the patients (Duke et al., 2014).

Nurses' attitudes have been shown to have an impact on the use of seclusion and physical restraints (Happell & Koehn, 2011). There is a relationship between burnout and

job satisfaction with the justification and use of seclusion (Happell & Koehn, 2011). It is a necessary intervention depending on the circumstances of the incident. If the patient is at risk for harming themselves, others, or property, the use of seclusion is considered appropriate. Many nurses believe the use of seclusion can help the patient calm and relax enough to reconnect with the patient population without being at risk for injury (Happell & Koehn, 2011). Nurses who experienced more symptoms of burnout were more likely to support the use of seclusion (Happell & Koehn, 2011). Nurses who were more experienced in mental health nursing were less likely to support the use of seclusion (Happell & Koehn, 2011).

Another factor to consider is the number of staff injuries related to the use of restrictive interventions. Ethical standards and law requires facilities to implement the least restrictive interventions to manage patient behaviors to ensure the safety of all involved. This has contributed to decrease numbers of physical restraint use and increased numbers of staff injuries. Frequently, assault on staff goes unreported because it may not have resulted in significant injury (Moylan & Cullinan, 2011).

Therapeutic Relationship Evaluation Tools

Several tools have been developed to evaluate the therapeutic relationships between patients and staff. The Scale to Assess Therapeutic Relationships (STAR), Client Satisfaction Questionnaire (CSQ), Interpersonal Relationship Inventory (IPR), Recovery Assessment Scale (RAS), and the Negative Events Schedule for staff (NES-S) and for patients (NES-P) are a few of the tools proven to be valid and reliable for assessing the therapeutic relationships between patients and staff (Sweeney et al., 2014). One specific tool used to evaluate communication between the care provider and children

is the Child Outcomes Survey (COS). It determines the caregivers' perception of a functional relationship between the child and family. It is important for providers to be aware of their personal perceptions to prevent interference in communication and building of therapeutic relationship with the child and the family (Terhorst et al., 2014). There are many tools that can be used to measure the communication between the provider and the patient, but there will seldom be one that measures all aspects of the therapeutic relationship (Zill et al., 2014).

Therapeutic Relationships and Process Improvements

There has been a long debate over the quality of care provided to mental health patients. When considering the adverse effects of restrictive interventions, one should also remember the need to maintain the safety of all persons involved in the incident. There are guidelines from governing bodies that promote the use of the least restrictive methods to maintain safety. The number of persons with mental illness who commit suicide or attempt to commit suicide is something to be considered. There are risk assessments completed on every person who enters a health care setting. But for those who do not seek any kind of care, the risks are unknown. Side effects of medications have been found to contribute to the mental illness (Bosanac et al., 2016). Electroconvulsive therapy has been proven beneficial for those who suffer from major depressive disorder that does not respond to other treatment; it is not the initial treatment of choice (Bosanac et al., 2016). These aspects of care are managed by the psychiatrist with the input of a multidisciplinary team.

Ward Milieu

For nursing staff, an important consideration is the setting in which care is being provided. The Ward Atmosphere Scale is often used to evaluate the perceptions of the nurses and nurse aides and reveals all staff have common perceptions of the milieu (Tuvesson, Wann-Hansson, & Eklund, 2011). Staff consider the required task of the environment, the social and organizational aspect of the milieu, and the individualized care component (Tuvesson et al., 2011). The environment should be satisfying to both patients and staff to help build quality relationships, offer encouragement, and develop skills. If the environment lacks resources, has high demands, and is not well organized it can create difficulties in social relations. Staff need to understand their roles as leaders on the unit and feel empowered to create an atmosphere that provides structure, rules, and expectations. Role clarity, communication, and support amongst coworkers is an important aspect of the environment. Improving the unit atmosphere contributes to the patients' ability to problem solve during difficult situations (Tuvesson et al., 2011). The environment can positively influence the mental health, physical well-being, and coping abilities of the staff. This directly impacts the ability of the staff to interact with the patients (Nicholls, Kidd, Threader, & Hungerford, 2015). Personal interactions with patients that consist of respect, empowerment, and a sense of worth contribute to the recovery of the patients. It improves their ability to function daily and leaves them satisfied with the care they have received (Browne et al., 2014). Nursing staff need to look beyond the satisfaction of care to determine what made a difference for the patient. This will help nursing staff, who provide care to thousands of people in their career, to provide a meaningful experience for the patient who is experiencing the care for what

might be the only time in their life (Bethke, 2014). Key drivers for patient satisfaction in mental health care include listening, respect, and helpfulness. CLEAR is an acronym used to describe improving the patient experience. It stands for connecting, listening, explaining, asking, and reconnecting (Bethke, 2014). These process improvement initiatives can help prevent problem behavior and provides effective behavior management. It requires special approaches that have been practiced and determined to be effective. The collaborative problem-solving approach has demonstrated the capacity to decrease the use of restrictive interventions (Duke et al., 2014).

Population and Community

The focus of this DNP project is on providing education and training of nursing staff to improve therapeutic relationships with the adolescent patients in the acute psychiatric facility. The nursing staff population in the project facility includes nursing administration, unit nurse director, unit nurse manager, nurse educator, registered nurses, licensed practical nurses, and nurse aide trained staff. Nurse aide trained staff make up at minimum 50% of the nursing staff population followed by the registered nurses accounting for approximately 22% of the nursing staff population. These nursing staff provide 24-hour care to the adolescent patient population ages 12 to 17. There is a maximum of 22 patients on the unit. The patient population is coed with maximum capacity of nine female and 13 male patients.

Patients cared for by the nursing staff suffer from a variety of disorders and diagnoses including but not limited to intellectual and developmental disabilities, post-traumatic stress disorders related to experiencing or witnessing a traumatic event or a history of abuse, neglect, or exploitation, or other mental health diagnoses. These patients

often lack skills needed to perform activities of daily living and struggle to provide self-care, socialize, and interact with their environment in appropriate ways. Nursing staff are challenged to engage these patients in activities of daily living in a meaningful manner to help them learn the skills they lack and need to re-enter the community.

The psychiatric unit for adolescents is a specialty care area and can be a demanding position for any nursing staff. Recruiting and retaining nursing staff for this care area has been a challenge. There is a vacancy rate of 67% for the registered nurses, which is currently covered by travel nurses. Approximately half of the travel nurses stay employed for more than a year, while others complete either one or two 13-week contracts and then leave for another position. All staff hired to work in the facility complete a 30-day orientation which is an introduction to the facility and psychiatric care in general, including training to ensure safety of staff and patients. If staff are hired into a position that requires nurse aide training, it will be provided if not already completed. There is no structured training on therapeutic relationships or communication with mentally ill, specifically for the child or adolescent patient population.

Nursing staff are expected to work in a multidisciplinary team environment in the project setting. The multi-disciplinary treatment teams meet bi-weekly to perform a treatment team meeting that includes the child and at least one member from each involved discipline. For nursing, this usually includes one Registered Nurse (RN) from the assigned unit and a second level Youth Program Educational Assistant (YPEA), the job title for nursing staff members who are Nurse Aide (NA) trained. The purpose of the treatment team meeting is to discuss the goals the child needs to work toward to be eligible for discharge and to evaluate progression toward these identified goals. The nurse

in attendance has the responsibility to bring the information gained through observation and caring for the patients from the unit nursing staff to the treatment team meeting. Any changes or updates made to the treatment plan are to be communicated to the nursing staff during shift report.

Sponsors and Stakeholders

External drivers impacting this project topic and direction include: regulation and public policies that address the treatment of patients with mental health disorders and prevent abuse, neglect, and exploitation of vulnerable populations. Regulatory agencies are responsible for monitoring and ensuring facilities provide appropriate care to the patients they serve. Other external stakeholders include: the citizens, families, health advocates, and support groups of the community. The community and public depend on mental health facilities to provide the best care to patients and help them return to the community as productive citizens. Internally, the leadership team and nursing administration depend on nursing staff to meet the needs of patients in a safe and therapeutic way 24-hours a day. Nursing staff work together as a team, along with patients to ensure safe care is received and results in positive outcomes. The nursing staff, patients, and patient families are stakeholders who are immediately impacted by the lack of education and training in therapeutic relationships. The better the relationships are inside the facility the sooner the adolescent patient can be discharged and begin to build therapeutic relationships in the home and community settings.

PICOT Question

In acute care in-patient psychiatric direct care nursing staff (P), who work with adolescent psychiatric patients, will an evidence-based staff education program that

encompasses content of diagnostic knowledge, treatment, and reflection of attitudes (I), impact (C) the knowledge base and attitudinal changes in direct care nursing staff (O) after completing the project staff education program (T)?

- P: Nursing staff
- I: Evidence-based staff education program with content
- C: before/after intervention
- O: Improvement in knowledge and attitudes
- T: After attendance and completion of DNP Project- Staff Education Program

Organizational SWOT

An assessment presented in Figure 1, of the project facility was completed to determine the strengths, weaknesses, opportunities, and threats in the project setting and adolescent care unit. This analysis was created to best determine the needs of the nursing staff and solidify the direction of the project. The development of this DNP project was guided by the assessment and the mission, vision, and values of the project facility. To overcome challenges the project facility nursing leadership and administration have committed to continue the support of this education and training by providing resources which include technology, training materials, and time for nursing staff to attend.

Support from nursing administration and leadership was granted in the beginning phases of the Improving Therapeutic Relationships amongst Psychiatric Nursing Staff and Patients project. It was clear that an improved effort to educate and train nursing staff on the adolescent unit would benefit all stakeholders. The project facility had the resources including educators and preceptors to sustain educational efforts. One area of concern is the facility provides most employee training and education during the initial

orientation phase. To provide education and training after orientation there must be special acquisition of technical equipment and consideration for nursing staff scheduling. Attending educational and training sessions removes staff from patient care, which can contribute to negative outcomes for the patients and remaining nursing staff on the unit and additional cost related to overtime. The project will improve the nursing staff knowledge of the most common diagnoses, Attention Deficit Hyperactivity Disorder, Intellectual and Development Disabilities, Post Traumatic Stress Disorder, Autism Spectrum, and other mental health disorders and attempt to improve the attitudes of nursing staff toward the mentally ill adolescent patients. It is the goal of the project that this improved knowledge and attitudes will assist the staff in focusing more on the problems the child is struggling with rather than the behaviors. This transition can be challenging for nursing staff to understand and accept as a new performance expectation. To overcome challenges the project facility nursing leadership and administration will continue to support education and training by providing resources which include technology, training materials, and time for nursing staff to attend. Figure 1 provides a comprehensive picture of the project SWOT analysis in further detail.

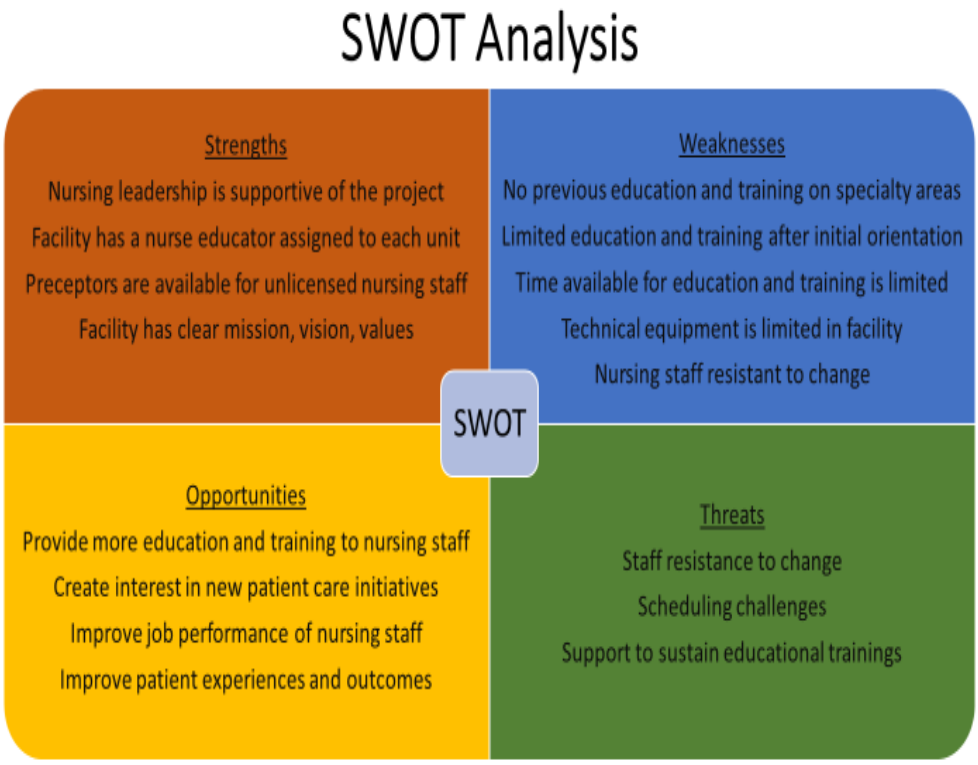

Figure 1. SWOT Analysis

Desired Outcomes

Restrictive interventions, physical restraint of the persons movements, is a means to ensure the safety of the child who is struggling, the other patients, and staff present at the time. When a restrictive intervention occurs, multiple staff are needed to manage the specific incident and maintain a therapeutic milieu. There is a therapeutic response team that responds to the overhead call for assistance, but the numbers of response team members coming to assist vary depending on the day, time of the event, and available personnel. During the restrictive intervention, staff available to assist the uninvolved

patients is often limited and this can lead to more incidents. At the project facility, there were an excessive number of restrictive interventions. Some incidents accounted for multiple interventions. For example, a child that cannot be redirected or de-escalated would be placed in a manual hold. If the child was released from the hold before they are completely calm, the child may immediately resume aggressive behaviors and need to be placed in another manual hold. Another example, when a child was taken to the quiet room, also known as the seclusion room, the behaviors that initially required the child to be placed in a manual hold may continue to escalate and require the child to be secluded for a period. This would be considered two interventions, a manual hold and a seclusion.

Staff assisting with the incident and the patient involved are at increased risk for injury. Restrictive interventions are implemented when a child or adolescent is considered a harm to themselves or others. The response team is trained to engage the child or adolescent in conversation or activity that may help de-escalate their behaviors. Prior to the call for the response team, de-escalation techniques were implemented unsuccessfully by unit staff. Often the calls for assistance are made when the incidents are out of control and the child or adolescent is being physically aggressive towards themselves or others.

Patient aggression against self or others often leads to the administration of as needed medications, usually in pill form or an intramuscular injection. Some of the most frequently prescribed as needed or stat psychotropic medications include Olanzapine, Quetiapine, Chlorpromazine, and Aripiprazole. These medications have side effects which can cause drowsiness, dizziness, blurred vision, and nausea and vomiting. The intramuscular injections can be traumatic for some children and cause pain at the site of

the injection. The children who receive medications during restrictive interventions are monitored for side effects after administration. The nurse is responsible for the assessment to determine if medication is needed and the effectiveness of the medication after administration, all of which are documented in the child's medical record and communicated to the appropriate treatment team members.

Some of the most common aggressive behaviors for adolescents resulting in restrictive interventions or use of as needed psychotropic medications include aggression against self, others, or property. Examples of aggression against self, include cutting, scratching, biting, head banging, punching, hitting, kicking, skin picking, and ingestion of foreign bodies. Aggression towards others can be towards nursing staff, other patients, or care team members. This includes punching, kicking, hitting, spitting, scratching, or pushing. Some of the aggression against staff often goes unreported if it is not significant enough to cause pain, swelling, or redness. Aggression towards property usually consist of property destruction. This could include personal property of the other patients or staff, or facility property. Sometimes patients attempt to break or destroy parts of the facility. These acts of aggressive behavior often result from unsolved problems that need to be identified and addressed. This can help prevent reoccurring behaviors and implementation of restrictive interventions. Restrictive interventions contribute to staff and patient injuries. There is a risk of staff exposure to blood and body fluids during restrictive interventions. Musculoskeletal injuries are a frequent complaint of staff involved in the restrictive intervention process. Some staff suffer from breaks in the integumentary system related to patient aggression including biting, hitting, and scratching.

Restrictive interventions also pose the risk of traumatization of the involved adolescent. Traumatic histories often lead to the patient experiencing mistrust and suspicion of staff (Dawson et al., 2005). They often fear that therapy was a process to pass judgment on them and that no one was sincere about helping them (Dawson et al., 2005). Six skills needed to effectively interact with the aggressive or violent patient include: basic interpersonal skills, humanity including being empathic and non-judgmental, knowledge about mental disorders, communication skills, personal qualities, and teamwork skills (Dawson et al., 2005). Patients' injuries are at times self-inflicted or related to the manual holding of the body to prevent injury to self or others. Leadership is charged with the responsibility of maintaining the safety of staff and the patients. This requires investigation into each incident. The restrictive intervention process is always monitored by the nurse on the unit and documented in the medical record as well as on the response team incident report. As a team, all participating staff discuss the incident, what led to the incident, and how future incidents could be prevented. This team debriefing occurs immediately after the incident is resolved. Audits are completed to ensure all aspects of the interventions are documented.

Project Team Selection

Developing the project team was not complicated as there were very qualified experts within the facility. These included the chief nursing officer as the practice partner and the unit nurse director and lead nurse educator as committee members. All members of the team have worked collaboratively on process improvement projects in the past. The project leader met with all members of the team to share the vision and plan for the project. The team members provided insight on the planning process, resources

available, and cost of implementing the project. Information about the need for and content of the project was shared as it developed.

Available Resources

The project facility is a state-funded facility. Resources needed for project implementation included: classroom space, computer, projector, paper and ink for printing, pens and highlighters, office space for project leader, and time for nursing staff to attend. Classroom and meeting space in the facility is readily available. The project leader had to schedule the space for training sessions with the assistance of an administrative assistant. Laptop computer and projector were made available and scheduled for use by the Information Services team. Paper, ink, pens, and highlighters are materials that are already available for staff to use to provide care for the patients. The office space and desk computer for the project leader to use was in the unit manager's office. The only resource that contributed to cost was the time for staff to attend the training sessions. This cost was only for the nursing staff who worked third shift, as they had to come in or stay over for an hour each day they had a training session. All project costs were covered by the project facility.

Scope of the Project

The nursing staff pre-project lacked the training needed to assist with the problems the children and adolescent patients encountered throughout the day. The nurses that practiced in the facility, specifically the child and adolescent units, have either associates or bachelor's degree education in nursing and various years of experience in mental health care practice. This experience often involves only adult populations, children, or a mixture of both patient populations. Approximately 75% of the staff nurses

were travel nurses, often with limited mental health experience. The nurse aide level staff had less formal education and training in mental health. Approximately 90% of the staff hired for the nurse aide positions received nurse aide training on the job. This training, along with the required nonviolent crisis intervention training is provided during orientation, prior to direct care patient exposure or duties. The authors, of the state nurse aide curriculum, based curriculum content on the 2009 job analysis report by the National Council for State Boards of Nursing (NCDHHS-DHSR, 2013). This report is a compilation of data from surveys of nursing staff in the acute medical hospitals and long-term care settings. Most of the respondents provided nursing care to elderly patients in the long-term care centers (NCSBN, 2009). While this training is meaningful in helping nurse aide level staff understand basic nursing care, personal care, and interpersonal care for the older person, there are significant limitations in the translation of care to children and adolescents with mental health care needs. The nonviolent crisis intervention training included information to help de-escalate the agitated or aggressive client and maintain the safety of both staff and patients. Yet, it also did not specifically focus on children or adolescents. Dr. Ross Greene's Collaborative and Proactive Solutions initiative was specifically focused on care and advocacy for behaviorally challenged kids and their caregivers.

Considering the gaps in staffing education and training, the Improving Therapeutic Relationships amongst Psychiatric Nursing Staff and Adolescent Patients project was developed and grounded in evidence-based material, to accommodate identified staff educational needs. The project focused on efforts to promote improved patient care, outcomes, and employee satisfaction and job performance. Staffing

guidelines required three nurses for each shift to care for patients and one nurse aide staff for every four or five patients. There was usually one roving nurse aide staff member to help meet the needs of the other nurse aide staff, allowing a staff member to always be physically present with patients. Without proper training, the nursing staff frequently encountered adolescent patients that struggled with various skills throughout the day and night. If staff were fortunate enough to have developed a therapeutic relationship with the child, they could help them to problem solve through the issue. If the staff with the established relationships were not available, a situation could quickly escalate for a child that was struggling and result in a restrictive intervention. The project facility in the past focused process improvement efforts on minimizing the use of restrictive interventions to address behaviors.

SECTION III

GOALS, OBJECTIVES, AND MISSION STATEMENT

Mission Statement

The mission of this project is to improve the necessary skills nursing staff require to develop therapeutic relationships with adolescent patients with mental health disorders and to provide a safe, therapeutic, goal oriented, goal directed, and structured milieu to aid in their skill development to function better in their community and society.

Goal

After participation in an evidence-based program and additional research-based learning activities, acute care mental health nursing staff, within two weeks of patient admission, will be able to identify at least two lagging skills for each assigned patient and demonstrate therapeutic communication techniques to aid in the management of lagging skills during the patient's hospital stay.

Staff Educational Program Objectives

1. Improved understanding of the roles of Youth Program Educational Assistant, Therapeutic Support Specialist, and Registered Nurse in the mental health facility, on the adolescent unit with regards to developing therapeutic relationships.
2. Increased knowledge base of the most common diagnoses affecting the adolescent patient population in the project facility.
3. Identify lagging skills of adolescent patients and interventions to assist the adolescent child with activities of daily living.

4. Demonstrate therapeutic communication techniques to promote positive character traits in the adolescent patients including; responsibility, caring, citizenship, fairness, respect, and trustworthiness.
5. Survey results will reflect changes in the attitudes and biases of the nursing staff toward the mentally ill.

SECTION IV

THEORETICAL UNDERPINNINGS

The first essential of doctoral nursing practice (DNP) states the underpinning of practice is theory (Zaccagnini & White, 2017). Theory is not always the first essential a practicing nurse considers when providing care, but it is the foundation of nursing practice. The DNP role is complex and includes researching, analyzing, processing, and using evidence-based practice in clinical practice (Houghton, Casal, Fortuna, & Larsen, 2015). The practice setting chosen for the project is an acute mental health care facility for adolescent children. This project used a systematic proven practice approach to help nursing staff change how they care for the patients they serve.

Peplau

Peplau's theoretical concepts have focused on developing therapeutic relationships and communication with psychiatric patients since she began her nurse training in 1931 (D'Antonio, Beeber, Sills, & Naegle, 2014). Her theory consists of an initial, working, and termination phase in therapeutic relationship and recognized the need to address the factor of anxiety in successful communication (D'Antonio et al., 2014). The Mental Health Act of 1946 recognized mental health care was a federal priority and nurses needed additional training in psychiatric care (D'Antonio et al., 2014). Patients have a basic human need to feel safe and secure. When this need is not met, tensions build and create energy that can be transformed into behaviors. The patient can become frustrated or angry, inattentive, feel guilty or doubt the efforts of those trying to help (D'Antonio et al., 2014). They can dissociate themselves from the situation (D'Antonio et al., 2014). The nurse has a responsibility to identify the needs and address

them in a manner that allows the patient and the nurse to move and grow through the experience. To accomplish this task the nurse must be neutral, nonjudgmental, understanding, and allow the patient to be an active participant (D'Antonio et al., 2014). For the nurse to establish themselves as a therapeutic agent, they should first be accountable to themselves. Their motives must be pure and honest (Peplau, 1999). Their priority needs to be to facilitate the best outcomes for the patients. It is important for nurses to be willing to continue to learn and practice new theories that assist them to focus on the problems of patients without making assumptions or acting upon preconceived ideas (Peplau, 1999). Important elements of therapeutic communication involve practicing with an open mind and disallowing personal beliefs from interfering with patient care (Peplau, 1999). The nurse is also accountable to their peers. Information sharing and peer review contribute to the profession and help to better define the responsibilities of the nurse in the mental health setting (Peplau, 1999). Overall, facility staff are accountable in the development of individually treatment plans that will be implemented by knowledgeable, well-trained staff. The staff must be competent and be able to problem solve with the patient to have the best outcomes (Peplau, 1999). The practice of caring, especially in mental health, can be abstract when compared to caring in the medical setting. It requires intelligence and thoughtful responses to the needs of the patients (Peplau, 1999).

It is important for the nurse to focus on providing care in an organized manner in relation to the stages of Peplau's framework. In the orientation phase, from the first encounter, the nurse begins to gather data. To effectively gather data the nurse should be aware of their body language and gestures. This will help the patient be more comfortable

and willing to share their beliefs, values, and choices, which can help develop a more individualized care plan (Deane & Fain, 2016). It is important for the nurse to look past the patient's deficits and empathize with the patient. Touch can be helpful in this phase if the patient allows it (Deane & Fain, 2016). It helps provide a sense of caring and compassion that can help decrease anxiety and help gain the patients trust (Deane & Fain, 2016). During the working phase the nurse takes on a new role in the care of patients. Being a counselor to the patient requires listening skills to allow the patient to connect with the nurse (Deane & Fain, 2016). As a teacher the nurse uses a respectful rapport with the patient to ensure they do not develop feelings of shame, humiliation, or embarrassment (Deane & Fain, 2016). During this working phase the nurse and patient identify the problems and determine the best way to solve the problems together (Deane & Fain, 2016). The termination phase is at discharge and requires a review of the work that has transpired between the nurse and the patient in hopes that the patient will utilize some of the skills obtained with them to use as they return to the community. This is a holistic practice and the nurses learn to process their own personal feelings, thoughts, and emotions about the patient and care provided (Deane & Fain, 2016).

Positive outcomes for patients once attributed to good nursing practice were considered the direct result of learning from physicians (Peplau, 2007). Nursing staff have since received their education from experienced nurses, theorists, nurse educators, and mentors. Nursing staff are charged with understanding how the challenges of the patient condition are affecting the ability of the patient to perform life functions. It is important nursing staff recognize where an individual is challenged and learn how to best help that individual overcome those challenges, whether it be physical or mental

obstacles. This requires nursing staff to begin to learn more about nursing theory and practice that addresses patient behaviors (Peplau, 2007). This is a change in practice for most psychiatric nursing staff.

The role of nursing staff in patient care is important. Nursing staff are at times the first to address patient needs either directly or through advocacy. In Peplau's theory, there are three phases the nursing staff must recognize and perform to build therapeutic relationships with the patient and promote positive outcomes (Butts & Rich, 2015). In the orientation stage, the nursing staff uses therapeutic communication to be open, concerned, and get to know the patient. This requires the nursing staff to recognize verbal and nonverbal cues to identify the patient needs. Once the needs are identified, the nursing staff begin the working phase and function as teachers, leaders, surrogates, and counselors for the patient. In the resolution phase, the nursing staff ensures the patient is increasing their ability to provide self-care and self-regulation more efficiently (Butts & Rich, 2015).

Rogers

Martha Rogers' Theory of Unitary Human Beings focuses on the relationship between the individual and the environment. Rogers defines health as an expression of the life process which reflects the characteristics and behaviors that result from how well the individual interacts with the environment (Petiprin, 2016). If the interactions are beneficial to the individual, their health will be optimal and if not well, the individual will not achieve maximum health. Martha Rogers' Theory of Unitary Human Beings recognizes that throughout the life process health can vary from a supreme level of health to being incompatible with maintaining life (Petiprin, 2016). The nursing care provided in

any facility should promote optimal health for all patients. The theory, Science of Unitary Human Beings and Nursing Process, states that nursing is two dimensional. It is a science that is organized and based on research and an art that allows for creative use of that knowledge to improve practice and better people (Petiprin, 2016). The people who benefit from nursing knowledge are not just patients. They are also the nursing staff who care for the patients. Rogers claims the nurses' ability to practice safely and serve people depends on the scientific nursing knowledge the nurse uses in his or her practice (as cited in Petiprin, 2016). Rogers' Theory of Unitary Human Beings has three steps: assessment, voluntary mutual patterning, and evaluation. Assessment should be a comprehensive observation of the individual and their environment (Petiprin, 2016). It determines the interactions between the two. The mutual patterning process identifies whether there is sharing of knowledge, choices being offered, does the environment empower the patient, how the environment affects nutrition, work/leisure activities, wake/sleep cycles, relationships, pain, and fear/hopes (Petiprin, 2016). The evaluation includes validating all this information with the patient through self-reflection (Petiprin, 2016). The nursing staff must understand that they are part of the patient's environment and their practice affects the patient (Petiprin, 2016).

Both theories focus on the role of the nursing staff in patient care, but in psychiatry the nursing staff is part of a team. The team is made of many entities including psychiatry, nursing, social work, psychology, and other professionals who all work together for best outcomes in patient care. There must be effective communication between the disciplines to ensure the patient receives best care and that all members are informed of the patient needs (Peplau, 1960). For this project, the focus will be on the

nursing team, which includes the nurse manager, nurse educator, charge nurse, staff member nurse, medication nurse, licensed practical nurse, and nurse aides. The nursing staff spend the most time with the patient in their environment, as they engage in patient interaction and observation. Peplau's theory focuses more on interpersonal relationships, specifically the relationship between the nursing staff and the patient. Therapeutic communication helps the nursing staff demonstrate concern for the patient. The nursing staff are the first in line to meet the needs of the patient. They have a responsibility to share the identified needs with the rest of the team. Roger's theory focuses on the setting in which care takes place and the nursing staff are part of that environment. The nursing staff must focus on the client's physiological, psychological, environmental, and spiritual wellbeing. This process will promote the exchange of experiences, thoughts, and feelings that are needed to have best outcomes.

Berne and Kohut

As the focus of this project included building therapeutic relationships and communication with the child and adolescent population, it is important to also consider the more contemporary concepts of Berne and Kohut. Berne's Game Theory suggests there is a cause and effect relationship between the patient and the nurse in which one person acts and the other reacts. In engagement with children, Berne's Game Theory notes the psychological game is often nonverbal, which is indicative of more behavioral manifestation (Eusden & Pierini, 2015).

Kohut's Theory of Self-development suggests that children go through a process of different desires. Initially, the child wants to be recognized, then they want to be idealized, and finally to be equal to the adult with whom they are forming a relationship

(as cited in Eusden & Pierini, 2015). Failure to recognize and respond to these desires or the failure to meet the desires can be a driving force in the relationship with the child (Eusden & Pierini, 2015). This recognition and response needs to come from many persons involved in the care of the patient (Eusden & Pierini, 2015). The nurse is not the only staff that will encounter the patient during their stay in the facility. There is a multidisciplinary team that will assist the patient. It is critical the team works together and understands that there are many ways to reach the goals of the patient. The team members must trust one another and respect their different functions in the care of the patient, understanding that the roles may overlap (Peplau, 1960).

Non-theoretical Techniques

Training for nursing staff should include therapeutic communication, including approaching the patient using a nonthreatening body stance, introducing self to the client, eye contact, efforts to put the patient at ease, maintaining appropriate boundaries, assessing for safety, responding appropriately both verbally and nonverbally, validating meaning of patient's response, summarizing content of interaction, and terminating the interaction (Webster, 2014). The nursing staff in the work setting may have learned about appropriate communication techniques in the school and clinical setting, but there must be a continuation of this learning in the work setting which focuses on the specific patient population. This is referred to as clinically relevant activity (CRA) which involves assessing, explaining, treating, and consolidating (Ruiz-Sancho, Froján-Parga, & Galván-Domínguez, 2015). This is very similar to the concepts of Peplau's theory. Assessing involves asking questions and getting to know the client and identifying their needs. Explaining is providing information to the client. Treating the patient can reinforce the

patient's actions if positive or relay disapproval if patients' actions are negative. Treatment allows the nursing staff to give instructions and allow the patient to accept or reject the information. Consolidating is like resolution in that the process includes summarizing the discussion or engaging in conversation that is not pertinent to the original conversation (Ruiz-Sancho et al., 2015). To best understand each individual patient's perspective on life and their feelings the provider needs to have good therapeutic communication skills (Smith & Kirkpatrick, 2013).

The nursing staff can also use Solution Focused Brief Therapy (SFBT) to help the client learn how to improve their life experiences by using the skills they already possess (Smith & Kirkpatrick, 2013). One example by Smith and Kirkpatrick (2013), the nursing staff engages the patient in a conversation about recent changes in health. After reviewing the recent changes, the nursing staff asks the patient about a miracle day and the patients' view on what and how that day would evolve. The nursing staff does not judge the patients' perceptions but looks for real solutions or exceptions in the description, things the patient could accomplish. The nursing staff is listening, demonstrating a sense of not knowing which allows the patient control in the situation to inform the nursing staff. The nursing staff then clarifies and measures the progress the patient has made towards achieving this miracle day. The nursing staff challenges the patient on how they might accomplish that miracle. When the patient fails to recognize their own abilities, the nursing staff can provide feedback which is comparable to the resolution stage to help the patient realize the control they have over their own destiny. SFBT considers individuals as resilient and imaginative problem solvers (Smith & Kirkpatrick, 2013). Allowing the patient to talk and asking very few questions demonstrates caring behaviors of the

nursing staff (Eusden & Pierini, 2015). Listening is a technique that allows the patient to learn from their own words (Eusden & Pierini, 2015). Listening and demonstrating care helps build therapeutic relationships between the nursing staff and the patients. The participants must be open to understanding each other's thoughts, feelings, and perceptions. The therapeutic relationship does not change, erase, or repair what the patient has lived and experienced, it helps the person make better choices about how they interact with others in the future (Eusden & Pierini, 2015).

Another method for building therapeutic relationships is CLEAR: connecting, listening, explaining, asking, and reconnecting (Bethke, 2014). Connecting involves acknowledging the patient, even if nonverbally. Listening consists of cues that demonstrate the nursing staff are paying attention. An example is explaining what you are doing in simple language, so they can understand. Ask if they have questions, to make sure they are comfortable with environment and information provided. Reconnecting with the patient every 10 minutes and when leaving demonstrates the nursing staff care about them (Bethke, 2014). Using CLEAR or similar method helps ensure therapeutic communication between the patient and the nursing staff.

There are many tools in existence that can be used to measure communication between the patient and the provider. Communication directly effects patient-centered care and satisfaction in the health care world (Zill et al., 2014). Observing and debriefing nursing staff communication techniques during and after interactions is most helpful in improving processes and promoting best outcomes for future interventions (Martin & Chanda, 2016). To provide optimum care, the nursing staff has a responsibility to create therapeutic relationships with their patients. They must be accountable for the work they

do each day. The nursing staff is accountable for knowing the circumstances of each patient's problems and to work toward problem resolution to create the best outcome for each patient. To do this in a collaborative manner with the patient, the nursing staff needs to identify not only the problem areas but also the strengths, abilities, hopes, and the individual's preferred future (Wand, 2013). The nursing staff are also accountable to their peers and their profession for knowing current theories that support their actions and for ensuring their actions are most useful in creating the best outcomes for patients (Peplau, 1999). Nursing staff must always strive to learn about evidence-based practice and seek out opportunities to implement practices daily to provide the best care to their patients (Langton, 2012).

SECTION V

WORK PLANNING

The project facility had an evidenced-based solution available to leadership that could be used to provide the education and training staff need to be more therapeutic with the children and adolescents they serve. The Dr. Ross Greene's Collaborative and Proactive Solutions (CPS) initiative from LivesIntheBalance.org recognizes that behaviorally challenged children/adolescents are often misunderstood and as a result are often treated punitive. This can potentially result in adverse outcomes. The research behind the CPS initiative has identified factors that contribute to the behaviors and considers lagging skills to be the area of focus to promote best care and outcomes. Lagging skills are defined as critical skills a child has not learned or mastered. It is a collaborative approach aimed at educating staff to recognize the needs of children and adolescents and training that will build more therapeutic relationships between the staff and the patients. The CPS initiative focuses more on the problems of the patient rather than the behaviors of the patients. It promotes proactive problem-solving instead of reactive problem-solving. The use of restrictive interventions is a reactive solution. It is important for staff to have a better understanding of each individual patient they care for to be able to provide the best care. CPS offers a tool that can be used to help staff identify lagging skills, the Assessment of Lagging Skills and Unsolved Problems. The DNP project focus was to help staff improve their attitudes toward children with behaviors, understanding the need to refocus care on the problems of the children rather than the behaviors of the children and to implement the CPS initiative and additional project educational content to assist staff with the identification of lagging skills. A timeline,

Figure 2, was created to organize planning of this project to help staff develop more therapeutic relationships and decrease the need for use of restrictive interventions, improving outcomes for both staff and the patients. Leaders in all specialty care areas have an obligation to help guide the continuing education of the nursing staff. To implement this project, the project plan and instruments were reviewed and approved for use by project facility administration and leadership and approved by the project academic setting IRB committee. The work plan provided a synopsis of the work that was completed for the project to be successful.

Problem Recognition Step 1	Aug-17	6 months
Drivers for the project		
Deficit in current practice		
Setting		
Mission, Vision, Values		
Target Audience		
Data Review		
Gaps in Practice		
Evidence Based Solutions		
Literature Review		
Needs Assessment Step 2	Aug-17	6 months
Current Practices		
Population		
Project Team		
Organization Assessment		
Desired Outcomes		
SWOT Analysis		
Cost Benefit Analysis		
Scope of Project		
Goals, Objectives, Mission Step 3	Nov-17	1 month
Theoretical Underpinnings Step 4	Feb-18	2 months
Hildegard Peplau		
Martha Rogers		
Lewin		
Work Planning Step 5	Jan-18	3 months
Synopsis of project plan		
Planning for Evaluation Step 6	Jan-18	3 months
Data collection instruments		
Data processing		
Project evaluation		
Implementation Step 7	Apr-18	3 months
IRB application and approval		
Implement		
Measure progress		
Closure		
Meet with Stakeholders		
Interpret Data Step 8	Jun-18	1 month
Utilization and Reporting Results Step 9	Jul-18	1 month

Figure 2. DNP Project Timeline

SECTION VI

PLANNING FOR EVALUATION

A descriptive, pre-test/post-test design was used to determine the effectiveness of the project. The Community Attitudes Toward Mentally Ill (CAMI) scale was used with the approval of the author and organization. Taylor and Dear (1981) presented the validity and reliability of the tool, which has been used to evaluate the personal attitudes of individuals towards the mentally ill since 1980. The scale was developed from two comprehensive and strongly validated existing scales, the Opinions about Mental Illness (OMI) and Community Mental Health Ideology (CMHI) scales (Taylor & Dear,1981). The OMI scales measured authoritarianism- which reflected a view of the mentally ill as an inferior class, benevolence- a sympathetic view of patients, mental hygiene ideology- a view of mental illness as an illness like any other medical problem, social restrictiveness- a view of the mentally ill as a threat to society, and interpersonal etiology- a result of stresses (Taylor & Dear, 1981). The CMHI scale has three conceptual categories focusing on characteristics of the total population, primary prevention, and total community involvement (Taylor & Dear, 1981). Considering the focus of these two scales, the CAMI was developed to measure four areas: authoritarianism, benevolence, social restrictiveness, and community mental health ideology (Taylor & Dear, 1981). Authoritarianism statements evaluate whether an individual thinks the mentally ill deserve the same care as others in society. Benevolence considers society's responsibility to the mentally ill, and the sympathy, kindness, and willingness of society to be involved in the care for mentally ill. Social restrictiveness addresses perceived dangerousness of the mentally ill. Community mental health

ideology instrument areas consider the impact of mental health facilities on the surrounding community and acceptance of community mental health care (Taylor & Dear, 1981). The response format is a standard Likert 5-point labeled scale: strongly agree/ agree/ neutral/ disagree/ strongly disagree. The four measures are separated into four sections and scored separately to minimize bias. Three of the four scales have high reliability: community mental health ideology ($\alpha = .88$), social restrictiveness ($\alpha = .80$) and benevolence ($\alpha = .76$). The fourth, authoritarianism ($\alpha = .68$), is lower, but remains satisfactory. The internal and external validity of the CAMI scales was extensively analyzed. Weak items were identified and replaced by the creators. High levels of internal validity were shown for the final scales based on item-scale correlations, alpha coefficients, and factor analysis. External validity was examined in two ways, construct and predictive validity. The strength, direction, and consistency of the relationships indicated strong external validity of the CAMI scales (Taylor & Dear, 1981).

Descriptive statistics using bar graphs were used to report the data from this survey, which are to be given to participants on day one and again on day four, per the pre-post survey design. Several other activities were utilized during the four training sessions. These additional activities included power point educational presentations, case studies in individual and group activities, and reflection exercises. All surveys and activities were pen and paper versions and completed on a voluntary basis. Participants submitted a blank document if they chose not to participate in the activities and could stop the survey at any time. They were instructed not to include any identifiable information on the documents. The project leader left the room while participants completed and submitted the surveys and activities. No identifying information of

participants was requested on any survey. A selected designee collected the documents after completion and placed them in a large envelope which was sealed prior to giving to the project leader. All participants were given the same writing utensil to complete surveys and activities. These procedures helped maintain confidentiality of the participants. The documents were kept in a locked file cabinet in the locked office of the project leader at the project facility. Quantitative data used and collected for the project consisted of facility data on staff member population, patient population, restrictive interventions, staff injuries, and aggressive behaviors the patients demonstrated. There were also pre-and post-test activities to determine a change in knowledge and learning because of training participation and completion. Finally, the project evaluation provided an opportunity for nursing staff to evaluate the training sessions. After all data was collected and compiled, the Focus Analyze Develop and Execute (FADE) process allowed the project team to focus on what needs to be improved, analyze what was effective, develop a plan to improve the initiative for future use, and execute a more effective version of the training in the future.

SECTION VII

IMPLEMENTATION

A relationship with the project facility was established through the creation of the project team including the project partner, the Chief Nursing Officer, project committee members, the Nurse Director, and Nurse Educator. The mission of the project coincides with the mission of the organization in that both missions indicate a desire to provide the best care to the patients served in the facility. Through literature and facility data review, there was an identified need to improve therapeutic relationships between the psychiatric nursing staff and the adolescent patients. The gap in practice is a lack of staff education and training which focuses on the patient areas of diagnoses, treatment, lagging skills, and behavioral origins. The lack of education and training can lead to poor relationships, misunderstandings of patient needs, use of physical restrictive interventions for behaviors which create a safety risk to the patient, staff, or property, and increased patient and staff injuries. The evidence-based program, Collaborative and Proactive Solutions (CPS) content is from the Livesinthebalance.org website. This program is designed to help care providers focus more on the lagging skills of children rather than their behaviors. The project facility had been trying to implement (CPS) in the facility for the past two years. The CPS approach identified the lagging skills, or skills that have not been fully developed or mastered of each child and focused less on the behavior and more on the cause of the behaviors. A small group of interdisciplinary team members were trained extensively on the approach and were expected to implement the approach as part of the treatment team meetings that occurred biweekly. This process of initiating the CPS

approach left out many team members who spend significant time with the children throughout every day, direct care nursing staff.

The nursing staff of the project facility child and adolescent units were utilized as a convenience sample to participate in Improving Therapeutic Relationships amongst Psychiatric Nursing Staff and Patients project. The nursing staff includes approximately 80 participants, including the nurse director, nurse managers, nurse educators, registered nurses, licensed practical nurses, and Youth Program Educational Assistants (YPEA) and Therapeutic Support Specialists (TSS). The project participants were notified via staff meetings, led by the facility management team, that they were required to attend the mandatory training sessions. These were scheduled by their nurse manager. The training session dates and times were communicated through a posted training calendar in the nurses' station. The plan was to provide training sessions to all staff within a four-week period. An attendance record was completed at the beginning of every session to ensure all participants attended all four training sessions. If there was an absence from one or more of the sessions, an opportunity to make up the missed session was provided. At the beginning of the educational session on Day One, the informed consent (Appendix A) was reviewed by the project leader which addressed project purpose, description, risks, confidentiality, right to refuse participation, and project leader contact information (Appendix A). Although attendance and participation of the staff educational program were required, participation in survey completion was voluntary. All participants were provided two copies of the consent signed by the project leader, one copy to be signed and returned to the project leader and one for the participant to keep. There was an opportunity for questions during and following informed consist review. Each participant

was asked to sign the consent and return it to the project leader after the review of the consent is completed. Participants could turn in blank forms to protect their anonymity and right to refuse participation in survey collection.

The training sessions consisted of four one-hour presentations provided on four different days in one week. The training calendar informed nursing staff of all four assigned training days. The four sessions were repeated weekly for the next assigned group and any participants that missed a session the prior week. This continued for four weeks. Initially, there were two sessions a day, one at 7:00 a.m. and one at 10:00 p.m. This allowed for first shift staff to attend in the morning, second shift staff to attend in the evening, and third shift staff could attend either morning or evening sessions. The morning session was changed after the first week to 9:30 am to better accommodate the shift change and transitioning of staff. The plan was to complete training for approximately 20 participants each week. The total number of participants was 61. The training presentations included lecture using power points, educational videos from the evidence-based program content, and individual and group activities from Collaborative and Proactive Solutions and the project leader. All materials focused on improving knowledge of diagnoses and treatments and developing therapeutic relationships with the patients. Your Story (Appendix B) was an activity created by the project leader that provided an opportunity for nursing staff to share their perceptions of patient care prior to receiving training. Collaborative and Proactive Solutions is an evidence-based program that was selected by the project facility administration and leadership to guide staff in the care of children with behavioral problems. With the permission of the Lives in the Balance organization, the participants were asked to complete The School Discipline

Survey (Appendix C) as an activity during day one training session. The Assessment of Lagging Skills and Unsolved Problems (ALSUP) tool (Appendix D) was presented on day two of training. These two documents came directly from Collaborative and Proactive Solutions and were not amended. The project leader created a brochure to supplement the discussion on the assessment tool. Other activities developed by the project leader included, "What do you already know?" (Appendix E) which was completed on day one of training and "What knowledge have you gained?" (Appendix F), completed on day four of training. These two activities promoted active participation in the sessions through analysis of case studies. The activities and content of the case studies facilitated an increased familiarity with commonly diagnosed disorders of the patient population. At the end of the DNP project implementation, the Improving Therapeutic Relationships Training Evaluation (Appendix G), developed by the project leader was distributed and completed by 79% of the participants. This evaluation survey provided information of the nursing staff perceptions of the overall effectiveness of the project. The websites used to obtain some of the instruments and videos included livesinthebalance.org, understood.org, youtube.com, and camiscale.com. Written permission was obtained via email from LivesintheBalance.org, Understood.org, and from the disclaimer on camiscale.com. All websites utilized had disclaimers that state the information on the site is available for use with clear acknowledgement of the source and that content is not edited without acknowledgement or permission. The content from the websites was used via a direct link to the websites in the presentations. There was no editing of the information used from the websites.

Training Sessions

Day one of training began with review and completion of informed consent. The CAMI pre-test and Your Story activity were distributed at the same time. The project leader left the room and allowed the participants to place these documents, informed consent and CAMI pre-test, in an envelope to maintain anonymity. There was a power point presentation that was designed to present the need for education and training using data from the facility and staff surveys. The data included information on the patient population, restrictive interventions, staff injuries, and patient aggression. The presentation of this information to the nursing staff was provided to potentially instill the need to change practice and create a more positive reception of the information to be presented on the following days. The roles of the nursing staff were reviewed to identify common themes which demonstrated the responsibility of all nursing staff to strive to have more therapeutic relationships with the patients. Nursing theorists Hildegard Peplau and Martha Rogers were introduced and briefly discussed on day one as their theories support therapeutic relationships. Another activity for day one was "What do you already know?" This activity identified learning needs of the nursing staff related to understanding common diagnoses of the children and interventions the nursing staff can implement to help children with these disorders.

Day two power point presentation provided more information about the patient population, common diagnoses, behaviors, and problems that may lead to behaviors. A brochure was created by the project leader to introduce participants to the Collaborative and Proactive Solutions ALSUP evidenced-based tool. The tool was accessed through a direct link to the Lives in the Balance website, which is the source of the tool. This

information was provided as a paper copy for the participants to review during discussion on the intended use of the tool. This tool can be used to identify lagging skills of children and adolescents. The project facility had chosen the Collaborative and Proactive Solutions program and ALSUP tool to be used in patient care but had not implemented full staff training. Select and limited numbers of management had received training over a year prior to project implementation, however, direct care nursing staff had not received formal training up to this point. The participants also completed an individual activity on day two, The School Discipline Survey, with the permission of the Lives in the Balance organization. The activity included a group discussion on the information presented in the activity.

Day three focused on improving participant knowledge of patient conditions. The most common diagnoses of the patient population, specifically causes, signs and symptoms, and techniques used to help the patient were reviewed. The power point presentation had direct links to videos from understood.org which have been approved for use by the website. The project leader developed a group case study activity for day three to help staff better understand how a patient with this disorder may present and feel about their diagnoses and how their diagnoses can affect their ability to perform daily living skills and interact with others.

Day four power point presentation focused on therapeutic communication, both verbal and nonverbal. Content included in this presentation was in place to reiterate to nursing staff they are role models to help patients learn positive character traits. The activity for day four is, “What knowledge have you gained?” This activity demonstrated improved understanding of patient conditions. The Improving Therapeutic Relationships

Training Evaluation was completed on day four. Nursing staff members were asked to complete the CAMI survey again on day four to determine if there was a change in nursing staff attitudes toward the mentally ill post-project participation, as content focused on considering the children and the origin of their problems versus solely their behaviors.

SECTION VIII

INTERPRETATION OF DATA

The Community Attitudes toward Mentally Ill (CAMI) survey was the instrument used in the project to determine improved knowledge and change in attitude of nursing staff towards persons who are mentally ill. The survey used four scales (authoritarianism, benevolence, and social restrictiveness and the Community Mental Health Ideology-CMHI) developed with health care professionals in mind as the potential respondents (Taylor & Dear, 1981). As noted in the following tables some statements on each scale expressed a positive sentiment with reference to the underlying concept, and the others were negatively worded (Taylor & Dear, 1981). The statements worded positively represent a pro-concept sentiment, and the others which were negatively worded were anti-concept. The response format was the standard Likert 5-point labeled scale: strongly agree/agree/neutral/disagree/strongly disagree. The statements were sequenced in 10 sets of 4, one pro-statement for each concept then one anti-statement for each concept (Taylor & Dear, 1981). The sequencing helped minimize response bias (Taylor & Dear, 1981).

Authoritarianism

The authoritarianism statements focused on the individuals' perception of the need to hospitalize the mentally ill, the difference between the mentally ill and normal people, the importance of custodial care, and the cause of mental illness (Taylor & Dear, 1981). Table 1 provides information on the authoritarianism statements that were most strongly scored by respondents and the difference between pre-and-post survey results. The purpose of the training provided was to help staff better understand the mental health disorders and identify the problems the patient may experience, which may lead to the presentation of behaviors. The significant difference in pre-and-post survey results for

Statement (i); There is something about the mentally ill that makes it easy to tell them from normal people, demonstrates a better understanding of the staff that indicates it is not easy to determine if a person has mental health problems.

Table 1

Authoritarianism

Authoritarianism Statement	Pre-Survey Result	Post-Survey Result	Change in Response
e. Mental illness is an illness like any other. – A ANTI	56.7% strongly agree or agree	61.4% strongly agree or agree	4.7% increase
i. There is something about the mentally ill that makes it easy to tell them from normal people. - A PRO	78% strongly disagree or disagree	59.1% strongly agree or agree	18.9% decrease
u. The mentally ill should not be treated as outcasts of society. - A ANTI	83.1% Strongly agree or agree	79.5% strongly agree or agree	3.6% decrease
y. The best way to handle the mentally ill is to keep them behind locked doors. -A PRO	88.1% strongly disagree or disagree	81.4% strongly disagree or disagree	6.7% decrease
cc. Mental hospitals are an outdated means of treating the mentally ill. - A ANTI	69.5% strongly disagree or disagree	67.4% strongly disagree or disagree	2.1% decrease
gg. One of the main causes of mental illness is a lack of self-discipline and will power. -A PRO	69.5% strongly disagree or disagree	65.1% strongly disagree or disagree	4.4% decrease
kk. Virtually anyone can become mentally ill. - A ANTI	89.1% Strongly agree or agree	93.8% Strongly agree or agree	4.7% increase

Benevolence

For benevolence, the statements focused on the responsibility of society for the mentally ill, the need for sympathy, kind attitudes, willingness to become personally involved, and anticustodial feelings (Taylor & Dear, 1981). Benevolence is the scale that

was overall more strongly scored than the other scales. This is a significant factor which demonstrates the level of compassion the staff have toward the patient population. Table 2 provides information on the statements that were most strongly scored by participants. The greatest changes in response were to statements: (hh); We have the responsibility to provide the best possible care for the mentally ill, and (f); The mentally ill are a burden on society. The change in these responses reflects a changing perception of staff attitudes toward patients. The nursing staff may present with a better understanding that while the patient is in the acute care setting it is the responsibility of the care team to provide the best care to the patient. It is not the responsibility of the individual nursing staff alone. Also, while in the acute care setting the goal is to stabilize the patient, identify disorders and problems that contribute to the behaviors. This allows the treatment team to begin working on interventions to address the disorders and problems which will continue when the patient is discharged to the next care setting. There was a 9.1% decrease in the number of respondents disagreeing with statement (ll); It is best to avoid anyone who has mental problems. The training focused more on identification of problems that underlie behaviors rather than focusing only on the behaviors. Staff may have been more agreeable to this statement after training if they were considering patient behaviors rather than the patient as a person when reading this statement. The training reflected and reviewed the poor outcomes that may occur when staff responded to strictly behaviors, often a result of unmet needs or lagging skills. The training taught staff to be observant, identify, and address the problem or lagging skill. The following statements: (b); More tax money should be spent on the care and treatment of the mentally ill, (j); The mentally ill have for too long been the subject of ridicule., and (r); We need to adopt a far more

tolerant attitude toward the mentally ill in our society, also showed significant change after training was completed, as reflected in Table 2. Training discussed the need for more resources to assist with the needs of mentally ill children.

Table 2

Benevolence

Benevolence Statement	Pre-Survey Result	Post-Survey Result	Change in Response
b. More tax money should be spent on the care and treatment of the mentally ill. - B PRO	71.7% Strongly agree or agree	79.5% Strongly agree or agree	7.8% increase
f. The mentally ill are a burden on society. - B ANTI	71.7% strongly disagree or disagree	81.8% strongly disagree or disagree	10.1% increase
j. The mentally ill have for too long been the subject of ridicule. - B PRO	75% Strongly agree or agree	68.2% Strongly agree or agree	6.8% decrease
n. Increased spending on mental health services is a waste of tax dollars. - B ANTI	84.7% strongly disagree or disagree	81.8% strongly disagree or disagree	2.9% decrease
r. We need to adopt a far more tolerant attitude toward the mentally ill in our society. - B PRO	73.3% Strongly agree or agree	79.1% Strongly agree or agree	5.8% increase
dd. The mentally ill do not deserve our sympathy. - B ANTI	83.1% strongly disagree or disagree	83.7% strongly disagree or disagree	0.6% increase
hh. We have the responsibility to provide the best possible care for the mentally ill. - B PRO	100% Strongly agree or agree	85.7% Strongly agree or agree	14.3% decrease
ll. It is best to avoid anyone who has mental problems. - B ANTI	89.1% strongly disagree or disagree	80% strongly disagree or disagree	9.1% decrease

Social Restrictiveness

Social restrictiveness statements included the following themes: the dangerousness of the mentally ill, maintaining social distance, lack of responsibility, and the normality of the mentally ill (Taylor & Dear, 1981). The statements in this category were the next group most significantly scored by the participants. Table 3 includes statements and the pre and post-survey responses of the participants. There was a significant decrease in the scoring for (k); A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered and (o); No one has the right to exclude the mentally ill from their neighborhood. This decrease is possibly an indicator that staff have a greater appreciation for the right of individuals with mental illness to live as normal a life as possible.

Table 3

Social Restrictiveness

Social Restrictiveness Statement	Pre-Survey Result	Post-Survey Result	Change in Response
c. The mentally ill should be isolated from the rest of the community. - SR PRO	73.3% strongly disagree or disagree	75% strongly disagree or disagree	1.7% increase
k. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered. -SR PRO	74.6% strongly disagree or disagree	54.5% strongly disagree or disagree	20.1% decrease
o. No one has the right to exclude the mentally ill from their neighborhood. - SR ANTI	86.4% Strongly agree or agree	72.7% Strongly agree or agree	13.7% decrease
w. Mental patients should be encouraged to assume the responsibilities of normal life. - SR ANTI	86.4% Strongly agree or agree	81.4% Strongly agree or agree	5% decrease
ee. The mentally ill should not be denied their individual rights. - SR ANTI	88.1% Strongly agree or agree	86% Strongly agree or agree	2.1% decrease
ii. The mentally ill should not be given any responsibility. - SR PRO	87% strongly disagree or disagree	75% strongly disagree or disagree	12% decrease

Community Mental Health Ideology

The CMHI scale, statements expressed these sentiments: the therapeutic value of the community, the impact of mental health facilities on residential neighborhoods, the danger to residents posed by the mentally ill, and acceptance of the principle of deinstitutionalized care (Taylor & Dear, 1981). Table 4 includes four significantly scored statements for this group. Factors that may contribute to these results include the survey being used in the clinical setting and training that occurred during work hours. Staff may

have been more focused on the clinical care environment rather than the neighborhoods that surround the facility. Also, the facility is in a rural area without many residents, possibly contributing to a geographical or demographic bias. There was a 13.2% increase in the number of nursing staff that either agree or strongly agree with the statement, (d); The best therapy for many mental patients is to be part of a normal community. During training there was discussion about the importance of having resources available in the community to assist with mental health problems, possibly preventing the worsening of conditions and admittance to acute care facilities. There was a 12.3% increase in the number of staff that either disagree or strongly disagree with the statement, (nn); It is frightening to think of people with mental problems living in residential neighborhoods. It may be frightening to know that people are living in the community with serious mental illnesses and the knowledge there are limited resources that exist. The possibility that people who do recognize mental illness symptomology may not assist the person in finding the appropriate resources to get the help they need can be frightening to all involved.

Table 4

Community Mental Health Ideology

Community Mental Health Ideology Statement	Pre-Survey Result	Post-Survey Result	Change in Response
d. The best therapy for many mental patients is to be part of a normal community. - CMHI P	55% Strongly agree or agree	68.2% Strongly agree or agree	13.2% increase
h. Locating mental health facilities in a residential area downgrades the neighborhood. - CMHI A	60% strongly disagree or disagree	61.2% strongly disagree or disagree	1.2% increase
l. As far as possible mental health services should be provided through community-based facilities - CMHI P	64.4% Strongly agree or agree	70.5% Strongly agree or agree	6.1% increase
nn. It is frightening to think of people with mental problems living in residential neighborhoods. - CMHI A	58.7% strongly disagree or disagree	71% strongly disagree or disagree	12.3% increase

Staff Knowledge

One of the goals of the project was to increase knowledge of staff regarding the most common diagnoses of children with mental health problems in the acute care setting. Figure 3 includes the results of an activity staff completed on day one of training to determine their current knowledge base. The activity results revealed the staff needed more information to distinguish between Asperger's and Attention Deficit Hyperactivity Disorder (ADHD). The pre and post-activity demonstrated staff could appropriately select nursing interventions to implement that assist the child with the problems they were experiencing. Results in Figure 4 provides information from the activity which was repeated on day four with additional questions to determine if learning had taken place because of the training. There was an increase of 15.1% of staff were able to identify ADHD as the possible disorder based on the information provided in the case study,

when comparing the results of the day one activity with the day four activity. The results of identifying Asperger's as the possible diagnoses decreased by 1.9%. These results indicate a need for further training on presenting factors of various disorders and diagnoses.

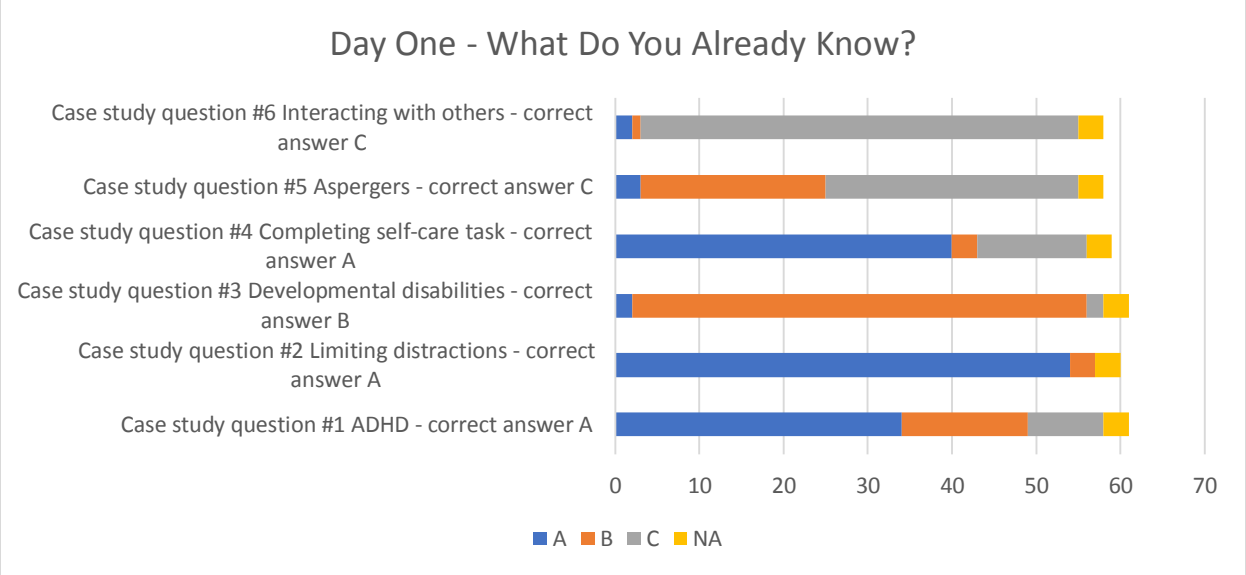

Figure 3. Day One Knowledge Activity

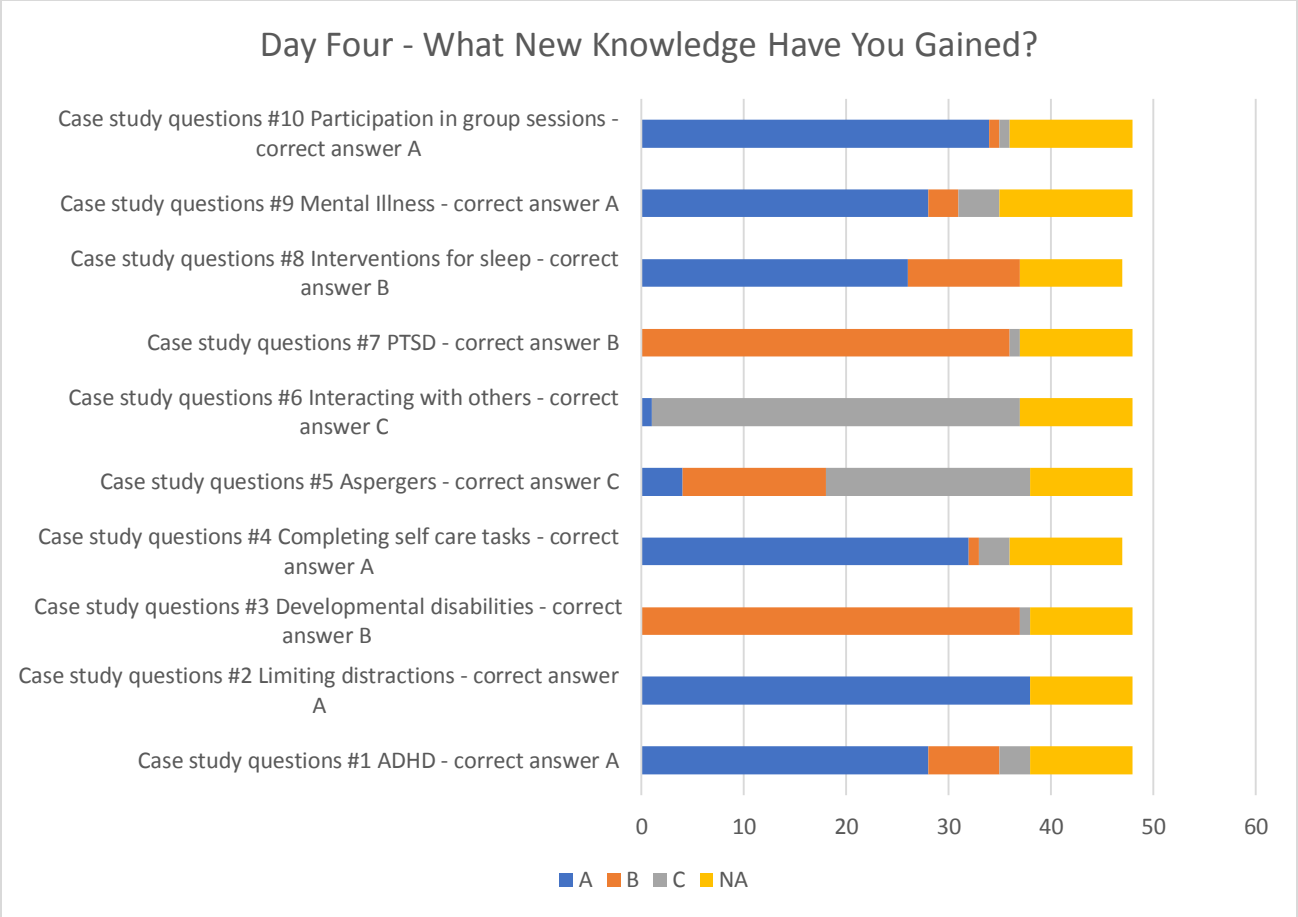

Figure 4. Day Four Knowledge Activity

School Discipline

The project setting is a school facility and academic services are an expectation for the in-patient adolescents. Many behavioral incidences occur in the school setting within the project facility and nursing staff are involved in managing those incidents. The school discipline survey was another activity completed during the training sessions. The purpose of this activity was to determine the nursing staff perceptions of the current interventions used to address the behaviors of the children. This survey is a part of the Lives in the Balance, Collaborative and Proactive Solutions program. The survey asks yes or no questions about the thoughts, perceptions, and responses of the nursing staff

who care for children. There was a 96% participation rate for this survey. As noted in Figure 5, the majority responded positively to only one statement, Does the discipline process rely heavily on adult imposed consequences? The majority, 51 of 59, or 86% of participants, responded no to this statement. Recently, the facility has been trying to implement the Collaborative and Proactive Solutions plan for addressing patient behaviors. Through this implementation process, many nursing staff have stated there are no longer consequences for the inappropriate actions of the children in their care. The majority of the nursing staff responded that the problems causing the behaviors include the following: behaviors are reoccurring, negative terms are often used to describe children with behaviors, children are often removed from the common area when presenting with behaviors, meetings about the children focus on the behaviors rather than the problems, behaviors are addressed more frequently than focus on the problems the child may be experiencing, and children return to in-patient treatment despite the treatment they have received and the discharge plans created to facilitate outpatient treatment and care.

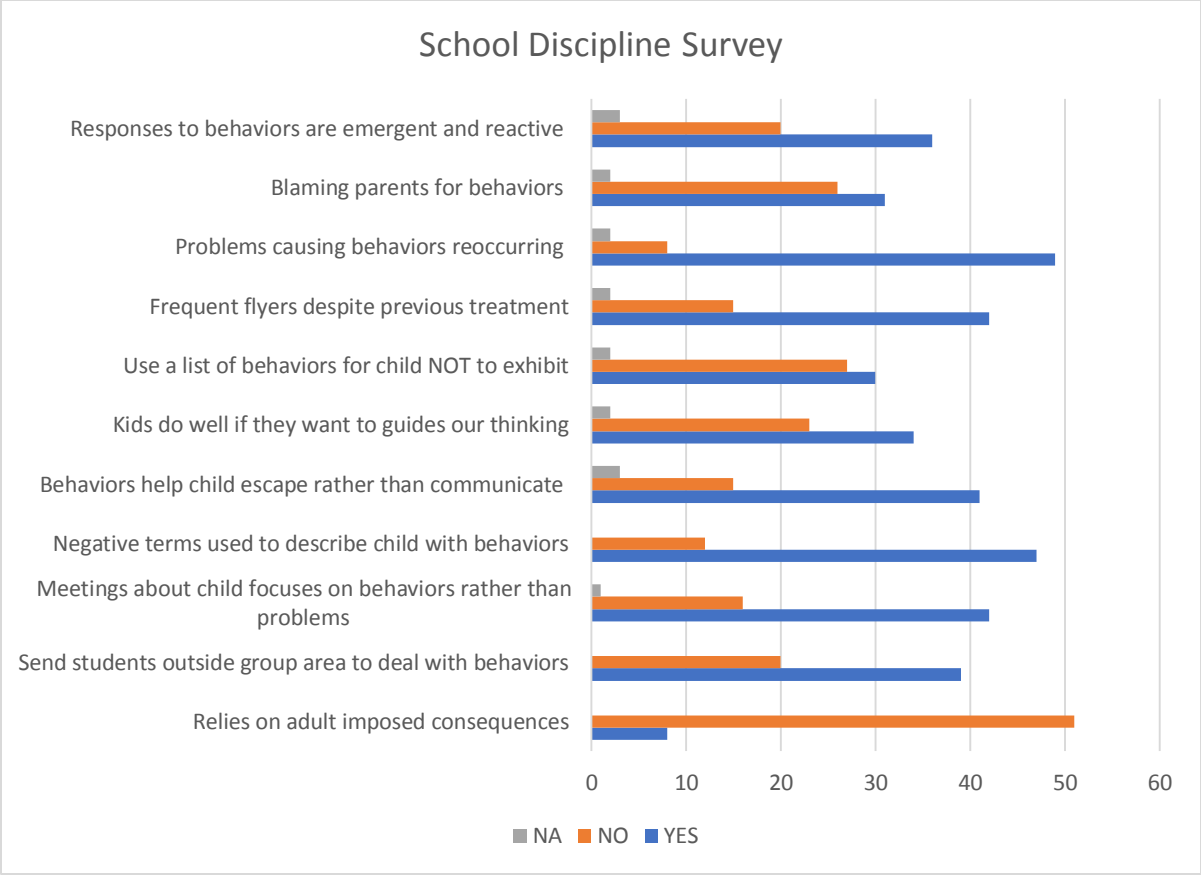

Figure 5. School Discipline Survey

Discussion

This DNP project focused on providing targeted, evidence-based training for direct care nursing staff focusing on noted gaps in knowledge of mental illness conditions, elements of therapeutic communication, development of therapeutic relationships among staff and patients, and expanding positive attitudes in staff members toward their patients. This educational project also included pertinent data from the facility and research-based evidence to demonstrate the need for staff education. Addressing the need for improved relationships among the psychiatric nursing staff and patients could assist with decreasing the number of restrictive interventions, staff injuries, and create a more therapeutic environment for patients and nursing staff. Figure 6

includes the results from the staff evaluation of the DNP project training. One hundred percent of the nursing staff responding to survey statements reported the training sessions were appropriate and helpful.

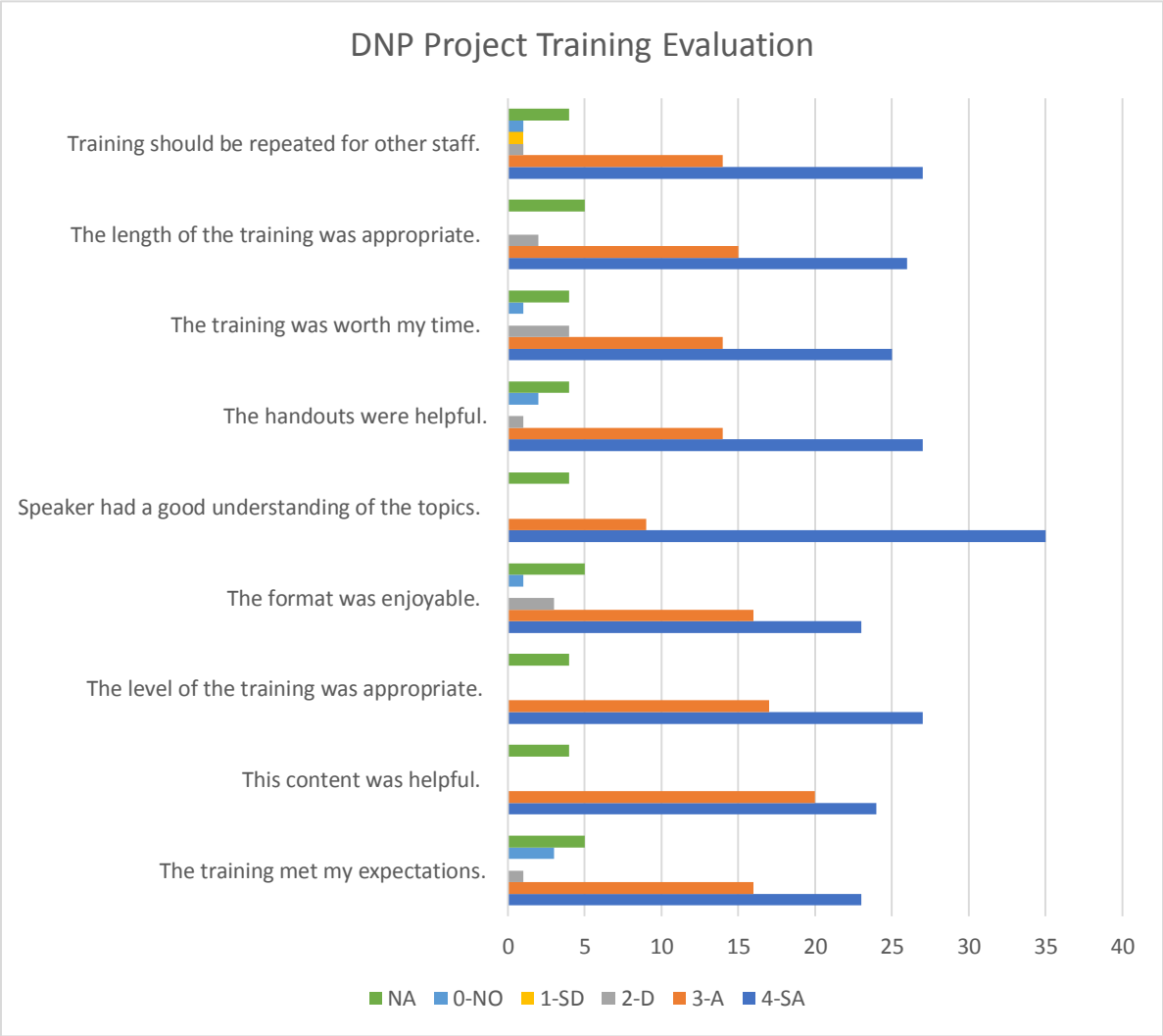

Figure 6. DNP Project Training Evaluation

The nursing staff had a good baseline knowledge of the possible disorders from which the children may suffer. The training did introduce and discuss the facility initiative of Collaborative and Proactive Solutions. Nursing staff's ability to identify the

problems that cause the behaviors demonstrated improvement post-training. Minimizing the negative outcomes resulting from addressing behaviors the children present with rather than addressing the problems they struggle to manage can create better outcomes for the patients and the nursing staff. The project results were reported to the project facility through meetings with administration and leadership, and nursing staff and via a presentation format at the project academic setting.

Sustainability

The post project plan is to sustain these educational training sessions as part of new nursing staff orientation on the adolescent unit. This will eliminate the need to pay overtime for attending training. It will provide the new nursing staff with beneficial information to help them perform their job duties and responsibilities better. Training of the preceptors to provide the information in an effective manner will also sustain the initiative. To maintain consistency and improve sustainability the preceptors will use the power point presentations with some modifications to decrease the time needed to cover the material. The facility data and links to the videos will need validation and updating on a regular schedule to ensure staff are receiving most current and relevant information. The training provides a clear message about nursing staff performance expectations.

Conclusion

Ongoing education and training may improve therapeutic relationships among psychiatric nursing staff and adolescent patients. This education and training should help nursing staff consider the physiological, psychological, environmental, and spiritual needs of each child individually. Nursing staff should understand the child's background, individual needs, and expectations of care. This information once known needs to be communicated amongst providers to prevent children from having to share information

every time a new provider takes over care. The nursing staff team should consist of well-established team dynamics which include common goals and concerns. It is important for nursing staff to be engaged in the milieu and the environment. Meeting the needs of the patient is a shared responsibility. To help children accomplish their goals and meet the expectations of patients and families, nursing staff work together as a cohesive team to balance of completing job tasks and providing patient care. There are barriers that need to be addressed to create the nursing care team that can efficiently meet the needs of the children and the nursing staff.

Nursing leaders are in excellent positions to assist with overcoming the barriers which include, patients' fear of being judged, feelings of quilt, or shame about what they have experienced in their past. Leaders need to be aware that some nursing staff can be persecutory, blaming, or rejecting when it comes to caring for children with behavior issues. The nursing staff need to be emotionally intelligent, aware of themselves, their personal feelings and knowledge or lack thereof. They need to be motivated to participate in continuous quality improvement. Nursing staff need to be consistent, accountable, and responsible with well-defined boundaries and expectations. All these concepts can be accomplished when a nursing team is in place that is focused on the goals, respectful, and honest.

Nursing leaders can provide opportunities for nursing staff to learn and practice caring for mental health patients, using therapeutic approaches and techniques. Restrictive interventions reinforce inequality of power in the nursing staff-patient relationship. The physical incidents are traumatic for all involved. Nursing leaders should be aware of innovative nursing education initiatives to improve nursing practice.

Innovative programs discussed in this DNP project include: CLEAR method for communicating effectively, Safewards©, Solution Focused Brief Therapy (SFBT), simulation with debriefing, role playing, and mindfulness training. Evidence-based training can be provided to help nursing staff identify more therapeutic ways to interact with the patients. With proper, research-inspired training, nursing staff may avoid stressful situations and burnout.

This DNP project had a positive impact on the nursing staff of the adolescent unit in the project facility. The nursing staff had improved understanding of their individual contribution as part of the team caring for the children. The results of the activities indicated improved knowledge of disorders and interventions that can be implemented to assist children who struggle to accomplish activities of daily living. The nursing staff attitudes toward mentally ill patients were more positive after the training sessions. Staff were more agreeable to mentally ill patients being treated as normal as possible and to providing the resources to meet their mental health care needs. Nursing staff are the leaders on an acute care psychiatric in-patient unit. They need to feel empowered to create an environment that is structured and organized. They need clearly defined roles, positive communication, and support from the nursing leaders. Patients will then be able to problem solve more efficiently and feel respected and empowered by the nursing staff. This will lead to better recovery from the life experiences that caused them to be admitted to an acute care mental facility. They need nursing staff who will listen, respect, and help them.

References

Bethke, W. (2014). The Secret to a Satisfied Patient. *Review of Ophthalmology*, 21(12), 20-22. Retrieved on November 28, 2017 Grefrom http://eds.b.ebscohost.com.ezproxy.gardner-webb.edu/eds/pdfviewer/pdfviewer?vid=7&sid=88692a60-d31c-4d83-b2af-957e25001ce7%40sessionmgr101.

Bosanac, P., Hopwood, M., Keks, N., Newton, R., Tiller, J., Coplov A., & Castle, D. (2016). Recovery is a core goal of psychiatrists. *Australian & New Zealand Journal of Psychiatry*, 50(10), 935-936. doi:10.1177/0004867416662918

Bowers, L., James, K., Quirk, A., Simpson, A., Stewart, D., & Hodsoll, J. (2009). Reducing conflict and containment rates on acute psychiatric wards: The safe wards cluster randomized controlled trial. *International Journal of Nursing Studies*, 52(9), 1412-1422. Retrieved on November 28, 2017 from https://www.clinicalkey.com.

Brooker, J., Webber, L., Julian, J., Shawyer, F., Graham, A. L., Chan, J., & Meadows, G. (2014). Mindfulness-based training shows promise in assisting staff to reduce their use of restrictive interventions in residential services. *Mindfulness*, 5(5), 598-603. doi:10.1007/s12671-014-0306-2

Browne, G., Hurley, J., & Lakeman, R. (2014). Mental health nursing: What difference does it make? *Journal of Psychiatric and Mental Health Nursing*, *21*(6), 558-563. doi:10.1111/jpm.12162

Butts, J., & Rich, K. (2015). *Philosophies and Theories for Advanced Nursing Practice (2nd ed.).* Burlington, MA: Jones & Bartlett Learning.

D'Antonio, P., Beeber, L., Sills, G. & Naegle, M. (2014). The future in the past: Hildegard Peplau and interpersonal relations in nursing. *Nursing Inquiry*, (4), 311. doi:10.1111/nin.12056

Dawson, P., Kingsley, M., & Pereira, S. (2005). Violent patients within psychiatric intensive care units: Treatment approaches, resistance and the impact upon staff. *Journal of Psychiatric Intensive Care*, *1*(1), 45-53. doi:10.1017/S1742646405000087

Deane, W., & Fain, J. (2016). Incorporating Peplau's Theory of Interpersonal Relations to promote holistic communication between older adults and nursing students. *Journal of Holistic Nursing*, *34*(1), 35. doi:10.1177/0898010115577975

Duke, S., Scott, J., & Dean, A. (2014). Use of restrictive interventions in a child and adolescent inpatient unit - predictors of use and effect on patient outcomes. *Australasian Psychiatry*, *22*(4), 360-365. doi:10.1177/1039856214532298

Eade, A., & Winter, C. (2017). Using simulated practice in pre-registration education to explore mental health issues. *British Journal of Nursing*, *26*(12), 690-694. doi:10.12968/bjon.2017.26.12.690

Easter, A., Pollock, M., Pope, L., Wisdom, J., & Smith, T. (2016). Perspectives of treatment providers and clients with serious mental illness regarding effective therapeutic relationships. *Journal of Behavioral Health Services & Research*, *43*(3), 341. doi:10.1007/s11414-015-9492-5

Eusden, S., & Pierini, A. (2015). Exploring contemporary views on therapeutic relating in transactional analysis game theory. *Transactional Analysis Journal*, *45*(2), 128-140. doi:10.1177/0362153715588300

Farrelly, S., & Lester, H. (2014). Therapeutic relationships between mental health service users with psychotic disorders and their clinicians: A critical interpretive synthesis. *Health & Social Care in the Community*, *22*(5), 449-460. doi:10.1111/hsc.12090

Fitzpatrick, J. (2016). How to bolster emotional intelligence among psychiatric mental health nurse clinicians. *Archives of Psychiatric Nursing*, 30131. doi:10.1016/j.apnu.2016.02.008

Geirdal, A., Nerdrum, P., Aasgaard, T., Misund, A. & Bonsaksen, T. (2015). The Norwegian version of the Scale to Assess the therapeutic Relationship (N-STAR) in community mental health care: Development and pilot study. *International Journal of Therapy & Rehabilitation*, *22*(5), 217-224. doi:10.12968/ijtr.2015.22.5.217

Greene, R. (1998). The Explosive Child. New York, NY: Harper Collins.

Greene, R. & Ablon, J. (2006). Treating Explosive Kids. New York, NY: The Guilford Press.

Goldsmith, T. (2017). A place to go for prompt help with behavioral health problems. *North Carolina Health News*. Retrieved on July 25, 2017 from https://www.northcarolinahealthnews.org/2017/02/01/place-go-prompt-help-behavioral-health-problems/.

Happell, B., & Koehn, S. (2011). Seclusion as a necessary intervention: the relationship between burnout, job satisfaction and therapeutic optimism and justification for the use of seclusion. *Journal of Advanced Nursing*, *67*(6), 1222-1231. doi:10.1111/j.1365-2648.2010.05570.x

Harper, B., Dickson, J., & Bramwell, R. (2014). Experiences of young people in a 16–18 mental health service. *Child and Adolescent Mental Health*, *19*(2), 90-96. doi:10.1111/camh.12024

Houghton, N., Casal, R., Fortuna, S., & Larsen, T. (2015). DNPs: Collaboration and practice. *Ohio Nurses Review*, *90*(4), 12-14. Retrieved on July 25, 2017 from https://www.ncbi.nlm.nih.gov/pubmed/26762015.

Knowles, S., Hearne, J., & Smith, I. (2015). Physical restraint and the therapeutic relationship. *Journal of Forensic Psychiatry & Psychology*, *26*(4), 461-475. doi:10.1080/14789949.2015.1034752

Langton, C. M. (2012). Introduction to the special issue: Treatment considerations for aggressive adolescents in secure settings. *Criminal Justice & Behavior, 39*(6), 685. doi:10.1177/0093854812436949

Levine, S. (2015). Strategic Communication Drives Outcomes. *Credit Union Times*, 26(24), 12. Retrieved on November 28, 2017 from https://www.cutimes.com/2015/07/07/strategic-communication-drives-outcomes/?slreturn=20180619152804.

Lives in the Balance, Fostering Collaboration, Transforming Lives, Inspiring Change. "About the CPS Model". Retrieved on July 25, 2017 from http://www.livesinthebalance.org/about-cps, July 25, 2017.

MacDonald, J. (2014). 'Formal' feedback in psychotherapy as psychoanalytic technique. *Psychodynamic Practice*, *20*(2), 154-163. doi:10.1080/14753634.2013.771566

MacInnes, D., Kinane, C., Parrott, J., Mansfield, J., Craig, T., Eldridge, S., & Priebe, S. (2016). A pilot cluster randomized trial to assess the effect of a structured communication approach on quality of life in secure mental health settings: The Comquol Study. *BMC Psychiatry*, 16:335. doi:10.1186/s12888-016-1046-8

Martin, C., & Chanda, N. (2016). Featured article: Mental health clinical simulation: Therapeutic communication. *Clinical Simulation in Nursing*, 12209-214. doi:10.1016/j.ecns.2016.02.007

McCloughen, A., Gillies, D., & O'Brien, L. (2011). Collaboration between mental health consumers and nurses: Shared understandings, dissimilar experiences. *International Journal of Mental Health Nursing*, *20*(1), 47-55. doi:10.1111/j.1447-0349.2010.00708.x

McCormack, L., & Thomson, S. (2017). Complex trauma in childhood, a psychiatric diagnosis in adulthood: Making meaning of a double-edged phenomenon. *Psychological Trauma: Theory, Research, Practice, and Policy*, *9*(2), 156-165. doi:10.1037/tra0000193

Miles, L., Mabey, L., Leggett, S., & Stansfield, K. (2014). Teaching communication and therapeutic relationship skills to baccalaureate nursing students: A peer mentorship simulation approach. *Journal of Psychosocial Nursing and Mental Health Services*, *52*(10), 34-41. doi:10.3928/02793695-20140829-01

Moylan, L., & Cullinan, M. (2011). Frequency of assault and severity of injury of psychiatric nurses in relation to the nurses' decision to restrain. *Journal of Psychiatric and Mental Health Nursing,* 18, 526-534. doi:10.1111/j.1365-2850.2011.01699.x

NCBSN. (2009). Job Analysis of Nurse Aides Employed in Nursing Homes/Long-term Care, Hospitals/ Acute Care and Community/Home Health Care Settings (2009). National Council of State Boards of Nursing Inc. Retrieved on July 17, 2018 from www.ncsbn.org/10_JobAnalysis_NAs_web.pdf.

National Council for State Boards of Nursing. (2013). State-Approved Curriculum Nurse Aide I Training Program (2013). North Carolina Department of Health and Human Services Division of Health Service Regulation Health Care Personnel Registry Section Center for Aide Regulation and Education. Retrieved on July 17, 2018 from https://www2.ncdhhs.gov/dhsr/hcpr/curriculum/index.html

Nesset, M., Rossberg, J., Almvik, R., & Friis, S. (2009). Can a focused staff training programme improve the ward atmosphere and patient satisfaction in a forensic psychiatric hospital? A pilot study. *Scandinavian Journal of Caring Sciences*, *23*(1), 117-124. doi:10.1111/j.1471-6712.2008.00597.x

Nicholls, D., Kidd, K., Threader, J., & Hungerford, C. (2015). The value of purpose built mental health facilities: Use of the Ward Atmosphere Scale to gauge the link between milieu and physical environment. *International Journal of Mental Health Nursing*, *24*(4), 286-294. doi:10.1111/inm.12138

O'Reilly, M., Karim, K., Stafford, V., & Hutchby, I. (2015). Identifying the interactional processes in the first assessments in child mental health. *Child and Adolescent Mental Health*, *20*(4), 195-201. doi:10.1111/camh.12077

Peplau, H. (1960). Problems in the team treatment of adults in state mental hospitals: Panel, 1958: 4. Must laboring together be called 'teamwork'? *American Journal of Orthopsychiatry*, *30*(1), 103-108. doi:10.1111/j.1939-0025.1960.tb03016.x

Peplau, H. (1999). The psychiatric nurse--accountable? To whom? For what? *Perspectives in Psychiatric Care*, *35*(3), 20. doi:10.1111/j.1744-6163.1999.tb00583.x

Peplau, H. (2007). A Glance Back in Time. *Nursing Forum*, *34*(3), 31. doi.org/10.1111/j.1744-6198.1999.tb00991.x

Pereira, S., & Woollaston, K. (2007). Therapeutic engagement in acute psychiatric inpatient services. *Journal of Psychiatric Intensive Care*, *3*(1), 3-11. doi:10.1017/S1742646407001057

Petiprin, A. (2016). Science of Unitary Human Beings. Retrieved on July 25, 2017 from http://www.nursing-theory.org/theories-and-models/roger-theory-of-unitary-human-beings.php

Quinterno, J. (2014). An Analysis of the Mental Health Work Force in North Carolina: The Work Force in the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and in State Facilities. *North Carolina Insight*. Retrieved November 28, 2017 from https://nccppr.org/wp-content/uploads/2017/02/mentalhealthworkforce.pdf

Ruiz-Sancho, E., Froján-Parga, M., & Galván-Domínguez, N. (2015). Verbal interaction patterns in the clinical context: A model of how people change in therapy. *Psicothema*, *27*(2), 99-107. doi:10.7334/psicothema2014.119

Shattell, M., Andes, M., & Thomas, S. (2008). How patients and nurses experience the acute care psychiatric environment. *Nursing Inquiry*, 15(3), 242. doi:10.1111/j.1440-1800.2008.00397.x

Smith, S., & Kirkpatrick, P. (2013). Use of solution-focused brief therapy to enhance therapeutic communication in patients with COPD. *Primary Health Care*, 23(10), 27. doi:10.7748/phc2013.12.23.10.27.e742

Smith, V. (2012). New Mental Health Policies are Harming People in Need. Retrieved on April 16, 2018 from http://www.ncpolicywatch.com/2012/02/28/new-mental-health-policies-are-harming-people-in-need/.

Stenhouse, R. (2011). 'They all said you could come and speak to us': patients' expectations and experiences of help on an acute psychiatric inpatient ward. *Journal of Psychiatric & Mental Health Nursing*, *18*(1), 74-80. doi:10.1111/j.1365-2850.2010.01645.x

Sweeney, A., Fahmy, S., Nolan, F., Morant, N., Fox, Z., Lloyd-Evans, B., & Johnson, S. (2014). The relationship between therapeutic alliance and service user satisfaction in mental health inpatient wards and crisis house alternatives: A cross-sectional study. *Plos ONE*, *9*(7), doi:10.1371/journal.pone.0100153

Taylor, M., & Dear, M. (1979). Community Attitudes towards Mentally Ill (CAMI) scale. Retrieved on April 16, 2018 from https://camiscale.com/cami-questionnaire/.

Terhorst, L., Hutchison, S., Sorbero, M., Mitchell, A., Dogin, J., & Stein, B. (2014). Psychometric investigation of a brief measure of outcomes in children's mental health. *Community Mental Health Journal*, *50*(2), 204-208. doi:10.1007/s10597-013-9627-1

Tuvesson, H., Wann-Hansson, C., & Eklund, M. (2011). The ward atmosphere important for the psychosocial work environment of nursing staff in psychiatric in-patient care. *BMC Nursing*, *10*,(12). doi.org/10.1186/1472-6955-10-12

Understood for learning and attention issues (2018). https://www.understood.org/en

Wand, T. (2013). Positioning mental health nursing practice within a positive health paradigm. *International Journal of Mental Health Nursing, 22*(2), 116-124. doi:10.1111/j.1447-0349.2012.00848.x

Webster, D. (2014). Featured Article: Using standardized patients to teach therapeutic communication in psychiatric nursing. *Clinical Simulation in Nursing*, 10e81-e86. doi:10.1016/j.ecns.2013.08.005

Wong, S., & Talmi, A. (2015). Open communication: Recommendations for enhancing communication among primary care and mental health providers, services, and systems. Families, systems & health: *The Journal of Collaborative Family Healthcare*, *33*(2), 160-162. doi:10.1037/fsh0000136

Zaccagnini, M., & White, K. (2017). *The Doctor of Nursing Practice Essentials* (3rd ed.). Burlington, MA: Jones & Bartlett Learning.

Zarea, K., Maghsoudi, S., Dashtebozorgi, B., Hghighizadeh, M., & Javadi, M. (2014). The impact of Peplau's Therapeutic Communication Model on anxiety and depression in a patient candidate for coronary artery bypass. *Clinical Practice & Epidemiology in Mental Health*, 10159-165. doi:10.2174/1745017901410010159

Zill, J., Christalle, E., Müller, E., Härter, M., Dirmaier, J. & Scholl, I. (2014). Measurement of physician-patient communication—A systematic review. *Plos ONE*, *9*(12), 1-20. doi:10.1371/journal.pone.0112637

Appendix A

Project Consent to Participate

Project Consent to Participate
Improving Therapeutic Relationships between Nursing Staff and Patients

Title of Study: Improving Therapeutic Relationships between Nursing Staff and Patients

Investigators:

Name: Carla Cozart MSN, RN, ONC **Dept:** DNP **Phone:** 919-931-5910

Introduction

- You are being asked to participate in a survey before and following the educational session, Improving Therapeutic Relationships.
- You were selected as a possible participant because you work in the nursing department and have direct communication and interactions with adolescent patients.
- Please read this form and ask any questions that you may have before agreeing to participate in the project surveys.

Purpose of Project

- The purpose of the project is to improve therapeutic communication of staff, develop positive patient/staff relationships, and increase staff knowledge.

Description of the Study Procedures

- This is a mandatory staff education requirement. You will be required to attend four one-hour educational sessions titled, Improving Therapeutic Relationships between Nursing Staff and Patients. Participation in the three surveys (pre and post educational session, and a staff development evaluation) is completely voluntary. The completion of all surveys will occur during the educational sessions and should take approximately 20 minutes of your time. There is no identifying data requested so your answers will be anonymous. You may return a blank survey if you choose to not participate. During the training sessions you will be asked to participate in discussion and group work with other participants.

Risks/Discomforts of Being in this Study

- There are no reasonable foreseeable or expected risks. There may be unknown risks.

Benefits of Being in the Study

- There are no monetary benefits or incentives for participating in this project although the information could improve staff/patient communication and relationships. The data/outcomes revealed from this project could help our facility improve staff orientation and provide information to assist with staff development curriculum and direction.

Confidentiality

- This study is anonymous. There will be no collection of identifying information. You may return a blank survey to maintain your confidentiality should you choose to not participate. No identifying data will be collected or disclosed in any future presentations or publications.

Project Consent to Participate
Improving Therapeutic Relationships between Nursing Staff and Patients

Payments

- You will not receive any payment/reimbursement for participating in this project.

Right to Refuse or Withdraw

- The decision to participate in this project is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the project leader or your employer. Your decision will not result in any loss or benefits to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely from the survey at any point during the process; additionally, you have the right to not participate by turning in a blank survey at the time of survey collection.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this project and to have those questions answered by me before, during or after the project. If you have any further questions about the project, at any time feel free to contact me, Carla Cozart at ccozart@gardner-webb.edu or by telephone at (919) 931-5910. If you like, a summary of the results of the study will be sent to you. If you have any other concerns about your rights as a project participant that have not been answered by the project leader, you may contact Dr. Yvonne Smith at Gardner-Webb University (704) 406-2517, ysmith@gardner-webb.edu.

- If you have any problems or concerns that occur because of your participation, you can report them to Dr. Yvonne Smith at the number above.

Consent

- Your signature below indicates that you have decided to volunteer as a project participant and you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

Subject's Name (print): _____

Subject's Signature: _____ Date: _____

Project Leader Signature: _____ Date: _____

Appendix B

Activity Day 1: Your Story

Activity Day 1: Your Story

Please tell me about a time when you helped a patient who was struggling with some aspect of daily life. This is anonymous, please **DO NOT** provide any identifying information about the patient or yourself. Your time and willingness to share is much appreciated. This information will be used to help improve patient care on the unit.

What was the problem, what was the patient struggling with?

How did the patient respond when requested, required, expected to interact, perform, or participate?

Specifically, how did you assist the patient to overcome the struggle?

How did this make you feel about your job?

Appendix C

School Discipline Survey

School Discipline Survey

Are your school's discipline practices in line with what we now know about why students exhibit challenging behavior? Take the brief survey below to find out!

1. My school relies very heavily on adult-imposed consequences – such as detentions, suspensions, paddling, and other punishments – in responding to challenging behavior.
2. In my school, classroom teachers frequently send students to someone outside the classroom – for example, the principal or assistant principal – to deal with behavior problems.
3. In meetings about students with behavioral challenges, discussions focus primarily on *behaviors* rather than on lagging skills and unsolved problems.
4. Terms such as *manipulative*, *attention-seeking*, *unmotivated*, *coercive*, and *limit-testing* are frequently used to describe students with behavioral challenges.
5. Our Functional Behavior Assessments focus on how a student's challenging behaviors are *working* to enable him or her to *get*, *escape*, and *avoid* rather than on the fact that the behaviors *communicate* that the student is lacking the *skills* to respond more adaptively.
6. The philosophy guiding our thinking about behaviorally challenging kids is *Kids do well if they want to* rather than *Kids do well if they can.*
7. In responding to challenging behaviors, the school relies heavily on a rubric system: a list of behaviors students mustn't exhibit and an algorithm for how adults should respond to those behaviors if they are exhibited.
8. There are many "frequent flyers" in the school: students whose behavior has not improved despite frequent exposure to the school discipline program.
9. The problems precipitating students' challenging behavior seem to occur again and again without ever being durably solved.
10. We're still blaming parents for the challenging behavior their children exhibit at school rather than on collaborating with them to understand the lagging skills contributing to that challenging behavior.
11. Our response to students' challenging behavior is primarily *emergent* and *reactive* rather than *planned* and *proactive*.

If you answered yes to any or many of these questions, your school may need a discipline overhaul...and ***Lives in the Balance*** can help! **Contact** us to find out how we can work together to get the ball rolling.

How did your school do? What areas still need the most work? How will you organize the effort and galvanize people? Tell us about it!

Appendix D

Collaborative and Proactive Solutions

ALSUP ASSESSMENT OF LAGGING SKILLS

Collaborative & Proactive Solutions
THIS IS HOW PROBLEMS GET SOLVED

CHILD'S NAME _____ DATE _____

INSTRUCTIONS: The ALSUP is intended for use as a discussion guide rather than as a freestanding check-list or rating scale. It should be used to identify specific lagging skills and unsolved problems that pertain to a particular child or adolescent.

If a lagging skill applies, check it off and then (before moving on to the next lagging skill) identify the specific expectations the child is having difficulty meeting in association with that lagging skill (unsolved problems). A non-exhaustive list of sample unsolved problems is shown at the bottom of the page.

LAGGING SKILLS	UNSOLVED PROBLEMS
☐ Difficulty handling transitions, shifting from one mindset or task to another	
☐ Difficulty doing things in a logical sequence or prescribed order	
☐ Difficulty persisting on challenging or tedious tasks	
☐ Poor sense of time	
☐ Difficulty maintaining focus	
☐ Difficulty considering the likely outcomes or consequences of actions (impulsive)	
☐ Difficulty considering a range of solutions to a problem	
☐ Difficulty expressing concerns, needs, or thoughts in words	
☐ Difficulty managing emotional response to frustration so as to think rationally	
☐ Chronic irritability and/or anxiety significantly impede capacity for problem-solving or heighten frustration	
☐ Difficulty seeing "grays"/concrete, literal, black & white, thinking	
☐ Difficulty deviating from rules, routine	
☐ Difficulty handling unpredictability, ambiguity, uncertainty, novelty	
☐ Difficulty shifting from original idea, plan, or solution	
☐ Difficulty taking into account situational factors that would suggest the need to adjust a plan of action	
☐ Inflexible, inaccurate interpretations/cognitive distortions or biases (e.g., "Everyone's out to get me," "Nobody likes me," "You always blame me, "It's not fair," "I'm stupid")	
☐ Difficulty attending to or accurately interpreting social cues/ poor perception of social nuances	
☐ Difficulty starting conversations, entering groups, connecting with people/lacking other basic social skills	
☐ Difficulty seeking attention in appropriate ways	
☐ Difficulty appreciating how his/her behavior is affecting others	
☐ Difficulty empathizing with others, appreciating another person's perspective or point of view	
☐ Difficulty appreciating how s/he is coming across or being perceived by others	
☐ Sensory/motor difficulties	

UNSOLVED PROBLEMS GUIDE:

Lives in the Balance

livesinthebalance.org

Appendix E

Activity Day 1: What do you already know?

Activity Day 1: What do you already know?

1. Male, age 12, lives at home with both parents, weighed 4lbs. 6oz. At birth, mom smoked heavily during pregnancy. He has trouble sitting for long periods of time at home and school. When doing school work is easily distracted by other people moving in the room. He has not been able to consistently remember to feed his 6-month-old puppy every morning before school, which is one of his chores. When dropped off in carpool every morning he attempts to get out of the car before the car is completely stopped. When he becomes frustrated with inability to complete task that takes longer than 30 minutes to complete, he becomes aggressive towards parents, hitting, kicking, screaming, and crying.

What is the likely diagnosis of this child?
A. ADHD
B. Autism
C. Asperger's

What should the staff focus on when trying to help the child?
A. Limit distractions
B. Car safety
C. Pet care

2. Female, age 15, born premature weighing 3lbs. 8oz., mother drank alcohol heavily during pregnancy, given up for adoption but lived in orphanage until the age of 10 when she was placed and moved in and out of various foster home settings. IQ test score is 60. She stays in her room most of the time. Her hair is unkept, clothes are dirty and smell of body odors, and her room is messy. She cannot read well, and writing is limited.

What is the likely diagnosis of this child?
A. ADHD
B. Developmental Disability
C. Asperger's

What should the staff focus on when trying to help the child?
A. Completing self-care tasks
B. Improving her participation in class
C. Improving her ability to interact with others

Activity Day 1: What do you already know?

3. Female, age 16, quiet, respectful, talks only when asked direct questions. She makes sure all her school work is organized and neatly written. Her room is clean and personal appearance is well groomed. She is always looking in the mirror to ensure her hair is in place. She spends a lot of time caring for her hair; shampooing, drying, combing, and styling. Her mom suffers from a developmental disability and dad is a coach for the high school. Her parents have tried to get her involved in different sports, but she gets injured and doesn't want to play anymore. She spends a lot of time in her room and refuses to participate in activities with other children her age. She is not able to summarize how she feels in group settings.

What is the likely diagnosis of this child?
A. ADHD
B. Autism
C. Asperger's

What should the staff focus on when trying to help the child?
A. Completing school work
B. Improving her participation in sports
C. Improving her ability to interact with others

Appendix F

Activity Day 4: What knowledge have you gained?

Activity Day 4: What knowledge have you gained?

1. Male, age 12, lives at home with both parents, weighed 4lbs. 6oz. At birth, mom smoked heavily during pregnancy. He has trouble sitting for long periods of time at home and school. When doing school work is easily distracted by other people moving in the room. He has not been able to consistently remember to feed his 6-month-old puppy every morning before school, which is one of his chores. When dropped off in carpool every morning he attempts to get out of the car before the car is completely stopped. When he becomes frustrated with inability to complete task that takes longer than 30 minutes to complete, he becomes aggressive towards parents, hitting, kicking, screaming, and crying.

What is the likely diagnosis of this child?
A. ADHD
B. Autism
C. Asperger's

What should the staff focus on when trying to help the child?
A. Limit distractions
B. Car safety
C. Pet care

2. Female, age 15, born premature weighing 3lbs. 8oz., mother drank alcohol heavily during pregnancy, given up for adoption but lived in orphanage until the age of 10 when she was placed and moved in and out of various foster home settings. IQ test score is 60. She stays in her room most of the time. Her hair is unkept, clothes are dirty and smell of body odors, and her room is messy. She cannot read well, and writing is limited.

What is the likely diagnosis of this child?
A. ADHD
B. Developmental Disability
C. Asperger's

What should the staff focus on when trying to help the child?
A. Completing self-care tasks
B. Improving her participation in class
C. Improving her ability to interact with others

Activity Day 4: What knowledge have you gained?

3. Female, age 16, quiet, respectful, talks only when asked direct questions. She makes sure all her school work is organized and neatly written. Her room is clean and personal appearance is well groomed. She is always looking in the mirror to ensure her hair is in place. She spends a lot of time caring for her hair; shampooing, drying, combing, and styling. Her mom suffers from a developmental disability and dad is a coach for the high school. Her parents have tried to get her involved in different sports, but she gets injured and doesn't want to play anymore. She spends a lot of time in her room and refuses to participate in activities with other children her age. She is not able to summarize how she feels in group settings.

What is the likely diagnosis of this child?
A. ADHD
B. Autism
C. Asperger's

What should the staff focus on when trying to help the child?
A. Completing school work
B. Improving her participation in sports
C. Improving her ability to interact with others

4. Male, age 14, born a healthy infant and lived with both parents and four siblings. He is the victim of both verbal and physical abuse for years before being removed from the home at the age of 11. He has been observed being aggressive towards children younger and smaller than him. He has poor hygiene and refuses to go to school. He has supervised visits with his mother and siblings. He does not talk unless asked direct questions. He has trouble sleeping at night and complains of nightmares but cannot provide details about them.

What is the likely diagnosis for this child?

A. Mental Illness
B. PTSD
C. Asperger's

What should staff focus on when helping this child?

A. Ensuring safety of others
B. Providing interventions to help with sleep
C. Limiting his interactions with other people

5. Female, age 17, lives at home with both parents. Refuses to attend school and quit attending school at the age of 16. Refuses to attend therapy sessions and does not

Activity Day 4: What knowledge have you gained?

participate in conversations with staff. When asked direct questions she answers in simple responses that are not always appropriate. She paces the halls when not in her room. She spends a large amount of time in her room alone. Staff have observed her talking to herself at times.

What is the likely diagnosis for this child?

A. Mental Illness
B. PTSD
C. Asperger's

What should staff focus on when helping this child?

A. Encourage participation in group sessions
B. Limit the amount of time spent pacing
C. Do not attempt conversation with the patient

Appendix G

Improving Therapeutic Relationships Training Evaluation

Day 4: Improving Therapeutic Relationships Training Evaluation

Date: _____ Time: _____

Please complete the following evaluation for the educational training you attended. Your feedback is important and will help us evaluate the effectiveness of the program and allow for improvements in future presentations we provide to you and other students.

4= Strongly Agree	3=Agree	2=Disagree	1=Strongly Disagree	0=No opinion

		Circle your response				
1.	The training met my expectations.	4	3	2	1	0
2.	This content was helpful.	4	3	2	1	0
3.	The level of the training was appropriate.	4	3	2	1	0
4.	The format was enjoyable.	4	3	2	1	0
5.	Speaker had a good understanding of the topics.	4	3	2	1	0
6.	The handouts were helpful.	4	3	2	1	0
7.	The training was worth my time.	4	3	2	1	0
8.	The length of the training was appropriate.	4	3	2	1	0
9.	Training should be repeated for other staff.	4	3	2	1	0