

THE IMPORTANCE OF A PSYCHIATRIC MILIEU IN INPATIENT SETTINGS

by

Leslie G. Caesar

JOANN MANTY, DNP, Faculty Mentor and Chair

CHRISTY DAVIDSON, DNP, Department Chair

Christy Davidson, DNP, Interim Dean, School of Nursing and Health Services

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Abstract

The patient experience, or patient satisfaction, is becoming one of the most important measures that healthcare systems look at when they are judging the efficiency and effectiveness of the services being provided. Mental health services are no different, and in fact, it could be argued that providers of mental health care have to work harder to ensure an exemplary patient experience. The cornerstone of psychiatric nursing is the therapeutic use of self and the development of relationships and structured programming. Patients still expect this as a part of their inpatient treatment and care, therefore, the focus of the Capstone Project was to create a structured and therapeutic program that included nurse led groups. Involving nurses in groups, created an environment in which they felt more engaged with the patients, and had more autonomy in their practice. An increase in nurse engagement has had a direct correlation with an increase in the patient experience and overall patient satisfaction on an inpatient geriatric psychiatry unit. The modernization of psychiatric medicine and managed care mandates on length of stay, have impeded the nurses ability to effectively meet these expectations. If mental health nurses are going to be successful in meeting modern patient expectations, then they will require ongoing support and training from their nursing leaders and hospital administration. This data will drive nursing practice in inpatient mental health settings in the 21st century.

Dedication

I dedicate this manuscript to my family, immediate and extended. To my parents, Harold and Gail Garcia, who provided me with an early foundation that exemplified that hard work and perseverance, will always end in reward. To my children, Brendan, Justin, and Maya, who have spent the majority of their lives, watching me pursue my educational and professional endeavors. They have been my inspiration to continue to push forward, despite the obstacles and barriers that present themselves. I can only hope that I have taught them how to survive and be successful in this world, through leading by example. And finally, to my husband Norman, who has the ability to recognize potential in me that I don't see in myself. He has been my personal cheerleader for twenty-two years, and has helped to guide and develop me into the person, the nurse, and the leader that I am today.

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I would like to acknowledge the staff and the patients who were willing to work with me on my capstone project, and for allowing me to be a part of their daily lives in my quest to improve patient care in inpatient psychiatric settings. Having the ability to complete my DNP clinical hours on an inpatient psychiatry unit has brought my inspiration and enthusiasm for nursing back to me. I can see the positive impact that I am having on the patients and the staff, as I connect with these two groups, and connect them to each other. I have been told that my smile is infectious, and it makes others want to smile, laugh, be happy, and enjoy what they are doing. Happy nursing staff has translated into more engaged care of the patients, which has translated into happy and satisfied patients and families. I miss this part of nursing, and now see more clearly, the path that I should take once I have completed the DNP program at Capella University. Nursing management is necessary; however, being able to incorporate clinical components into my day-to-day practice will help me to feel better about what I am doing, and give me purpose in my daily practice. I also see this as a way of engaging the nursing staff, and building a stronger, trusting team that can deliver excellence in nursing care, to the very vulnerable population that we serve. As the leader of this team of nurses, it is important for them to see the human side of me, as an expert clinician who is willing to work with them, side by side, as we navigate the new and ever changing waters of healthcare in the 21st century.

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CHAPTER 1. INTRODUCTION

With quality improvement as a goal, a focus has been placed on satisfaction with inpatient services, because satisfaction is an important predictor of future service use (Kuosmanen, Hätönen, Jyrkinen, Katajisto, & Välimäki (2006). Nurses traditionally make up the bulk of the workforce in inpatient units, and as such, have had to be on the frontline, adjusting and managing the multiple changes that have plagued inpatient mental health care, such as increased census compounded by rapid turnover and shorter lengths of stay. This has created demands on nurses' time, for non-patient related tasks, as taking care of the chart has become the norm, while patients are managed with more medications and less therapy. Moyle (2003) reported that the only time during hospitalization, that patients perceived the nurse's presence was during the admission process. Whittington and McLaughlin (2000) determined that only 42.7% of nurses' time was spent in patient contact, and of that, just 6.75% was spent in individual therapy. This is important as the work of psychiatric nurses occurs in the context of the interpersonal relationship (Peplau, 1997). Mental health nursing has become automated care, consisting of a series of tasks that have to be cleared, and that lacks the therapeutic relationship that psychiatry is so well known for.

Depression in the elderly is an important medical problem. Beyond personal suffering, depression contributes significantly to morbidity and all-cause mortality, increases suicide rates, and causes significant impairment of physical and social

functioning. Depression is the leading cause of disability as measured by years lived with the disability, according to the World Health Organization (2012). Greater attention to mental health problems among older adults in primary care is critically needed, especially given the role that mental health problems have on physical health, service use, and longevity. Enhanced detection and treatment of psychiatric disorders in geriatric primary care patients, including greater awareness of and referral to specialty mental health resources, can make substantial inroads to reducing enduring and substantial unmet mental health needs in late life and provide for more efficient and effective medical care and clinical outcomes.

The late 1980s witnessed a major shift in inpatient care. The shift in psychiatric hospitalization policy, together with major advances in psychopharmacology, the advent of crisis theory, the decreased reliance on somatic therapies, and the emergence of new mental health professionals, has resulted in dramatic changes in the character and function of the acute inpatient unit. The challenges for the profession are many, not the least of which are the dominant reductionistic biological paradigm, consumer demand for a quick fix, and the influence of powerful pharmaceutical money for research and marketing. Although psychotropic medications have changed the lives of many with serious mental illness, the integration of relationship and psychotherapy skills with psycho-pharmacotherapy is essential in order to maximize the benefit of medications. Prescribing in a vacuum without the attending relationship skills in the context of a psychotherapeutic relationship marginalizes the nurse as well as the patient.

A successful unit program values group therapy, and builds the program around it. All admitting physicians are aware that the patients that they admit will automatically

enter the unit group therapy program, and that they, the physicians, must schedule their individual therapy hours accordingly.

Nature of the Capstone Project

Currently, the quality of inpatient units, medical and psychiatric, is a concern for the safety and better outcomes of patients (Hanrahan, Aiken, & Hanlon, 2010).

Researchers have found that in the last decade, increases in mortality, low morale from staff, and low employee satisfaction have been associated with poor or underdeveloped patient care environments. Moreover, nurses leave these environments for other inpatient units, which contributes to increases in nurse turnover rates (Hanrahan et al., 2010).

Psychiatric nursing care has had a major shift from the majority of the focus being on building a therapeutic relationship with patients, to a completely different focus that is not patient centered, and instead, has a heavy emphasis on non-clinical time in meetings, on tasks, and on administrative duties, leaving patients to the care of medications and impersonal groups. Nurses must find the time to build the therapeutic relationships that have been the cornerstone of mental health nursing, since Hildegard Peplau first studied, and wrote about this specialty area of nursing.

Better environment, resources, and tools to do a better job, can decrease mortality, increase nurse retention, provide better support for the nursing process, and increase better patient outcomes. Medical units and psychiatric units can be viewed as similar in that better organizational factors can be associated with a decrease in adverse occurrences (Hanrahan et al., 2010). Placing focus on inpatient psychiatric milieus can provide a needed adjunct to the multiple pharmacological treatments that exist today.

Patients experiencing distress in psychiatric settings, typically have few options for symptom management. Usual interventions include staff contact, medication, decreased stimulation, and group participation. Individuals with mental health problems want to be involved in their treatment decisions. Communication, the cornerstone of psychiatric nursing, depends on cognition, intellect, and the verbal expression of feelings.

Scholars, in recent decades, have criticized mental health nurses for their lack of interaction and therapeutic engagement with patients (Cleary, Hunt, Horsfall, & Deacon, 2012). The assumption underlying this is that nurses do not spend enough time with patients to establish a therapeutic relationship, and/or that they are not utilizing standard psychological interventions. Essentially, if nurses are spending their time doing other things, and are not seen to be engaged in nurse-patient talk, then it is assumed that they are not working therapeutically.

Many nurses, who practice mental health nursing, will describe in detail the importance of the therapeutic relationship between the nurse and the patient and between the nurse and the interdisciplinary treatment team. In contrast, research evidence on patients' perceptions of nurses describes a group that is negative, unhelpful, and disengaged from the patient population. Creating a therapeutic milieu is a basic intervention in mental health nursing practice (Chan, 2007), and is inclusive of everything in the immediate inpatient environment. Everything in the milieu is meant to promote healing, and includes the staff, the physical structure of the unit, and the emotional climate of the staff and patients on the unit. Participants in a recent study regard conversational therapy, based on patient needs, as an important intervention for promoting their recovery (Chan, 2007). In general, when asked, patients are very

positive about any type of therapeutic interaction that allows them to express their thoughts, feelings, and ideas in a way that makes them feel listened to and understood. Having an appreciation for these types of therapies should propel the mental health nurses to seek to acquire the knowledge and skill set to effectively engage in one-to-one interactions and to be able to conduct patient group therapy.

Description of the Problem, Environment, and Target Population

Statistics reported by the Federal Interagency Forum (2012) show that when looking at Americans aged 65 and older in 2008, there was approximately 10 – 19% of the population who were categorized as having a clinically significant depressive disorder. Recognition of mental health disorders, like depression, remains poor in primary care settings. Of the patients that are diagnosed, approximately 70% continue to be followed by their primary care provider, rather than being referred out to a specialist in geriatrics or mental health.

Mild depression has been estimated to affect up to 10% of older adults, with a 3% prevalence of major depressive disorder in healthy elderly persons living in the community (Roman & Callen, 2008). Medical co-morbidities, isolation, pain, or dementias are among the risks for a late-onset first episode, and risk increases after age 75 (Roman & Callen, 2008). Routine screening for depressive disorders in older adults in primary care settings has been endorsed by several professional organizations, notably the Institute of Medicine, American Association of Colleges of Nursing, and the Hartford Institute Nurses Improving Care for Healthsystem Elders faculty (Roman & Callen, 2008). Despite this, depression in geriatrics continues to be unrecognized and under-treated.

Older adult males have the highest rate of completed suicides (Roman & Callen, 2008). Suicide is more common in the elderly, than in any other age group. In studies of older adults who committed suicide, nearly all had major depression, typically a first episode. Suicide among white males aged 85 years and older was nearly six times the United States average rate (65 per 100,000 compared with 11 per 100,000) in 1996, the most recent year for which statistics are available (Federal Interagency Forum, 2012). Of note, retrospective reviews show that the majority of these people had been seen in their primary care providers' office within the month prior to the suicide. Depression is the strongest risk factor for late-life suicide and for suicides precursor, suicidal ideation; and recognizing depressive symptoms is a first step toward preventing suicide in older adults and warrants specific inquiry concerning thoughts of self-harm (Roman & Callen, 2008).

Depression is one of the most successfully treated illnesses. When properly diagnosed and treated, more than 80% of those suffering from depression, recover and return to their normal lives (Craske, 2003). Most depressed elderly people can improve dramatically from treatment. The reasons for treating depression in the elderly are compelling. Untreated, the condition is likely to persist causing distress, disability, wasted health care dollars, substance abuse, and medical complications or death. Depression presents as a significant life challenge for humankind; and by the year 2020, depression will be the second most significant cause of injury and disease globally (Feely & Long, 2009). Current focus in the United States continues to support a medical model in the treatment of depression through the heavy use of prescription medications; however, this must change if we are to truly treat the mind, body, and soul.

Common treatments for depression include psychotherapy, antidepressant medications, and electroconvulsive therapy (ECT). Psychotherapy can play an important role in the treatment of depression with or without medication (Gould, Couson, & Howard, 2012). This type of treatment is utilized in cases of mild to moderate depression and is usually for a defined period of time (10-20 weeks). Antidepressant medications work by increasing the level of neurotransmitters in the brain. Many feelings such as pain and pleasure are a result of the functioning of the neurotransmitters and when the supply of neurotransmitters is imbalanced, depression may result. Results from the medication may not be evident until at least four weeks after the initial dose. ECT is also a treatment that is safe and effective for severe depression. This treatment is used for life threatening depression that does not respond to antidepressants.

Depression in late life is a serious public health concern. Aside from sizable emotional and social consequences, mental illness in late life leads to increased disability, poorer health outcomes, increased mortality risk, greater use of medical services, and reduced treatment compliance. Despite recent advances in mental health treatments for older adults, less than one-third of older individuals with a mental health or substance use disorder receive treatment. Compared with younger adults (aged 16 – 24), older individuals are three times less likely to report receiving any form of mental health treatment.

Unfortunately, due to advances in the safety and efficacy of newer generation antidepressant medications, primary care providers have developed a greater comfort level in treating geriatric patients with mental health concerns, opting not to refer them out for specialized geriatric or mental health services. Conservative estimates report that

these numbers could be as great as 80% of the geriatric population. This, coupled with the fact that geriatric patients tend to have a lack of knowledge where mental health is concerned creates a perfect storm where these patients rely on their primary care providers to make appropriate treatment decisions, that they don't have the knowledge or skill to make, resulting in pharmacotherapy and psychotherapy often being offered below recommended guidelines.

The clinical question is what effect will the implementation of a therapeutic psychiatric program, that includes one nurse-led group per day on an inpatient geriatric psychiatry unit, have on patient quality outcomes, patient satisfaction, and staff satisfaction over a period of 18 months?

There is a direct correlation between the statistical growth of the aging population in the United States; comprising those people in the 65 and older group; and the increase in numbers of those reporting acute and chronic mental health issues. The current state in the United States is not supportive of geriatrics or geriatric mental health care as a specialty, resulting in a growing demand for limited supplies in the form of treatment programs that specialize in this type of care. Limited by finances, as most Americans in this category have their healthcare funded by federal Medicare or state Medicaid, mental health laws that lack parity, and a lack of healthcare workers trained to provide optimal care to this population, has created a challenge whereby care for this specialized population is occurring in traditional settings. Greater attention to the mental health needs of older adults is critical in light of recent research documenting substantial under-treatment of mental health problems in late life.

According to Feely and Long (2009), the personal experience of depression is often a private encounter that is seldom understood fully by others, and psychiatric nurses are in a unique position to accompany people while they live with this despair. Their therapeutic presence, coupled with human-care qualities and skills, influences the outcome of this painful journey in a positive and connecting manner (Feely & Long, 2009).

There is compelling evidence to support the efficacy of collaborative care for depression in older adults, rather than psychotherapy alone. On the basis of a review of 97 intervention studies, one researcher-practitioner expert panel (Flood & Buckwalter, 2009), strongly recommended interventions based on the depression care management (DCM) model in older adults. Common components include diagnosing depression through validated screening instruments and providing psychotherapy or antidepressant medications according to evidence-based guidelines (Flood & Buckwalter, 2009).

Pharmacotherapy, with selective serotonin reuptake inhibitors (SSRIs), and psychotherapy are currently recommended for treatment of depression in adults of any age, based on evidence from random controlled trials (Gould et al., 2012). Inpatient group therapy assists patients in acquiring skills in socialization, and reduces overall feelings of isolation by talking about feelings with others who are experiencing the same symptoms. Inpatient group therapy realizes two essential benefits: (1) patients are provided with an opportunity to learn social skills to deal with interpersonal problems; and (2) patients interact more with other patients during their hospitalization, thus helping to decrease their sense of isolation and loneliness (Hsiao, Lin, Liao, & Lai, 2004).

Through in-depth ethnographic research, mental health nurses are challenging negative perceptions of their work. The claim that nurses cannot, or do not, form therapeutic relationships, implying that their work is non-therapeutic, is disconcerting.

Acute inpatient psychiatric wards are failing to meet the needs of those who experience them (Sainsbury Centre, 1998). The National Health Service (NHS, 1999) reported that mental health units were becoming more custodial, contact with nurses was inadequate, and there was little or no formal therapy taking place. Improving the mental health nurses' skill base should facilitate the development of a therapeutic milieu. An evidence-based model of therapy is needed, upon which to establish the acute mental health nurses' practice from the moment of admission to the completion of discharge. Such a model might stabilize the crisis that necessitated the person's admission and might begin to frame the process that, ultimately, might be called recovery (Baker, 2013).

The literature repeats, time and again, of the environments of inpatient mental health units being difficult for the patients. One of the main themes contributing to this difficulty is the lack of activity, in which patients describe feelings of boredom and feelings of time not passing fast enough.

When reviewing the experiences of both patients and nurses in the inpatient mental health environment, many similarities surfaced. Both groups expressed a feeling of confinement and isolation, with patients reporting that their connections were mainly with other patients, while nurses reported that they mainly communicated with other nurses. Neither group (patient or nurse) connected in a meaningful way with the other. The major difference between the groups was with respect to their concept of time. For nurses, the work shift moved too fast, and they felt that they were not allotted enough

time to complete their assigned tasks, let alone have time to sit and talk with patients. On the other hand, patients saw time as standing still, with little to do other than to talk with other patients. The patients reported that having so much downtime was actually hurtful, not helpful, to their overall progress towards health while hospitalized.

The nurses described, with frustration, the many time consuming activities that impeded their real work. They were not happy that their purpose on the unit had become task focused nursing, leaving them little to no time to work with patients on developing a therapeutic relationship. Falling in line with this, was also a consistent complaint of being assigned too many patients, which they felt, prohibited them from having enough time to do anything more than tend to the chart.

Purpose of the Capstone Project

The patient experience and patient satisfaction are terms that are interchangeably used as important measures of efficiency and effectiveness of the services being provided in the healthcare environment. In modern day health care, there is a constant push to improve quality in healthcare delivery. Regulatory agencies and insurance companies are driving this push, as research has identified a clear link between patient outcomes and patient satisfaction scores. The institute of medicine's landmark report, "Crossing the Quality Chasm", highlighted patient-centered care as one of six priority areas for improvement in the U.S. health care system. Recent Medicare payment reforms include financial incentives to hospitals that report patient satisfaction data using a common instrument; and provide additional incentives based on patient satisfaction results. Patient satisfaction is also a core part of the Centers for Medicare and Medicaid Services (CMS) reporting requirements for hospitals to qualify for full payment.

The purpose of the Capstone Project therefore, is to improve patient quality outcomes and positively impact patient satisfaction on a geriatric psychiatry unit, by engaging nurses in the care of their patients. This will be done by utilizing therapeutic techniques such as one-to-one interactions with patients, conducting group therapy sessions, and by re-focusing attention onto the patients through the use of the primary nurse model of care.

Treatment Of Depression In The Inpatient Setting

Patients experiencing distress in psychiatric settings, typically have few options for symptom management. Usual interventions include staff contact, medication, decreased stimulation, and group participation. Individuals with mental health problems want to be involved in their treatment decisions. Communication, the cornerstone of psychiatric nursing, depends on cognition, intellect, and the verbal expression feelings. When a patient is stressed, capacity for thinking and problem solving is diminished, sometimes leaving the patient less able to take advantage of cognitive-based therapies (Craske, 2003).

There are advantages and disadvantages to working with geriatric patients in a group, rather than in individual therapy. When looking at the cost effectiveness of group therapy, it is more efficient to have one group leader for five to ten patients for one hour, rather than paying three to four staff to be available for enough individual time per patient. The group environment becomes a safe place to discuss interpersonal issues in a therapeutic manner, as everyone else in the group has also lived these experiences, and can offer empathy and support beyond what the group facilitator can provide.

Groups for the depressed elderly have used cognitive behavioral techniques, focused imaging, autobiographical writing, and general support. Cognitive behavioral approaches are a valuable tool in reducing both psychiatric morbidity and the strain on mental health resources (Karlin & Fuller, 2007).

The Therapeutic Milieu

A major concern in psychiatric hospitals or wards is the patients' and employees' view of the environment in which they work, live, and perform activities of daily living. Often this view affects employee work performance, which may adversely affect the patient outcome. When a study of American psychiatric facilities was evaluated, both patients and nurses agreed that when there was a lack of activities, that there was an increase in mayhem, which was the result of boredom and decreased caregiver-patient interaction (Shatell, Andes, & Thomas, 2008).

The concept of milieu therapy developed from a desire to counteract the negative, regressive effects of institutionalization. The ultimate goal of any treatment program is patient autonomy. As providers of patient care in psychiatric environments, it is vital for nurses to understand that therapeutic relationship building reinforces the patients' plan of care and patient satisfaction (Shatell et al., 2008).

According to Peplau (1989) the milieu of an inpatient facility is considered to be a treatment modality, and nurses are charged with the creation and maintenance of this therapeutic milieu. Originally implemented in the long-term treatment care of institutionalized psychiatric patients, this type of treatment can still be relevant in the inpatient settings of today. It is the structure of the milieu that helps inpatients to learn

how to organize their day and be productive, rather than living in isolation in their rooms, ruminating about their depressive symptoms.

The milieu has both structured and unstructured components, the latter including the diverse interactions between patients, staff, and visitors that take place throughout the hospitalization (Shattell et al., 2008). A preponderance of the literature describes the structure of the milieu, such as the group program schedule, as contributing to the overall success in treating mental health patients in the inpatient setting; however, the literature lacks studies on the potential benefits of the unstructured milieu which includes interpersonal interactions with other patients and with staff.

Changing the environment with the goal of affecting a patient's behavior and improving his or her health is the definition and function of a milieu. Milieus are changes in environments, creating surroundings that are therapeutic, and improve the individual plan of care. The patient learns how to exist within, and to interact in a better environment. This facilitates learning, and helps to develop the skills to make behavioral changes after his/her hospital experience, by learning adaptive techniques (Nursing Planet, 2011).

When milieu therapy first began, the intent was to create re-socialization for the patient, back into their everyday lives. It eventually evolved into a democratic, collective-therapeutic community tradition. In milieu therapy, patients' lives are organized, and they learn practical and social ways of coping with their symptoms through group therapy and individual one-to-one discussions with their nurse or other healthcare providers. Furthermore, the patients who are involved in milieu therapy

actively take part in groups and activities, to help to provide some sense of normalcy (Nursing Planet, 2011).

The goals of milieu environments are to change the patients' environment to a therapeutic area of healing. In the environment, the patient and healthcare provider must practice respect. Communication occurs between the patient and the healthcare provider to enhance the patients self esteem and to help to create autonomy. In the milieu, patients are encouraged to take part in decision-making, and are given responsibility for their activities. Disciplinary approaches to negative behaviors are implemented, such as seclusion and group discussions (Nursing Planet, 2011).

Theorists have described the importance of environment on patient care and outcomes. Florence Nightingale discussed the role of nursing in enhancing environments to create better outcomes for decreasing illness. The appropriate evaluation of any environment is to consider all of its components, including sound, equipment, walls, activities, clothing, behavioral interactions, and people. Environment as an aspect of healing, holistically, is rarely taken into consideration daily on an inpatient unit (Shaner-McCrae, McCrae, & Jas, 2007). Jean Watson explains that nurses must work to develop healing environments for patients. She explains that nurses must promote physical and spiritual environments, which represent human dignity (Watson Caring Science Institute & International Caritas consortium, 2013).

When asked, patients report that expectations of the inpatient hospitalization are relationship development with staff and group therapy, where they can not only express themselves openly in a safe environment, but also gain insight into their thoughts and behaviors. Managed care has changed the face of inpatient psychiatry forever,

transitioning from long-term treatment facilities to short lengths of stay with a focus on crisis stabilization and return to the community. This has led to a decrease in the number of nurses who choose mental health as a specialty, resulting in inadequate number of trained nurses to maintain a therapeutic milieu. The introduction of managed care has led to a deterioration of the milieu in inpatient mental health environments. Focus is now placed on the research based tangible treatments, such as medications, with little respect given to the intangible treatments, such as the therapeutic relationship; which is what patients are telling us they need. And finally from the patient's perspective, Hopkins, Loeb, and Fick (2009) advised that as researchers, that the patients report that they expect more therapy, counseling, staying busy, and keeping their minds from thinking because time tends to be their biggest problem. Thinking is correlated with hurting, which in turn, is correlated with dying, so staff engagement is imperative to the psychiatric patients overall well being and mental health.

One consequence of phenomenological research is greater appreciation of what it is like for your patients to experience something; and although nurses may feel gratified that psychiatric patients experience the hospital as a refuge from their turbulent existence in the outside world, not enough is being done to prepare patients for their return to that world (Shattell et al., 2008). According to Townsend (2010), there are five basic functions of the therapeutic milieu, and from the patients perspective, one area in particular, warrants improvement. Patients feel that when implemented properly, containment, support, structure, and involvement occur. Validation, which is defined by the affirmation of individuality through one-to-one interactions with staff, is lacking.

When looking at the continuum of care for mental health service users, the bulk of the patients are managed in the outpatient setting; however, the specialized inpatient units remain a necessary option for crisis situations, requiring rapid stabilization. Despite the short lengths of stay, there remains an expectation that the nurses will utilize the therapeutic milieu as a treatment modality, and will use themselves as a therapeutic tool by developing a trusting interpersonal relationship with the patient. To meet this demand, renewed focus must be placed on attracting new nurses to this specialty environment, and creating a training program for them to competently meet the needs of the patients.

The potential benefits of this are that nursing, as a care partner in the interdisciplinary team, can reestablish themselves as the experts in milieu management and autonomy in practice. Nurses must make themselves available to their patients, and accept full ownership and responsibility for their care, including time throughout their scheduled shift, to talk with them. To facilitate this, obstacles that impede interaction, creating physical barriers between the nurses and patients, like doors and/or windows that are kept closed at the nurses' station, should be eliminated, or at the very least, minimized.

When nurses share activities with patients, they connect more often. The activities can be dining, singing, talking, or any other non-medical types of interactions. Not only are they sharing the actual space, but also the place in time.

In general, the literature supports the notion that nurses and patients fail to achieve meaningful closeness (Hanrahan, Kumar, & Aiken, 2010). The current environmental milieu hinders, instead of facilitating, the therapeutic relationship between

the nurse and the patient. Time is the enemy for the patients and nurses, though each group's perceptions of time differ.

Through the effective use of the therapeutic milieu, with group therapy as one of the tools, patients are able to learn more about their relationships with others and their interpersonal problems through the groups' interaction (Gould et al., 2012). Inpatient group therapy realizes two essential benefits. The first is that patients interact more with other patients during their hospitalization, thus helping to decrease their sense of isolation and loneliness; and the second, is that patients are provided with an opportunity to learn social skills to deal with interpersonal problems (Hsiao et al., 2004).

Significance of the Capstone Project

What Is Causing The Trend

Two-thirds of all depressed patients nowadays are treated pharmacologically, with only about a third receiving psychotherapy (Hollon & Sexton, 2012). 20 years ago, the reverse was true. The introduction of the selective SSRIs and serotonin norepinephrine reuptake inhibitors (SNRIs) in the late 1980s is responsible for this shift, as they have proven to be a safe and effective improvement from the monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants of the 1950s, 60s, and 70s. Because of this, primary care providers felt safe prescribing and managing their patient's care, shying away from making referrals for psychiatric consultation and evaluation. Antidepressant medications have their efficacy in reducing the negative symptoms of depression that are related to chemical imbalances in the brain, but do nothing to help resolve issues causing depression that are not bio-chemically based. The empirically supported psychotherapies often are efficacious in the treatment of depression and appear to have broader or more

enduring effects than medications (Hollon & Sexton, 2012). Adopting a multi-systemic focus can enhance the treatment of depression.

These bio-scientific developments have a direct correlation to the change in mental health care focus from functional or situational etiologies that can be treated psychotherapeutically. For physicians, prescribing medications is easier and more cost effective in the inpatient psychiatric setting, rather than spending time on the greater challenges involved in conducting psychotherapy. As physician focus has changed, the inpatient therapeutic milieu for patients and nurses has deteriorated.

Rationale For Change

According to Dagg and Evans (1997), learning how to conduct group therapy can enhance a clinician's ability to listen. Group psychotherapy, as an adjunctive treatment to pharmacotherapy, has been shown to have an additive effect to symptom improvement.

Group psychotherapy generates an energy that is different from an individual one-to-one interaction. It allows the leader to see patients engaging in interactions with others, giving them direct access to more than just a superficial knowledge of the patient, which assists the nurses in treating them with maximal effectiveness, despite time limitations imposed by reduced length of stay during the hospitalization.

Modern inpatient mental health units are lacking in their ability to effectively engage patients in meaningful activities and provide psychological and emotional support, while also making it a place of safety. Boredom and frustration of the inpatient routine are factors repeatedly recurring within the literature and echoed by both researchers as well as service users writing about their own personal experiences of hospitalization (Griffiths, 2008).

The Role of the Mental Health Nurse

Research has been the backbone for developing innovative ways in dealing with current problems. Because gerontology, and particularly geriatric psychiatry are relatively new specialty areas, research-based practices often lag behind. Most evidence-based treatment modalities in current use (e.g. newer psychotropic medications) are the result of studies based on the general population.

Cognitive behavior therapy (CBT) has been established as a standardized and consistently effective treatment. Despite overlapping roles in multidisciplinary teams, formal therapy tends to be delivered by psychologists. Nurses, meanwhile, have limited opportunities to develop their role in therapy. The paucity of evidence for therapeutic interventions by nurses is unsurprising given the disadvantaged position of nursing in research infrastructure and funding (McCrae, 2014). There is also a simplistic notion that nursing is “care” but not “treatment”. For example, in reviewing patient’s charts, when a patient recovers from depression, the discharge summary is most likely to attribute this primarily to an antidepressant prescribed by the psychiatrist, not by the therapeutic relationship developed with the nurse or other members of the treatment team.

Ongoing assessment, diagnosis, outcome identification, planning, implementation, and evaluation of the environment are necessary for the successful management of a therapeutic milieu (Tuveson, Eklund, & Wann-Hansson, 2011). Nurses are involved in all day-to-day activities that pertain to patient care. Nurses have input into therapy goals and participate in the regular updates and modifications of treatment plans.

The nurses’ role has become one of assessing symptoms and risk and maintaining

safety and administering medication. The provision of therapeutic and recreational activities is thought of as somebody else's job, either the occupational therapist or unqualified staff such as unlicensed assistive personnel. Activities are not viewed as a vital component of treatment or as important as medication. Unit staff needs supervision and training to change custodial care into therapeutic care; collaborating closely in care provision will facilitate this. In sharing therapeutic roles, nurses will be better prepared to define their own core skills.

Mental health nursing is different from the medical model of nursing in that the nurse helps the patient to become mentally healthy by teaching and encouraging the use of coping skills and strategies. The objectives of planning and implementing therapeutic interventions are to assist the patient to achieve an optimal state of health. Diagnosis and identification of signs and symptoms is the responsibility of the psychiatrist; however, collaboration in an interdisciplinary environment is strongly encouraged, and ultimately necessary, in establishing nursing's role in mental health care.

The mental health nurse's role is to develop a treatment plan for mental health problems and psychiatric disorders based on bio-psychosocial theories, evidence-based standards of care, and practice guidelines. They may conduct individual or group therapy, and they plan individualized care to minimize the development of complications and promote function and quality of life using these treatment modalities. The mental health nurse educates and assists the patient in evaluating the appropriate use of complementary therapies to their prescribed pharmacotherapy. Through relationship development, the nurse is able to recognize and interpret the patients' implicit communication, by listening to what the patient is saying and observing non-verbal

behaviors. To sum this up, the mental health nurses' purpose is to apply therapeutic communication strategies based on theories and research evidence to reduce emotional distress, facilitate cognitive and behavioral change, and foster personal growth.

A schedule that provides groups focused on the geriatric population is imperative. The programs should include exercise or movement groups, as well as groups on activities of daily living. Groups where patients have an opportunity to express themselves with respect to grief, current events, reminiscence, discharge planning, and medication management are also important.

Definition of Relevant Terms

GDS: Geriatric Depression Scale. This is a fifteen – question questionnaire with yes/no answers, which can either be handed to a patient to fill out, or a registered nurse can verbally administer it.

Group Therapy: Any form of psychotherapy when delivered in a group format, where the group context and the group process is explicitly utilized as a mechanism of change by developing, exploring, and examining interpersonal relationships within the group.

MAOIs: Monoamine Oxidase Inhibitors, prescribed for the use and treatment of depression. This drug class has a potential for lethal drug and dietary interactions, and as such, is usually a last resort with other medications fail.

Milieu: The French word for “middle”. In the English translation, the word means surroundings or environment.

Milieu Therapy: The treatment of mental disorders by making substantial changes in a patient's immediate life circumstances and environment in a way that will enhance the effectiveness of other forms of therapy.

Press Ganey: As a strategic business partner to more than 10,000 health care organizations across the country and across the continuum of care, Press Ganey is the leader in helping create continuous, sustainable improvement.

SNRIs: Selective Norepinephrine Reuptake Inhibitors, second generation. Class of antidepressant drugs used in the treatment of major depressive disorder.

SSRIs: Selective Serotonin Reuptake Inhibitors, second generation. Class of compounds typically used as antidepressants in the treatment of depression, anxiety disorders, and some personality disorders.

Tricyclic Antidepressant: The first generation of antidepressant medication. They were first used in the 1950s, but rarely used now due to the newer generation antidepressant medications that have fewer unpleasant side effects.

Assumptions

The DNP learner has made the assumption that the implementation of a structured milieu, that includes at least one nurse-led group, will result in increased patient satisfaction and increased nurse job satisfaction. By actively engaging psychiatric nurses into the therapeutic milieu by engaging them in the group process, it is assumed that they will feel that they have more purpose in their roles, which will increase their job satisfaction. More satisfied nurses will increase their level of engagement with the patients, which will create a more satisfactory inpatient environment, that will be

communicated as a positive outcome on the Press Ganey patient satisfaction questionnaires that are distributed to all patients at the time of discharge.

Mental health parity

In the United States, access to treatment for the millions who suffer with mental health disorders, remains a topic of discussion. Unlike other physical healthcare conditions, mental health issues can begin to manifest in young adulthood and go untreated until the illness becomes debilitating. This is first manifested as difficulties in school, and as they get older, transitions to difficulties in the workplace. The result of this chronic dynamic, is many people with mental health disorders are either unemployed, or work in low-paying jobs, and are typically uninsured. The expansion of mental health care benefits would be of great benefit to this population.

What is mental health parity? Simply stated, this means that health insurance coverage for mental illness has the same terms and conditions as other medical illnesses. Individuals and families are frequently unaware of their limited mental health/substance abuse insurance benefits until they try to access coverage. Despite the fact that depression success rates are over 80%, the insurance coverage is not there. Untreated depression will be far more costly to the patient, family and insurance company. Absenteeism and lost productivity are very costly.

The National Institute of Mental Health has estimated that 26% of American adults experience a mental disorder in any given year and that an estimated 15 million receive mental health services (Rosenberg, 2010). Usage of these services represents approximately 5% of the \$2.6 trillion in annual U.S. healthcare spending, and yet, insurance coverage for these services is minimal, when compared with coverage for

disorders that are physical in nature. In addition, insurers often have more stringent guidelines and questions around providing reimbursement for such services.

Health care reform in America will have an overall financial and moral impact on the health and wellness of Americans. According to Rosenberg (2010) in the U.S., mental disorders collectively account for more than 15% of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer; and the U.S. spends upwards of \$99 billion a year for the direct treatment of mental and substance abuse disorders, which is more than 8% of total annual health expenditures.

The better insurance coverage for mental health services required by the new parity rule and the Affordable Care Act will make it more attractive for healthcare providers and investors to operate mental health facilities; and experts say many areas of the country are underserved (Demko, Johnson, & Kutscher, 2013). When faced with funding cuts, state budgets traditionally choose to reduce mental health offerings and services. Reform for our mental health system is timely, as aging baby boomers are creating a demand for these services that is unprecedented. Due in part to the current economic turmoil, community mental health and substance use treatment centers nationwide are experiencing a 20% increase in demand for services, according to a 2009 survey by the National Council for Community Behavioral Healthcare (Demko et al., 2013).

Parity for mental health care is one of the most important legislative concepts currently being discussed. Federal law was passed in 2008, in an attempt to level the playing field where mental health use treatment limits and financial requirements are

concerned. Mental health parity will help to continue to normalize mental illness and substance abuse as treatable diseases, eliminating access issues to effective therapies.

Americans suffering with mental health problems have been discriminated against since the Salem witch trials. We are finally at a point where we are able to close the gaps in healthcare coverage. As a vulnerable population, these people have traditionally been unable to fight for themselves; however, new laws are providing patients with benefits and entitlements that they can access as American citizens. In addition to providing equal benefits for mental illness as physical illness, there will be a need for strong monitoring and enforcement at both the state and federal levels (Demko et al., 2013).

In the U.S. people with mental illness are more likely to die prematurely, as a result of co-morbid medical illnesses. Three out of every five people diagnosed with mental illnesses die from preventable, co-occurring chronic diseases such as asthma, diabetes, cancer, heart disease, and cardiopulmonary conditions (Demko et al., 2013). Health care reform will not fix the problems of the mentally ill; however, by providing parity in healthcare coverage, it may slow the rate of premature death in people who are diagnosed with mental illness.

A tragedy for all Americans is the fact that in 2014, greater than 50% of Americans with mental health issues went untreated. Health care reform should provide for greater access to mental health services. State government and policy makers need to address the behavioral health needs of a rapidly increasing population of older adults. This is especially true given the experience that the baby boomer generation has had with community based mental health treatment services to date.

Limitations

The capstone project was limited to the staff on one inpatient geriatric psychiatry unit at a large academic multi-hospital healthcare organization. The unit is a twenty-two bed unit that focuses on patients with mood disorders such as depression, bipolar disorder and psychosis. The age range of the patients is 65 years and older, with the average age being 78 years old. The average length of stay is approximately 12 days, with some patients remaining hospitalized longer if an index course of ECT was attempted. The staff has recently gone through a major transition of the unit, as the focus has changed from providing basic psychiatric care, to a new focus on treatment resistant mood disorders.

Capstone Project Objectives

There are two main objectives of the capstone project. The first is to decrease patient boredom while in the hospital and provide patients with tools to use after discharge to help them manage their mood disorder. This will be tracked through the Press Ganey patient satisfaction questionnaire that is given to all patients at the time of discharge, and will reflect an increase in the “overall rating of nursing care” question as well as an increase in the “overall rating of patient visit” question.

The second objective is to increase nursing staff satisfaction with their jobs, by assisting them with group planning and facilitation with the patients. The hope is that the staff will feel more engaged with the therapy and treatment of the patients, and will feel that they have more purpose in their daily activities. This will be tracked through a pre and post implementation survey as well as survey results from the Press Ganey employee engagement survey that is distributed yearly to all staff members.

Although most research on mental health issues is conducted on younger adults, there is evidence to support transference of the results to geriatrics. The main difference is that any treatment modality takes a little bit longer to see the clinical effectiveness in geriatrics. Treatment of depression in geriatrics has a 60 – 80% success rate, whereby patients experience a remission of symptoms. A therapeutic program that is structured with groups appropriate for geriatric patients can have a positive impact on the patient's outcomes. Pharmacological and psychological interventions for geriatric patients with depression have shown statistically similar efficacy; and many studies report the benefits of a combination of treatment modalities, due in part to the fact that one has its focus on the chemical dysfunction in the brain, while the other focuses on the interpersonal causes of the depressed mood.

Milieu therapy interventions are recognized as one of the basic-level functions of psychiatric-mental health nurses as addressed in the American Nurses Association Scope and Standards of Psychiatric-Mental Health Nursing Practice, 2014. It is time for mental health nurses to become reacquainted with the concept of the therapeutic milieu and to reclaim nursing's traditional milieu intervention functions. Nurses need to have the autonomy to carry out structured and unstructured milieu functions consistent with their standards of practice, without causing undue stress to the nurse due to the sheer number of tasks (Tuveson et al., 2011). Nurse-led groups, that are educational in nature, should be added to the milieu program, to enhance the development of a therapeutic relationship between the nurse and the patient.

CHAPTER 2. THEORETICAL FRAMEWORK AND LITERATURE REVIEW

Theoretical Framework

The notion of the therapeutic milieu has come under fire for lack of relevance to current inpatient psychiatric care environments. Yet, in different fields of health care, scholars are suggesting a need to build healing environments. A view of the therapeutic milieu as an optimal healing environment based on continuous healing relationships, patient-centered care, safety as a systems priority, and cooperation among clinicians provides a framework to organize care in a holistic manner that supports positive health outcomes. This approach provides a platform for nurses and other clinicians to expand the view of a milieu traditionally limited to the unit environment to one that includes a broad systems context.

The evidence based practice model that was used to structure the change process is Rosswurm and Larrabee's model for change. This model recognizes that translation of research into practice requires a solid grounding in change theory, principles of research utilization, and use of standardized nomenclature. The model contains six phases including 1) assess the need for change in practice, 2) link the problem, interventions, and outcomes, 3) synthesize the best evidence, 4) design practice change, 5) implement and evaluate the change in practice, and 6) integrate and maintain the change in practice.

Placing focus on inpatient psychiatric milieus can provide a needed adjunct to the multiple pharmacological treatments that exist today. Improving the mental health nurses' skill base should facilitate the development of a therapeutic milieu.

The proposed change, therefore, was to introduce a structured therapeutic milieu into an inpatient geriatric psychiatry unit. A schedule that provides groups focused on

geriatric patients was imperative. The program includes seated exercise groups, groups focused on activities of daily living, grief management, current events and reminiscence, discharge planning, problem solving, spiritual health, and medication management. The new care delivery model is being used as a means of increasing patient quality outcomes, as well as addressing the overall satisfaction of the nursing staff with their job roles.

The DNP learner, who assumed the role of project lead and manager for the proposed change, has facilitated the change process. According to Rosswurm and Larrabee, phases one through six are listed in table format (see Table 1), with the implementation strategy that was proposed and executed.

Table 1

Rosswurm and Larrabee’s Model For Change Phases

Rosswurm & Larrabee’s Model For Change Phases	Steps To Implement The Proposed Change
Phase 1 - Assess the need for change in practice	<ul style="list-style-type: none"> The DNP student identified the clinical problem through review of Press Ganey patient satisfaction survey results and comments, review of Press Ganey employee engagement and satisfaction results and comments, and interviewing hospital nursing leaders and administration
Phase 2 - Link the problem, interventions, and outcomes	<ul style="list-style-type: none"> The clinical question - What effect will the implementation of a therapeutic psychiatric program, that includes at least one nurse-led group, on an inpatient geriatric psychiatry unit, have on patient quality outcomes and staff satisfaction over period of 18 months? Interventions – Introduce a structured therapeutic milieu into an inpatient Geriatric Psychiatry Unit.
Phase 2 - Link the problem, interventions, and outcomes	<ul style="list-style-type: none"> Outcomes – The proposed new care delivery model will be used as a means of increasing patient quality outcomes, as well as addressing the overall satisfaction of the nursing staff with their job roles.

Rosswurm & Larrabee's Model For Change Phases	Steps To Implement The Proposed Change
Phase 3 - Synthesize the best evidence	<ul style="list-style-type: none"> • The program should include seated exercise groups, groups focused on activities of daily living, grief management, current events and reminiscence, discharge planning, problem solving, spiritual health, and medication management.
Phase 4 - Design practice change	<ul style="list-style-type: none"> • A schedule that provides groups focused on geriatric patients is imperative • The staff RN's • Create a schedule of groups that an optimally functioning multi-disciplinary therapeutic milieu would include • Develop a minimum of one nurse-led treatment group, and train staff RN's as facilitators
Phase 5 - Implement and evaluate the change in practice	<ul style="list-style-type: none"> • Once the nurse-led group is developed, the DNP learner will co-lead the group with one staff RN each day • This process will continue until all RN's on the day shift have had at least three separate training sessions • Have one-on-one discussions with nursing staff daily about the successes and failures of the nurse-led group, and make changes accordingly
Phase 6 - Integrate and maintain the change in practice.	<ul style="list-style-type: none"> • Approximate timeframe = 3 months • After all day shift RN's have been trained, the nurse-led group will be delegated to the staff RN's as a daily expectation and assignment • Once successfully established on the 7am shift, the DNP learner will repeat the process with the 7pm shift nurses, adding an additional nurse-led group to the daily program • Approximate timeframe = 6 months from the inception of the nurse-led group on the day shift

Kurt Lewin is widely known as the father of change theory, and spent his professional lifetime attempting to explain human behavior and ways in which we could

improve said behaviors. Lewin described changed in the context of a force-field analysis, and believed that all change is related to opposing forces within a particular space.

According to Lewin’s theory, there are three basic steps that are used when describing the process of change: unfreezing, moving, and re-freezing. Table 2, seen below, illustrates how Lewin’s Change Theory fits into Rosswurm and Larrabee’s Model For Change.

Table 2

Lewin’s Change Theory Fit Into Rosswurm and Larrabees Model For Change

Rosswurm and Larrabee’s Model For Change Phases	Steps To Implement The Proposed Change	Lewin’s Change Theory
Phase 1 - Assess the need for change in practice	<ul style="list-style-type: none"> The DNP student identified the clinical problem through review of Press Ganey patient satisfaction survey results and comments, review of Press Ganey employee engagement and satisfaction results and comments, and interviewing hospital nursing leaders and administration 	<ul style="list-style-type: none"> Unfreezing – this is where the need for change is first noted, and the change agent becomes motivated by the need to create change.
Phase 2 - Link the problem, interventions, and outcomes	<ul style="list-style-type: none"> The clinical question - What effect will the implementation of a therapeutic psychiatric program, on an inpatient geriatric psychiatry unit, have on patient quality outcomes and staff satisfaction over a 2-year period? Interventions – Introduce a structured therapeutic milieu into an inpatient Geriatric Psychiatry Unit. Outcomes – The proposed new care delivery model, will be used as a means of increasing patient quality outcomes, as well as addressing the overall satisfaction of the nursing staff with their job roles. 	<ul style="list-style-type: none"> Continue unfreezing

Rosswurm and Larrabee's Model For Change Phases	Steps To Implement The Proposed Change	Lewin's Change Theory
Phase 3 - Synthesize the best evidence	<ul style="list-style-type: none"> • The program should include seated exercise groups, groups focused on activities of daily living, grief management, current events and reminiscence, discharge planning, problem solving, spiritual health, and medication management. • A schedule that provides groups focused on geriatric patients is imperative • The staff RN's 	<ul style="list-style-type: none"> • Continue unfreezing
Phase 4 - Design practice change	<ul style="list-style-type: none"> • Create a schedule of groups that an optimally functioning multi-disciplinary therapeutic milieu would include • Develop a minimum of one nurse-led treatment group, and train staff RN's as facilitators 	<ul style="list-style-type: none"> • Continue unfreezing
Phase 5 - Implement and evaluate the change in practice	<ul style="list-style-type: none"> • Once the nurse-led group is developed, the DNP learner will co-lead the group with one staff RN each day • This process will continue until all RN's on the day shift have had at least three separate training sessions • Have one-on-one discussions with nursing staff daily about the successes and failures of the nurse-led group, and make changes accordingly 	<ul style="list-style-type: none"> • Moving – this is where the change begins to gain momentum as those affected, begin to accept and try the new innovation.
Phase 6 - Integrate and maintain the change in practice.	<ul style="list-style-type: none"> • Timeframe = 3 months • After all day shift RN's have been trained, the nurse-led group will be delegated to the staff RN's as a daily expectation and assignment • Once successfully established on the day shift, the DNP learner will repeat the process with the evening shift nurses, adding an additional nurse-led group to the daily program • Timeframe = 6 months from the inception of the nurse-led group on the day shift 	<ul style="list-style-type: none"> • Refreezing – this becomes the time of full integration and stabilization of the change.

Lewin's theory is divided into three stages. The first stage is called unfreezing, which is where the need for change is first noted, and the change agent becomes motivated by the need to create change. Unfreezing is the process which involves finding a method of making it possible for people to let go of an old pattern that was counterproductive in some way.

The second stage is called moving. This is where the change begins to gain momentum, as those affected, begin to accept and try the new innovation. This stage involves a process of change in thoughts, feeling, behavior, or all three that is in some way more liberating or more productive.

The third and final stage is called re-freezing, and this becomes the time of full integration and stabilization of the change. Refreezing is establishing the change as a new habit, so that it now becomes the "standard operating procedure".

Summary of Relevant Research

A powerful and consistent theme that came out of all of the articles was one of boredom and powerlessness from the perspective of the patient who was admitted to an inpatient psychiatric unit. They further articulated that these feelings grew stronger as their mental health status improved. Participating in the groups has been shown to alleviate some of those feelings. Patients did describe caring and support they received in the hospital, but mostly from members of their peer groups; patients supported patients and nurses supported nurses (Shattell et al., 2008).

Nurses' descriptions included an inability to function in a more therapeutic capacity, because of organizational policies and procedures that took precedence over the patient interactions. Mandates, such as charting, which were sometimes repetitive and

unnecessary, participation in multiple meetings, high turnover rate with multiple admissions daily, and being assigned too many patients to have a meaningful conversation with all of them, were all repeated themes. Despite this, a theme of teamwork was also expressed, whereby the nurses described supporting each other by providing care, whether or not they were actually assigned to a particular patient.

Quite often staff is absent altogether and patients are left alone in corridors or other unsupervised areas. Extended time away, physically, and mentally from a patient, can have a major impact on patient safety. When there is a lack of supervision, the milieu can quickly escalate, as one patient out of control can contribute to the anxiety and agitation of other patients'. The behavior can be defined incorrectly as negative behavior, when in actuality, it was brought on by the nurse or provider not being present or available to notice the preliminary stages of disruption (Edvardsson, Sandman, & Rasmussen, 2012).

The preferred approach for psychiatric patients is to make the environment calm, involved, and positive. Current studies have stressed the importance of staff involvement and staff being aware of the environmental influences on patient outcomes. Proactive approaches should be initiated and taught to caregivers on inpatient units regularly. Furthermore, being present in the patients' physical and psychological space can curb adverse attitudes and behaviors (Edvardsson et al., 2012).

Training in group therapy facilitation for nurses, social workers, and physicians, is almost non-existent. Despite this, literature shows that nurses still enjoy and appreciate the experiential groups and often feel increased job satisfaction when involved in developing and utilizing group psychotherapy skills. In the last fifty years, mental health

nurses educated in the facilitation of group psychotherapy has decreased. This is directly correlated to physicians' reliance and use of pharmacotherapy, compounded by the modern day shorter lengths of stay. Mental health nurses need to get back to their core purpose as the facilitators of the therapeutic milieu. Training in group therapy enhances their abilities to work in inpatient units and partial hospitalization programs. Group therapy skills can also complement psychopharmacology instead of competing with it.

Shattell et al. (2008), describes how patients report feeling bored in inpatient environments, attributing the lack of structured activities as a detriment to their physical and emotional well-being. Patients frequently found that nurses on the wards often appeared too busy to spend time with them, enhancing patients' experiences of boredom and frustration (Shattell et al., 2008). As a result of this, people who use mental health services often find that the greatest therapy on an inpatient unit is the companionship of other patients.

Studies have found that people who use mental health services often feel that they are not helped by being in the hospital, and are not treated with respect by staff; and high bed occupancy rates coupled with low staffing levels means that there is often little time for interaction to take place between staff and service users (Stickley & Hui, 2012).

The literature repeats, over and over again, about the importance and the value of the nurse-to-patient relationship in mental health environments. The atmosphere and structure of the inpatient environment can be one of the most important factors of the patient experience, and more specifically, nurses attitudes and approaches to care have been perceived as the primary contributors to affecting ward atmosphere (Stickley & Hui, 2012).

The Change – Implementing the Nurse-Led Group

Currently, there is a strong movement toward implementing recovery model concepts in the care of people experiencing mental health difficulties. Although the concept that people can recover from mental illness is not new, the recent surge toward implementing recovery principles in psychiatric acute care was spurred by The President's New Freedom Commission on Mental Health (NFCMH; 2003) report and consumer's accounts that the medical model approach to treating mental illness was not therapeutic, empowering, or conducive to healing. The NFCMH report outlined fragmentation in care, inequitable treatment, and continued stigmatization for those with mental illness. Most alarming from consumer accounts and the NFCMH report is that the current system is not oriented towards the hope of recovery. The American Nurses Association (2007) responded to this initiative by including recovery ideals as an important aspect of psychiatric nursing practice in the revised Psychiatric Mental Health Nursing Scope & Standards of Practice (2007).

Complicating the implementation of recovery principles for nurses working in acute care psychiatric settings are the past decades of managed care and the increasingly persistent focus on the medical model (Seed & Torkelson, 2012). The medical model of care was a good fit with the goals of third party payers who were focused on reducing costs by shortening the length of stay on inpatient units. Psychiatric nurses were pressured to respond to these factors by focusing on the illness and relieving symptoms with physician-ordered medications in a timely fashion. Shortened lengths of stay and high acuity on the inpatient units contributed to the high expectation that psychiatric nurses ensure patient safety. Chen, Krupa, Lysaght, McCay, and Piat (2011) found that

the emphasis on safety may have created conflict within nursing between the responsibilities of maintaining control on the unit and delivering patient-centered care that was conducive to recovery. Finally, researchers measuring the amount of time inpatient psychiatric nurses spent on specific functions during a typical shift found that nurses spent a majority of their time on paperwork, medication administration, keeping the unit safe, and team meetings; although they were more satisfied with their jobs when delivering direct patient care. Hanrahan and Aiken (2008) also found that 40% of psychiatric nurses are dissatisfied with their job and that 34% of psychiatric nurses were not at all confident that their patients would be able to manage their own care when discharged. The recovery movement, the internal conflict regarding the quality of care and dissatisfaction experienced by nurses working in acute care settings, can be an opportunity to change the way patient care is delivered. Dedicating time for nurse-patient contact is a strategy that can result in major improvements in patient care (McCrae, 2014).

A national agenda has been set to renovate mental health systems in order to create care with a major focus on recovery. The call to transform mental health systems is an opportunity for psychiatric nursing to return to its roots and deliver care that is patient-centered and conducive to recovering from mental illness. Leadership and research are needed in psychiatric nursing that supports this transformation in order to enhance the important aspects of care that nursing brings to the table. Nurses are taught to form therapeutic relationships in order to help individuals cope and manage the debilitating effects of mental illness symptoms. Nurses can provide patient and family-centered care that allows recovery from illness, and that optimizes functioning within a

community. The nursing focus will be instrumental in the recovery movement, and must be brought to the forefront of the current mental health system.

CHAPTER 3. CAPSTONE PROJECT DESIGN

Project Design and Description

Practice Decision

Clinically researched interventions, focused on effective treatment for the older adult, can make a significant contribution towards decreasing the potential for disability, morbidity, and mortality, for the many older adults who suffer from depression. A minimum of one nurse-led group has been incorporated into the geriatric psychiatry unit's daily schedule.

Nursing has made a substantial contribution to the care and health promotion of older adults. Since the 1950s, nurses have been leaders in therapeutic milieu groups. Today, nurses lead psycho-educational groups, therapeutic milieu groups, spirituality groups, behavioral groups, self-help groups, and cognitive behavioral groups. Cohesiveness is the most universal, of all factors, in group therapy. The experience of sharing, of being accepted, and of successfully negotiating a group experience can be highly therapeutic. Cohesiveness is an important element in the experience of universality. In the group, patients hear others share similar concerns, feeling, and life experiences. The disconfirmation of the feeling of uniqueness in suffering offers considerable relief and a welcome to the human race experience (Nance, 2012).

For the purposes of this project, a minimum of one nurse-led group was introduced into the structured milieu program, facilitating the therapeutic relationship between the nurse and the patient. The timeline from project implementation to complete hand-off to the nursing staff was approximately six months, and was evaluated for success at monthly intervals. If successful, the implementation of the structured program

and nurse-led group will positively impact both patient and staff satisfaction scores and engagement, which will be measured via the Press Ganey survey process that is already standard practice for all nursing staff and patients of this academic teaching hospital facility, as well as by conducting an interval survey that was created by the DNP learner (see Appendix I). The major barrier that has been identified is that the nursing staff is very anxious about doing groups. It is not something that is taught in nursing school, and many of the staff lack a strong psychiatric nursing background. This was addressed by creating a co-leader environment between the nursing staff and the DNP leader, with an intentional plan for complete hand-off within six months of group implementation. This has proven to be a successful way of teaching/mentoring the nursing staff to group facilitation, and has required a substantial commitment of time from the DNP learner, for successful complete hand-off.

Rationale for Design Framework

Methods

The project is a qualitative design that was non-invasive in nature. A minimum of one nurse-led group was incorporated into the patient's daily routine. Patients overall satisfaction with the care that they received during the hospitalization is being measured using the Press Ganey patient satisfaction questionnaire; however, consideration was also given to utilizing the geriatric depression scale, which is a fifteen – question questionnaire, with yes/no answers, that can either be handed to a patient to fill out, or it can be verbally administered by a registered nurse.

Nurse staff satisfaction was also measured utilizing the Press Ganey staff engagement and satisfaction survey that is distributed every year as well as an interval survey created by the DNP learner (see Appendix I).

Implementation

The key stakeholders are hospital administration, as they have a vested interest in developing a strong inpatient psychiatric program that will generate more admissions by becoming a magnet for healthcare needs for those suffering from mood disorders that are seeking inpatient psychiatric care. The nursing staff and the multi-disciplinary care partners are a stakeholder group, as providing meaningful work with a purpose increases overall satisfaction in the workplace, which increases retention. The final key stakeholder group is the patients who are the recipients of care. They have expectations of what the inpatient hospitalization will do for their overall health and well-being.

A minimum of two nurses were identified as needing to be trained as group leaders, as the geriatric psychiatry inpatient unit functions on 12-hour shifts, with each staff nurse working 36 hours per week. Initially, the DNP learner facilitated the daily group, with the trainees present in the group as observers. The DNP learner and the trainee performed a debriefing after every group, to discuss the goals and any issues that arose during the group that might have required follow-up. Once the trainees achieved a level of comfort with the group, then the role as leader transitioned to the trainee, with the DNP learner as the observer. The same debriefing process occurred after each group meeting, and a total of 10 nursing staff were developed as leaders and co-leaders as part of the plan for long-term continuation of the daily group.

Two groups were developed. Community meeting and goals setting group, which lasted approximately 45 minutes, was held after breakfast every morning. In addition, a wrap-up group was also developed, and it occurred daily after dinner, and lasted for approximately 30 minutes. As the identified clinical practice concern relates to improving patient satisfaction scores and improving nurse engagement and satisfaction, the purpose of this topic is two-fold. If the patients are helped to develop daily goals, then it gives the patients and the nurses something to work on together throughout the day. This will help to build the therapeutic relationship, thus, increasing satisfaction for both patients and nurses with the inpatient environment. By adding the wrap-up group, the night shift is also incorporated into the care of the patient, because their job is to go over the goals from the morning, and ensure that the staff and patients are working towards goal completion by the end of the day.

Capstone Project Intervention

A paradigm is a way of seeing or construing the world which underlies the theories, operating principles, rules and methodologies of science during a particular period of history. Such a model incorporates values, assumptions and beliefs accepted by the scientific community and by those engaged in applying science, such as in the field of healthcare. A paradigm shift involves a major conceptual change in both theory and practice. It is necessarily a development or extension of what has gone before. To improve nurse-patient engagement, there must be more focus on what is done rather than how much. Whatever strategy is applied, managers of acute mental health units must ensure that patients have appropriate emotional support, while the more highly skilled nurses in the team should be enabled to devote time to therapeutic interventions. With

the will and direction of nursing leaders and practitioners, meaningful engagement is an achievable goal.

The role that the DNP plays in this process is identifying the clinical issue and then developing a practice change based upon evidence-based practice and current research in the literature. Because the average staff nurse has very little experience with research, the DNP's role is to function as the translator of the research into clinical practice at the bedside; or in this case, to the therapeutic milieu. As an expert clinician and nursing leader, the DNP is in the perfect position to implement clinical changes that impact and improve patient care. In addition, the DNP leader holds the responsibility of ensuring that all of the key stakeholders are knowledgeable about the practice change, and are supportive of the practice change. The intervention was to add a minimum of one nurse-led group daily to the therapeutic program.

Facilitating The Change Process – Implementation of the DNP Capstone Project Leadership, Resources, and Organizational Readiness

In order for change to take place, the organization must demonstrate a commitment and a readiness to change. Inclusive of this is the level of engagement of leadership, having adequate and available resources to support change, and access to information and knowledge about the change process. Successful implementation of any change requires that leadership involve and commit themselves, and accept accountability to and for the change. It is important to define leadership in the organization as any formal or informal leader, at any level, who has the power and influence to effect the change. Practical and sustainable organizational change is dependent on effective leadership, where the leaders ensure that all necessary

communications and resources are made available to those being directly affected by the change.

In addition to effective leadership, it is important that managers exercise patience during the implementation process to allow time for the intervention to solidify. It is equally important, during this time that leaders provide an adequate supply of resources. This might include time, money, physical space, education, and training, to ensure continued implementation and sustainability of the change process.

Beliefs, Knowledge, and Practitioner Readiness

Most implementation efforts are hampered by a lack of enthusiasm and willingness for most, to engage in the change process. Evidence based practice (EBP) adoption by the mental health nurse can be impacted by the following attitudes: an openness to change; the perception of the organizations willingness to try new practices; an openness to innovation and innovative practice; the intuitive appeal of the practice change; and finally, the palpable difference between current and suggested practice.

Mental health practitioners are more likely to adopt a particular practice if the evidence and support for the practice is generated by colleagues close to the practitioner (Kimber, Barwick, & Fearing, 2012). This articulates that where the information for the proposed EBP comes from, is a strong predictor of practitioner adoption.

The Change Process - Implications For Mental Health Care

EBP implementation and organizational change provides preliminary support and insight regarding the field use of the National Implementation Research Network's (NIRN) implementation model as a guiding framework for behavioral healthcare organizations (Kimber et al., 2012). The implementation of EBP in mental health

settings requires that leadership create buy-in of the change, by clearly articulating and communicating the process for the change, while also planning for the disruption that will come as the change is put into practice.

Policy on mental health care continues to promote implementation of new EBPs, without regard to the toll that this takes from an organizational change and labor-intensive perspective. As gaps in workforce preparation for the EBP environment continue to be exposed, hospital educators and institutions of higher learning must begin to become active participants in the educational process, to ensure that our 21st century nursing workforce remains modern and current. Colleges and universities must constantly modify their curriculum to include EBP knowledge in the didactic courses and offer appropriate learning experiences in the clinical courses. Clinical educators for providers of mental health care must continuously offer annual staff educational opportunities that enhance, and build upon the excellence and efficiency in patient care that has already been established. They can also influence state and federal governments to amend their policies to be inclusive of evidence based practices, while making acknowledgment to the complexities involved with implementation and the needs of mental health nurses for ongoing support and training.

The importance of staff buy-in, shared leadership, readiness for organizational and practice change, effective communication, and resource availability for implementing and sustaining broad-based organizational change, cannot be over-emphasized (Kimber et al., 2012). As mental health nurses, the focus and goals should be on delivering excellent care to an extremely vulnerable population that is typically underserved and forgotten in society.

Barriers To The Application of Evidence in Behavioral Healthcare Settings

There are two major barriers to applying EBP in acute inpatient mental health settings. The first is that nurses feel like they do not have enough authority to change patient care procedures. Despite nursing leaders exposing staff nurses to EBP and constantly discussing the importance and the benefits of EBP adoption, the nurses themselves feel like nursing management and advanced practice nurses are the best people to implement the change. In addition, lacking a healthy relationship with physician partners stifles growth and development of the staff nurses.

The second is ensuring that staff is given an adequate amount of time in their workday, to implement new ideas. When nurses work 12-hour shifts, three days per week, they are then not willing to come in to work and participate in committees outside of their scheduled work shifts. In addition, several months of low census, has driven a mandatory reduction in workforce, increasing the nurse to patient ratio, and decreasing the number of hands to get the work done.

Source of the Barriers – Process For Eliminating Barriers

The introduction of EBP into healthcare brings with it many changes and improvements that aren't necessarily embraced and accepted. As nurses play a crucial role in the delivery of health care, they need to embrace new and innovative techniques to provide effective and best possible treatments for their patients (Majid et al., 2011).

By ensuring that nurses are given adequate professional development opportunities away from the bedside, nursing leaders can expect to see greater adoption and dissemination of information. In addition, nurse leaders can capitalize on nurse's tendency to consult with each other about new information, by providing social

opportunities that promote peer-to-peer information and knowledge sharing. Similarly, as evidence based practice is an information-intensive activity, library and information professionals working in hospitals can play a significant role in developing basic information literacy skills, particularly literature searching skills, among nurses and other medical practitioners (Majid et al., 2011).

The Stakeholders

The stakeholders for the capstone project are hospital administration, the physician group, the nursing staff, multi-disciplinary nursing partners, and the patients. The DNP learner approached all of these groups, and discussed the capstone project plans in detail. The discussions centered around building a therapeutic milieu on the geriatric psychiatry inpatient unit; something that was not occurring at that time. Part one of the plan was to create a structured group schedule that included at least one nurse-led group per day; however, the majority of the schedule now includes groups led by other disciplines.

The key strategic supporters of the project are the hospital administration group. They have taken a leap of faith, and have decided to invest \$1.5 million into updating and renovating the current inpatient unit space, and restructuring the entire unit program to become a specialty program that is market competitive in the southeastern United States. They are very interested to see group therapy being done on the unit on a daily basis, and are looking forward to positive results fiscally if the program is successful. Their expectations are very high, because their vision is to create a state-of-the-art brain health center, specializing in treatment resistant mood disorders and specialty therapies for depression. They want to be something special and different in the Southeast region.

The physician group is skeptical about the success of the new program. They are not a very cohesive group, and are very outdated in their thinking and their practices. There is no standard of care, and each physician does things “his/her way”, usually without engaging any of the other healthcare providers, and showing little to no respect for the nurses except to administer medications to their patients and perform basic ADLs. They have no interest in leading or co-leading any of the groups, stating that they are too busy with other non-patient duties, to commit to a daily, or even a weekly group. Unfortunately, without the support of this group, the program may very well fail; as they will need to write physicians orders stating that their patients may participate in certain groups.

The nursing group is also skeptical about the success and future viability of the new program. Most of them have not conducted groups in over five years; some longer; and they are uncomfortable with being asked to do this. They have put up barriers, stating that they are too busy as it is, and that they don’t feel like they can add one more thing to their plates. They have become desensitized to their role in the healing process for the patients, and have learned to become very task oriented where patient care is concerned.

The multi-disciplinary partner group includes social workers, pastoral services, dietary, occupational therapy, pharmacy, and physical therapy. The social workers and pastoral services have also added groups to the structured program. Pastoral services were already doing this three times per week, but this was a new initiative for the social workers. Occupational therapy, physical therapy, dietary, and pharmacy primarily do one-to-ones with patients, in the form of a consult that is requested via physician’s orders.

The final stakeholder group, the patients, has gained the most benefit from the structured program. Prior to implementation of the program, boredom and lack of activities were the most frequently cited complaints on the Press Ganey patient satisfaction questionnaires. Most of the patients that are admitted, have chronic mental health issues, and have been hospitalized multiple times throughout their lives. They remember how the inpatient hospitalization used to be, and constantly complained about the current state, which was primarily focused on medication management.

Several meetings with several different stakeholder groups were necessary, starting with hospital administration; followed by nursing staff who work on the geriatric psychiatry unit; and finally the provider group (MDs and NPs), to ensure understanding of the practice change and the potential need for doctor's orders for patients to attend the groups. Doctor's orders are necessary as the provider knows best, what level of functioning his/her patient is at, based upon baseline assessment data, and/or other treatment modalities being used during the hospitalization, i.e. ECT treatments, pharmacologic agents, etc.

Although the meetings varied slightly, dependent on the stakeholder group, the main theme of the message was to provide patient-centered care in a therapeutic environment, with the hope of increasing patient and nursing staff satisfaction. To do this, a structured schedule of groups was developed, that is multi-disciplinary in nature, and implemented by adding a minimum of one nurse-led group to the daily program. The groups varied in size, from four participants to as many as ten participants at a time, so a room large enough to comfortably accommodate ten people, was reserved in advance.

The meetings also included a brief summary of the review of the literature, as well as a timeline for implementation and review.

Stakeholder Analysis

Thompson (2013a), describes the need for a stakeholder analysis to be done any time a new project is being proposed in an organization. Figure 1 below, has been taken from the MindTools website, and illustrates how one should map out how you treat and engage each stakeholder group that you identify in your project.



Figure 1 - Power/Interest Grid for Stakeholder Prioritization

The hospital administration group falls into the “manage closely” block above, as they have a high level of interest in the success of the project, as well as a high level of power to ensure the projects success. The physician group has a low level of interest, but a high level of power in that they control whether or not orders will be written for their patients to be able to participate. They fall into the “keep satisfied” block. The nursing staff have a low level of interest and a low level of power, so they will need to be monitored with minimal effort. The multidisciplinary partner group, like the nursing group, have little power; however, their interest in the program is high, so they will fall into the “keep informed category”. Finally, the patients have a high level of interest with a low level of power, and so they will be kept informed of the progress of the group program.

Assessment Tools

Success will be measured as an increase in specific patient satisfaction scores; overall rating of nursing care and overall rating of the visit; from the 70th percentile to the 75th percentile within the first three months. Success will further be demonstrated by continued incremental increases of 5%, every three months thereafter, with a goal of reaching the 90th percentile by the end of the DNP program. Nursing engagement and satisfaction will be seen as successful if the baseline data improves by 3% during the first three months of the project, and an additional 3% every three month thereafter, with a goal of reaching the 80th percentile by the end of the DNP program.

Results lower than the projected goal, for any area, when surveyed at the three-month intervals, will result in changes made to the process, based upon feedback from the staff and the patients. If no tangible improvements have been made after nine months, as evidenced by an increase in the satisfaction scores, then the project will be re-evaluated for continued use in the clinical area.

Other Evaluative Strategies

Baseline data has been reviewed and graphed for visual impact (see Appendices C – I). A two-year review of the Press Ganey patient satisfaction results and comments has occurred. In addition, the past two years employee engagement and satisfaction scores and comments were reviewed. Both data sets show a need for improvement, as the median overall rating of nursing care in the patient satisfaction survey is in the 70th percentile, with frequent comments by patients, of being bored while hospitalized. Similarly, the nurse engagement and nurse satisfaction scores are in the 50th percentile,

with frequent comments about not feeling that their work is meaningful, and not feeling a strong connection to the organization.

During the course of the two-year DNP program, and due to the amount of time allowed for project submission and IRB approval, approximately 12 months was spent evaluating the patient satisfaction data on a monthly basis, and the nurse engagement and satisfaction data on a yearly basis. Because a year is too long to wait for re-evaluation, the DNP leader has also incorporated a short survey, which has been hand-distributed to the nursing staff at three-month intervals (see Appendix I).

For the purposes of the capstone project, the facilitator of the group was a master's prepared registered nurse with 21 years of experience working in mental health settings. In addition, the facilitator holds certification from the American Nurses Credentialing Center (ANCC) as a psychiatric/mental health nurse, with nine years of experience working specifically with the geriatric mental health population. The aim of the nurse-led group was to improve emotional functioning of the geriatric inpatient as a complementary treatment to the prescribed medication regime. Long-term affects of group are new friendships and increased socialization.

Group therapy has been advocated for geriatric patients' both for its cost-effectiveness and to counteract the isolation and loneliness presumed to be common in old age. The consensus statement of the Royal College of Psychiatrists and the Royal College of General Practitioners on recognition and management of depression in general practice recommends that psychological treatments have a key role in the management of depressed patients (Procter & Alwart, 1995). Procter and Alwart (1995) also write that early recognition and treatment of depression seems to improve outcomes and prevents

the illness from becoming severe and chronic. Detecting and treating illness early, including therapeutic groups, may well save resources in the long term.

Measurement

Once the therapeutic program (including the nurse-led group) was defined (see Figure 2), staff engagement was the first area in which theories of change were developed. The evaluation is aimed to provide empirical evidence of the group's successes and failures, through systematic observations about levels of engagement and participation in the group development and implementation. The early aspect of the evaluation was to concentrate on understanding why nurses engage or disengage in participating in the therapeutic milieu through groups. Some assumptions for not engaging included lack of time, under-staffed conditions, and feelings of inadequacy with respect to leading a group. In order for the group to be successful, the DNP leader had to be able to initially supervise, and then hand-off responsibility of running the daily group to the staff nurses.

Patient satisfaction with the overall hospitalization is also measured, through monthly review of the Press Ganey patient satisfaction data that is sent to the hospital. Each inpatient unit is individually represented, with several ratings questions that roll up into the overall rating of care.

Finally, a measure of improvement in depressive symptoms can be obtained by administering the geriatric depression scale to each patient at the time of admission and one day prior to discharge from the hospital, to track whether or not the patient has experienced an improvement in mood. A major drawback to this method of measurement is that pharmacological therapy or ECT or both, are often administered to the patient, in

addition to group and milieu therapy, as part of the hospitalization; therefore, it has been difficult to correlate an improvement in depressive symptoms solely with the offered nurse-led group.

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7:00 am	RN Bedside Shift Report / Wake-up Call	RN Bedside Shift Report / Wake-up Call	RN Bedside Shift Report / Wake-up Call	RN Bedside Shift Report / Wake-up Call	RN Bedside Shift Report / Wake-up Call	RN Bedside Shift Report / Wake-up Call	RN Bedside Shift Report / Wake-up Call
8:00-9:30 am	Breakfast / A.M. Hygiene	Breakfast / A.M. Hygiene	Breakfast / A.M. Hygiene	Breakfast / A.M. Hygiene	Breakfast / A.M. Hygiene	Breakfast / A.M. Hygiene	Breakfast / A.M. Hygiene
9:30-10:00 am	Community Meeting & Goal Setting	Community Meeting & Goal Setting	Community Meeting & Goal Setting	Community Meeting & Goal Setting	Community Meeting & Goal Setting	Community Meeting & Goal Setting	Community Meeting & Goal Setting
10:00-10:45	Leisure Skills	Process Group	Process Group	Process Group	Process Group	Process Group	Life Skills
11:00-Noon	Social Work Group	Lifestyle Management	Lifestyle Management	Pet Therapy	Lifestyle Management	Lifestyle Management	Social work group
12 - 1:00 pm	Lunch Med Pass	Lunch Med Pass	Lunch Med Pass	Lunch Med Pass	Lunch Med Pass	Lunch Med Pass	Lunch Med Pass
1 - 1:50 pm	AA Meeting	Leisure Skills	Relapse Prevention	ADL Group	Spirituality	Leisure Skills	
2:10 - 3:00 pm	Sunday Worship	Reminiscence / Review Therapy	Transitions Group	Leisure Skills	Relapse Prevention	Exercise Group	
3:00 - 3:30 pm		Lifestyle Management	Lifestyle Management	Lifestyle Management	"In Our Own Voice"	Lifestyle Management	
4:00 - 8:00 pm	Visiting Hours	Visiting Hours	Visiting Hours	Visiting Hours	Visiting Hours	Visiting Hours	Visiting Hours
5:30 - 6:30 pm	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner
7:00 - 7:30 pm	Bedside Shift Report	Bedside Shift Report	Bedside Shift Report	Bedside Shift Report	Bedside Shift Report	Bedside Shift Report	Bedside Shift Report
8:00 - 8:45 pm	Wrap Up	Wrap Up	Wrap Up	Wrap Up	Wrap Up	Wrap Up	Wrap Up
9:00 - 10:00	Personal Time	Personal Time	Personal Time	Personal Time	Personal Time	Personal Time	Personal Time
10:00 pm	Lights Out	Lights Out	Lights out	Lights Out	Lights Out	Lights Out	Lights Out

Figure 2 - Geriatric Psychiatry – Group Therapy and Milieu Schedule

Formative Evaluation

Formative evaluation is part of the theory to action continuum of research (Fish, 2008). As opposed to action research, which attempts to solve a specific problem in a program, organization, or community, the aim of formative evaluations is to shape the object that is being studied. The nurse-led group has been monitored on a daily basis, as to its effectiveness in improving patient satisfaction with the inpatient admission, and in improving nurse engagement and nurse job satisfaction. No attempt is made in a formative evaluation to generalize findings beyond the setting in which the evaluation takes place. Formative evaluation is a method of judging the worth of a program while

the program activities are forming or happening. Formative evaluation focuses on the process, which at its most basic is an assessment of efforts prior to their completion for the purpose of improving the efforts (Riley, Byng, White, & Smith, 2008). Formative evaluation is more commonly used, since it is always possible to improve services and it is vital to have accurate feedback if one is to do so efficiently.

Summative Evaluation

Evaluation has two main functions. One is formative, and focused on providing feedback on the relationship between a service and its objectives. The second is summative, and is concerned with the extent to which certain standards are achieved.

Summative evaluations often start at the program's inception and continue until the program is completed. Their focus is on identifying changes that have occurred as a result of the program. Although the less prominent of the two, summative evaluation can be used if/when managers want to use data to make judgments about the quality of a service.

Results from the Press Ganey patient satisfaction survey were used to measure changes in patients overall rating of nursing care and overall rating of the inpatient hospitalization. Historical data has been reviewed, and a goal of reaching the 90th percentile for both variables has been set. In addition, the Press Ganey staff engagement survey was used to measure improvement in nurse engagement and satisfaction scores, over the course of an 18-month period. Historical data has been reviewed, and a goal of reaching the 60th percentile for both variables has been set.

CHAPTER 4. ANALYSIS OF IMPACT

Outcomes of Current Practices

Depression is secondary only to dementia in terms of prevalence, with estimates varying from 6 – 20% for major depression, and up to 50% when milder depressive disorders are taken into account (Konnert, Dobson, & Stelmach, 2009). Current studies report depression prevalence estimates of 32% in residential care.

The treatment of depression is largely pharmacological. Data from Ohio's Minimum Data Set for 76,735 residents in 921 nursing homes found that, among residents diagnosed with depression, 23% received no treatment, 74% received antidepressants, 0.5% received psychotherapy and 2% received both (Konnert et al., 2009). However, pharmacological treatments have well-known side effects and drug-disease interactions that are particularly problematic in the geriatric population. Numerous meta-analyses have demonstrated the effectiveness of psychotherapy for depression in the elderly, with moderate to large effect size. Duffy and Karlin (2004) provide an overview of the types of interventions that have shown promise in treating depression in nursing home residents. In the United States, the population aged 65 and older is expected to double by 2020 and triple by 2040, which are increasingly important facts to consider, as Americans living longer also correlates to increases in debilitating co-morbid conditions.

The imperative to detect and treat depression cannot be overstated. Increased mortality, anxiety, pain, poorer health status, and decreased functional and cognitive abilities have all been linked to depression. Moreover, the impact of sub-syndromal depression should not be minimized, as a growing body of research has clearly indicated

that it is a risk factor for the onset of major depression.

Antidepressants represent an approximately \$5 billion per year market in the United States, and several of these drugs can be found among the top ten prescribed medications (Glaser, 2000). Consequently, intensive marketing campaigns tout the advantages of one drug over another. Yet when treatment outcomes are examined, success is driven mostly by how these drugs are used, not by the specific drug selected. That is not to say that antidepressants are equivalent, but all FDA-approved agents are effective in treating depression. When administered in a research clinic, antidepressants yield a response rate of 70 – 80%. Every drug will not necessarily work in every patient, though.

Most patients' symptoms improve with drug therapy, and as such, prescription of antidepressant medication remains a top treatment modality for this disorder. It is important to note that antidepressant use can only have a strong therapeutic response if the depression is related to chemical imbalances in the brain. Depressive symptoms that are brought on by situational life stressors are more apt to improve with some form of psychotherapy. Because many of our elderly experience depression due to one, or both of these factors, and they tend to be a marginalized group in society, psychotherapy gives them an outlet to express and evaluate their feelings of loss, sadness, anxiousness, and worthlessness, while socializing and connecting with others who are having similar experiences, developing new bonds and a new support system.

For transient or mild depression, psychotherapy alone may be sufficient, whereas a combination of psychotherapy and antidepressant medication may be needed to treat moderate or severe depression (Glaser, 2000). With major depression, the initiation of

antidepressant medications may be necessary to even get the patient to the point where they can participate in psychotherapy. As the vegetative symptoms of depression improve with pharmacological assistance, the patients clearer thinking and increase in energy increase their ability to have continued improvements with psychotherapy or other adjunctive treatment modalities.

Synthesis of Existing Literature

Cognitive behavioral therapy (CBT) is an evidence-based form of therapy used to treat a variety of mental health problems (Wong & Laidlaw, 2012). CBT can be done with an individual, or as part of group psychotherapy, and is proven to be very useful for older adults, especially for late life depression. Group therapy is particularly appropriate as an intervention with older people, as it is skills-enhancing, present-oriented, problem-focused, straightforward to use, and effective. The primary aim of group therapy is symptom reduction, and it achieves this aim by a combination of cognitive and behaviorally oriented interventions such as restructuring maladaptive thoughts and the use of behavioral experiments to promote new learning of effective coping strategies.

Because CBT is a brief form of psychotherapy, there is an expectation that treatment ends once symptom reduction has been achieved, but in many cases with older people this optimal outcome may be more difficult to achieve because depression may be more complex either due to chronicity or co-morbidity. Relapse prevention is also an important feature of CBT treatment. Thus CBT may be a very good choice of therapy for older people who may espouse high levels of hopelessness about the future.

As many older people will have successfully met and dealt with adversity throughout their lives, in CBT with older people, patients are not necessarily “taught”

new skills but instead are provided with a means of rediscovering old skills and competencies that have been forgotten by the patient when depressed, as their cognitive processing of information and access to autobiographical memories of competence are blocked by mood congruent biased processing (Wong & Laidlaw, 2012). Because group therapy is skills enhancing, patients are taught self-monitoring skills to identify thoughts that are associated with negative mood and maladaptive behavioral response.

Working with older people can be complex, thus the problem-focused, symptom reducing orientation of group therapy may be especially helpful when working with patients who present with a complex interaction of personality, mood, and physical illness deterioration.

Based on evidence presented in multiple randomized controlled trials (RCTs), recommendations for a combination of pharmacotherapy with SSRIs and psychotherapy have been made for modern treatment of depression in adults. It must be noted that the majority of RCTs are not conducted on the older mental health population, and results from those studies with younger adults, are inferred to have a similar positive clinical effect with this population as well. Caution should be exercised in making these assumptions, as treatment response in the geriatric population can be affected by chronicity of disease process, as well as a greater diversity in etiological factors that may be driving the depressive symptoms. As an example, slower response rates to pharmacotherapy have been reported in older people, suggesting that treatment outcomes might vary depending on age (Gould et al., 2012).

There are several published results of meta-analyses for use of CBT in depression in geriatrics. Although reported results show promise, it is important to note that the

majority of the studies failed to differentiate between use of active (group therapy) and non-active (waiting list) controls. The result is that there may have been an overestimation of pooled effect sizes, since those studies that did distinguish between the two, report smaller effect sizes when making the same comparisons. In addition, when calculating effect sizes, none of the studies accounted for pre-intervention scores. Finally, none of the previous meta-analyses included studies published after 2006, and several important large-scale RCTs have been published since then (Gould et al., 2012).

CBT for depression in older people is more effective than being on a waiting list or continuing with medication therapy alone, but efficacy has not been demonstrated over active controls or other treatment (Gould et al., 2012). For patients with major depression, medication alone is insufficient to correct patients' dysfunctional attitude or cognitive errors. Feng et al. (2012), concluded that the implications of their study, showed that cognitive behavioral therapy could be a good non-medication therapy to reduce depression, soothe emotions, and correct individuals cognitive errors in clinical settings. The results of this study suggest that patients with depression should be provided with cognitive behavioral therapy to help them achieve improvement in depression.

Care Delivery Approach

Most treatment guidelines advocate psychological interventions as adjunctive to pharmacotherapy. Rojas-Fernandez, Miller, and Sadowski (2010), discussed four major psychotherapeutic treatment approaches: psychodynamic therapy, intrapersonal therapy, supportive counseling, and cognitive-behavioral therapy.

The most common of these is CBT. This therapy focuses on depression as the result of an inability to cope with life stressors, poor affect regulation skills, social

isolation, and difficulty solving problems. Trained therapists or inpatient psychiatric nurses, usually deliver this treatment as part of group therapy, in mental health settings. Psychotherapy should be considered if antidepressant treatment is not preferred or is ineffective. Older patients may prefer this therapy because it does not require them to take another medication.

The primary care environment is the perfect inroad for geriatric patients who are suffering from depression. As stated previously, primary care providers in the United States, function as the gatekeepers to care, and as such, are in a prime position to improve the treatment of depression and other mental illnesses for this population. However, under-treatment, poor adherence to depression treatments, and treatment dropout remain high among older adults treated for depression in primary care (Alexopolous, 2005).

The patient-centered model of care has its focus on the patient as a partner in their care, providing that all treatment decisions will be made with the patient and his/her family, who are given a range of treatment options as part of the clinical discussion. A barrier, or learning opportunity for the primary care provider who relies on prescribing antidepressants for treatment, is educating the patient about the chemical changes in the brain that may be driving the patients' mood or behaviors. This may also be a reflection of their level of dissatisfaction with referrals to specialists in mental health, or it may be highlighting their own knowledge deficit with respect to adjunctive treatments to medication. Geriatric patients are more apt to attribute their depressive symptoms to normal aging and loneliness that has resulted from life losses such as friends, a spouse, and also their own physical health. To increase compliance and adherence, healthcare providers need only listen to what the patient has to say, allowing them to discuss or

address their explanations of depression.

Potential depression interventions include short-term psychotherapy, activity engagement, social interaction, and physical exercise programs. Activities should be intellectually stimulating and educational, including education about depression for older adults, their families, and the community.

Intervention Strategies

Cognitive and behavioral therapies have received a great deal of attention, both in the theoretical and empirical literature concerning the treatment of depression in the elderly. Their appeal for this population stems in part from the fact that these approaches are structured and time-limited, which is advantageous in an inpatient setting where patients spend a relatively short period of time. Moreover, these approaches are problem-oriented and designed to teach specific skills, which is appealing to many older adults. Behavioral approaches are especially interesting because they can be used with a broad clientele and caregivers can be trained to apply treatment techniques.

Other approaches, such as psychodynamic therapy, family interventions, problem-solving therapy, and interpersonal psychotherapy are also potentially useful. In any case, selecting a treatment model should be guided not so much by the general characteristics of a particular approach, but by its relevance to the patient. Careful assessment is essential to determine both the main processes underlying the depressive episode and the potential of a given individual to benefit from a particular treatment.

Depression in people with physical problems (co-morbidities) may be resistant to psychotherapy alone. Treatment of depression in the medically ill may require adjunctive mental health services to increase treatment effects by helping patients to solve difficult

life situations that they may not be able to do on their own. Treatment of depression in the elderly may require a multi-component treatment plan including psychotherapy, nursing interventions, social work interventions, and pharmacotherapy.

For late-life depression initiated by a stressor, psychotherapy alone or psychotherapy combined with an antidepressant is recommended. Minor depression in late life is more likely to respond to non-specific supportive interventions than other forms of depression. Watchful waiting for at least two weeks is appropriate in minor depression. However, if symptoms persist for longer than two to three months, a combination of SSRI plus psychotherapy is the treatment of choice, though drug treatment alone or psychotherapy alone are reasonable alternatives.

With respect to cognitive techniques in the elderly, anecdotal reports suggest that older patients might benefit from adaptations to traditional CBT. The capstone project for this DNP program focuses on the addition of one nurse-led group, goals setting and community meeting, to the structured therapeutic milieu.

With selection of realistic, concrete goals, there is more emphasis with the elderly on activities, behaviors and early achievement of success and less on cognitive restructuring. Pleasant activities, self-reward, small manageable goals, task-setting in early sessions, role plays and rehearsals are aspects of this approach. The greater the degree of cognitive impairment, the more concrete the therapy. Reinforcement strategies such as provision of printed handouts, slower pace, frequent reworking of issues and more sessions may be helpful.

Group CBT, appears clinically to be more important with the elderly, perhaps because of its potential to lessen isolation and encourage openness of discussion.

Common themes of ageing such as loss, low self-esteem and anxiety about the future occur more frequently in the elderly and may require particular attention.

Evidence-Based Practice in Mental Healthcare

Statistically speaking, it can take 15 – 20 years for scientifically based EBP to make it to the patient in both inpatient and psychiatric environments, but more importantly, into the outpatient primary care setting. This can be detrimental to the care of a population with double vulnerability; the elderly patient with mental health needs. It is a well-known fact that The Institute of Medicine (2014) has reported that it can take up to 20 years for new knowledge, generated by research, to be translated to the bedside as an EBP change that benefits patients and their choices for healthcare.

Prominent reports from the surgeon general, the President's New Freedom Commission on Mental Health and the Institute of Medicine all underscore the importance of narrowing the gap between research and implementation of evidence-based practices (Nault, 2013). It should also be noted that significant funding is allocated to continuing research annually, resulting in dissemination of information on new practices, therapies, and other treatment modalities that are improving the overall evidence-based approach to mental health care.

According to Mental Health America (2014), the 2010 Affordable Care Act authorized the development of an independent, non-profit organization to drive the development, synthesis and use of research. The Patient Centered Outcomes Research Institute (PCORI) is governed by a twenty-one member Board of Governors, and is tasked with helping patients', clinicians, purchasers and policy makers make better-informed health care decisions. PCORI will commission research that is responsive to

the values and interests of patients and will provide patients and their caregivers with reliable, evidence-based information for the health care choices they face (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009).

Evidence-Based Practice In Mental Health Setting – Implementation

As stated by the National Institutes of Health (2014), implementation is defined as the use of strategies to introduce or change evidence based health interventions within specific settings and, support the need for implementation and translational research. Although the U.S. state and local governments, as well as the healthcare sector are interested in what affects the implementation of EBP, most of the supporting literature is coming from outside of the U.S.

Implementation of EBP in mental health settings takes concerted and focused efforts from consumers, funding sources, and policymakers. This is necessary to ensure its success. This includes valuing the evidence tested in research, for its intervention efficacy and effectiveness. It considers the context and the clinical setting where practices are to be implemented. And finally, this method ultimately helps to ensure that the interface between evidence and policy is strengthened. There have been several analyses made to create a model of implementation barriers and facilitators that can serve as a heuristic for policymakers and researchers and can be tested in real-world settings; and recent work examining factors affecting EBP implementation at the state level is also considered (NIH, 2014).

The meaning of evidence in the mental health setting must be made clear. Considering the perspectives of multiple stakeholders in mental health; the users and consumers of services; can be different depending on where they fit in the mental health

system, and therefore, the types of evidence that each values, will differ as well. The focus of researchers and intervention developers is typically focused on the treatment effects, with little regard to system and organizational constraints and policies.

Conversely, the mental health system as an organization must focus on the financial impact and funding source availability, to ensure the current and continued viability of the innovation.

According to NIH (2014), scholars have identified multiple types of evidence used in making policy decisions including research, knowledge, ideas, political factors, and economic factors, and have determined, for instance, that researchers and policymakers may have very different agendas and decision-making processes. Engagement of stakeholders at all levels is required to ensure that all perspectives are taken into account with respect to potential barriers and facilitators of EBPs.

The literature documents that there are several factors that affect the implementation of EBP as well as other forms of organizational change. Adoption of change can be linked to the potential for the organization to benefit. High cost and turmoil can prove fatal to the change process, whereas, lower cost and lower risk and deviation from the organizations existing norms and processes, could increase early adoption and implementation. It is also important to note that leadership that is supportive of change, in terms of assuring ongoing training for staff and incentives, are much more likely to solidify the change process in the organization. Mental health agencies, like all other specialty areas, can increase favorable clinician attitudes towards adopting EBP, if the leadership is positive and supportive of the change.

There are marked differences in the ways that researchers and policymakers

develop and use information for decision-making; and although models for linking research to action are being developed, they still require empirical examination to determine their viability (Ciha, 2013). In order to successfully transition research to practice, or evidence to the bedside, it is imperative that all stakeholders' views and concerns are assessed and addressed. The science must improve the clinical outcomes for the patient, while maintaining practicality in the mental health clinical environment.

Evidence-Based Healthcare – Position Statement 12 – Mental Health Policy

Approved on September 17, 2011 by the Mental Health America Board of Directors, this policy focuses on evidence based strategies, developed and tested through research, to improve knowledge and treatment of mental health and substance use disorders.

Mental Health America has it's interests in promoting evidence based practice, that is supported by research, to help people with mental illness and/or substance issues, find the road to recovery. MHA is able to do a robust comparison of mental health interventions and their effectiveness because they look at all aspects of research related to mental health, from development to implementation.

As the mentally ill are classified as a vulnerable population, it is imperative that patients and clinicians have access to reliable evidence so that they can make informed decisions about treatment options. In addition, this evidence must be made available to policymakers and insurance administrators, to ensure that they have full understanding and appreciation that innovation in mental health care is a balance between scientific knowledge, clinical expertise and experience, and patient and family experiences and values. Most evidence based treatments currently in mental health care practice, is

supported and reimbursed by insurance companies, but are reflective of approaches from ten to twenty years ago. While cost will always be a consideration in reimbursement decisions, it should be equally important to consider patient requirements for rapid access to alternative therapies, when standard treatment options are no longer tolerated, or, are inefficient or ineffective in relieving negative symptoms of mental illness.

The National Registry of Evidence-Based Programs and Practices (NREPP) (SAMSHA, 2014) has helped to create a centralized clearinghouse for evidenced-based practices with transparent criteria for evaluating and approving such practices. In mental health care, it is essential that this type of clearinghouse remain flexible in its use of criteria when determining what constitutes acceptable evidence. This would include observational studies, quasi-experimental studies, as well as randomized clinical trials, with recovery for patients with mental illness and patient-centered care, driving the evaluation criteria.

Randomized controlled trials have their place in mental health care in terms of getting to firm scientific conclusions about effectiveness and safety, but an expanded view must be employed so as to address the many problems experienced when attempting to treat mental health conditions. Open-label trials, observational, and quasi-experimental methods have an important place in mental health research, since so much of mental health care is dependent on psychosocial impacts on symptom improvement.

Of greatest importance, investments must be made in longitudinal research that demonstrates the effectiveness of treatments in real-world settings that account for the breadth of experience and the diversity of the larger population. This is the ultimate level of evidentiary support, referred to in the federal Affordable Care Act as Patient Centered

Outcomes Research (Goldman, 2009). Research design and evaluation truly needs to follow a patient-centered approach, to ensure that the evidence is representative of the health outcomes, goals, and values that they are seeking. Finally, when published, the research findings must be written in common, everyday, simplified terms that patients can understand and use to make educated choices and decisions about healthcare options.

Summary

New technologies and health interventions are creating a dynamic clinical environment where the ethical responses they generate, may need to be revisited periodically. The acquisition of knowledge and application of critical thinking skills are required to tackle the clinical and ethical dimensions of new approaches and technologies.

There is a growing emphasis on conducting research that represents the voices of mental health patients and their families, in relation to their experience of, and desires for healthcare. However, this type of research may sometimes be complicated, as mental health patients are frequently identified as a vulnerable research participant population.

Several international policy documents have advocated greater inclusion of mental health service users in the planning and development of services. Service user involvement is crucial, if mental health professionals are to understand the experiences of people with mental health problems. The knowledge gained from such research can be used to ensure that services more appropriately meet the needs of those they serve.

People with mental health problems are frequently considered to be a vulnerable group. In consequence, researchers could be deterred from conducting service user

research due to the challenges they may face in obtaining ethical approval, and because of concerns regarding the potential for ethical issues to arise. These issues often stem from misconceptions about the nature of mental illness and negative assumptions about individual's ability to understand the research process and provide informed consent. Furthermore, issues such as gaining ethical approval, research access from health service providers, and recruitment of potential participants can be complex to navigate.

In order to maximize the development of policies and services designed to meet the real needs of service users, mental health service users' voices need to be heard. One way in which to access the perspectives of such persons is through appropriate and well – designed research.

In conducting such research, the interests of the research participant are paramount. To ensure this is the case, extensive consideration must be given to the ethical conduct of the research. While the issues addressed are relevant to all research participants, they take on particular significance when applied to research participants perceived as particularly vulnerable. Including mental health service users in qualitative interview based research is difficult but imperative to improving our understanding of the experience of mental illness.

CHAPTER 5. IMPLICATIONS AND CONCLUSIONS

Implications for Practice

There is an increasing need for specialized services as the graying of the United States continues. Although the need for geriatric psychiatric nursing care crosses all care settings, the growth of dedicated geriatric psychiatric inpatient units over the last decade emphasizes the important role this type of care may play in providing quality health services to older people (Smith, Specht, & Buckwalter, 2005). There is a critical need for mental health services geared towards the geriatric population, despite the limited use of these services that has been reported. Disproportionately low use of mental health services by the geriatric population can be attributed to individual, system, and policy challenges. According to Karlin and Duffy (2004), these barriers include stigma toward geriatric mental health, held by professionals and the public, physicians' under-detection of psychopathology in older adults, the medical community's overreliance on pharmacotherapy with older patients, physicians' low referral rates of older patients for psychotherapy and limited confidence in the efficacy of gero-psychological treatments, a shortage of gero-psychology professionals including nurses, older adults limited knowledge of mental health and mental health services, and restrictive legislative policies, namely limited Medicare mental health reimbursement.

Recognizing The Need

America is graying. The U.S. Census Bureau (2012) reports that according to the projections, the population aged 65 and older, is expected to more than double between 2012 and 2060, from 43.1 million to 92 million. The older population would represent just over one in five U.S. residents by the end of the period, up from one in seven today.

The increase in the number of the “oldest old” would be even more dramatic. Those 85 and older are projected to more than triple from 5.9 million to 18.2 million, reaching 4.3% of the total population. According to the Substance Abuse and Mental Health Services Administration’s (SAMHSA, 2012) community conversations about mental health information brief, approximately 19.6% of Americans ages 18 and older; about one in five adults; will experience a mental health problem in this year alone.

According to the Centers for Disease Control (CDC, 2008), it is estimated that 20% of people aged 55 years or older, experience some type of mental health concern. The most common conditions include anxiety, severe cognitive impairment, and mood disorders (such as depression or bipolar disorder). Mental health issues are often implicated as a factor in cases of suicide.

Depression, a type of mood disorder, is the most prevalent mental health problem among older adults. It is associated with distress and suffering. It also can lead to impairments in physical, mental, and social functioning. The presence of depressive disorders often adversely affects the course, and complicates the treatment, of other chronic diseases. Older adults with depression visit the doctor and emergency room more often, use more medication, incur higher outpatient charges, and stay longer in the hospital.

As people age, so do the percentages of Americans with either newly diagnosed, or chronic, mental illness disorders. Mood disorders, such as major depression and bipolar disorder, that may be chronic over one’s lifetime, can cause acute impairment and disability in later life. In addition, most aging psychiatric patients now present to the inpatient setting with multiple medical co-morbidities, which complicates their care,

impacting the mental health delivery system and the overall healthcare system as a whole.

According to Nadler-Moodie and Gold (2005), true bio-psycho-social care for older adults requires more than routine and basic psychiatric care; and mental and physical health care should be integrated with an implementation of evidence-based practices for the older adult population. The success of any geriatric mental health unit is dependent on recognition of the need for on-site consultative and internal medicine services for follow-up, and stabilization of medical co-morbidities, while addressing the acute psychiatric needs that warranted hospitalization. This can prove to be a difficult balancing act, as insurance companies are not willing to pay for an inpatient psychiatric hospitalization that ends up having more of a medical focus than mental health.

Although dedicated inpatient geriatric psychiatric units have been available in various hospitals and health care facilities across the U.S. for many years, organizations and systems to support practitioners in this specialized field have only recently emerged (Smith et al., 2005). The Hartford Center for Geriatric Nursing Excellence is at the forefront of collaborating with nurse providers of geriatric care, targeting best practices to improve the overall quality of care to geriatric patients and their families.

Therapies On The Gero-Psychiatric Unit

Niemeyer, Musch, and Pietrowsky (2013), performed a meta-analysis on what they term is publication bias, with respect to articles published on the efficacy of psychotherapeutic interventions for depression. They provided a reanalysis of 85 published meta-analyses, and their results found that despite a minor tendency toward a selective publication of positive results, that the efficacy of all reviewed interventions remains substantial even after correction with a trim and fill procedure. These results

demonstrate that publication bias alone cannot explain their considerable efficacy, and it could be concluded that despite some evidence for publication bias, cognitive behavioral therapy and other psychotherapeutic interventions can still be considered efficacious and recommended for the treatment of depression.

In their survey, Smith et al. (2005) identified that individual respondents selected from 2 – 22 therapies from a list of 24 options. The top three selections included reminiscence groups, patient and family education, and groups related to leisure activities, such as exercise, music, and recreational therapy. Nurse-led groups were offered in only 55% of the facilities that responded.

Resources Needed For A Successful Gero-Psychiatric Unit

When surveyed about the resources that would be necessary for a geriatric psychiatry unit, the overwhelming majority of comments related to staff and teamwork, including the staff and team's desire to work with geriatric patients, the fact that staff truly enjoy the elderly, and dedicated, caring staff (Smith et al., 2005). Respondents also commented on the importance of certain physical qualities of the unit, such as private rooms, and the addition of nurse-led groups as an improvement in patient care services.

Group psychotherapy has been used with older adult patients since the 1950s. Because older individuals often experience isolation and loneliness, group-based treatments, that are nurse-led, may provide a much-needed sense of social interaction. Although no published meta-analyses have examined the effectiveness of group therapy for older individuals across presenting problems and treatment approaches, meta-analytic reviews have demonstrated that group psychotherapy is an effective modality for treating a variety of populations (Stevens, 2013). Despite the limitations of the research

literature, the existing evidence suggests that group psychotherapy, shows promise for older adults with depression. Given the evidence of its effectiveness, this low-cost, relatively easy to deliver intervention, should be highlighted to health care and aging service providers, and attention should be given to ensuring that nurses who work with this population, are trained to lead this form of therapy.

Organizational Culture Change

The organization is ready for the practice change, and is primed at this point due to massive restructuring of the Psychiatry department, all occurring over the course of the last twelve months. In order to be market competitive, now and for the future, this academic healthcare system invested over a million dollars in a complete departmental overhaul, including construction/renovations of the current facility and turning over many of the staff, with the express intent of specializing in treatment resistant mood disorders. The entire department is still in transition; however, re-focusing the staff on the patients and the quality metrics is changing the overall tone of the atmosphere.

Changes In Nurses Belief Systems Related To Practice

Evidence-based nursing care is informed by research findings, clinical expertise, and patients' values, and its use can improve patients' outcomes. Use of research evidence in clinical practice is an expected standard of practice for nurses and health care organizations, but numerous barriers exist that create a gap between new knowledge and implementation of that knowledge to improve patient care. To help close that gap, DNP learners can be at the forefront of developing resources for clinicians, including practice alerts and a hierarchal rating system for levels of evidence. Using the levels of evidence, nurses can determine the strength of research studies, assess the findings, and evaluate

the evidence for potential implementation into best practice. Evidence-based nursing care is a lifelong approach to clinical decision-making and excellence in practice.

A recent Cochrane review concluded that a tailored implementation intervention is more likely to improve professional practice than no intervention or dissemination of guidelines (Bernhardsson, Larsson, Eggertsen, Olsen, Johansson, Nilsen, & Oberg, 2014). Guidelines, that are evidence based, must be accompanied by implementation that is also evidence based. Leadership that supports change through staff education, ongoing training, and staff incentives is a way to target potential barriers to adoption of the new evidence based practice.

Common Clinical Challenges

In recent years, the delivery of mental health care in the United States has shifted from specialty mental health settings to general medical settings, such that most Americans currently receive mental health care in general medical settings (Arean, 2013). Of Americans with a mental disorder, less than half receive any services, but more care is received in general medical than mental health specialty settings. This trend is particularly striking for adults aged 65 and older, who are much less likely to receive specialty care, including psychotherapy, than younger age groups (Arean & Gum, 2013). There are several reasons for this trend, including co-morbidity of physical and mental health conditions, greater familiarity and preference for the medical system than mental health specialty settings, availability of newer-generation psychotropic medications being prescribed at increasingly higher rates by non-psychiatrist physicians, and the multitude of barriers in accessing specialty mental health services that are not overcome by referrals alone (Arean & Gum, 2013).

As geriatric psychiatric care evolves as a specialty, so have the needs of the patient. Nursing roles, functions, and interventions with this population have had to adapt to effectively and competently manage these increasingly complex patients; many of who present with multiple co-morbid medical diagnoses. This coupled with a push for decreased lengths of stay, create challenges for those caring for the geriatric psychiatric inpatient.

In the patient-centered care model, it is important that the nurse assesses and understands the rationale for family involvement as it relates to successful treatment of the geriatric psychiatric patient. Treatment objectives are two-fold; overall improvement of quality of life and reduction of negative symptoms related to the mental illness. This requires a belief that elderly individuals can benefit from psychiatric treatment such as psychotherapy, medication, and other interventions enjoyed by younger adults, when these interventions are modified for age and health status (Punttil, 2005). In order to be successful in their role in geriatric psychiatry, nurses must be multi-skilled in psychiatric, medical surgical, and community health nursing.

In most industrialized countries, gaps exist between knowledge of effective psychosocial practices and the application of those practices in routine mental health services. Such gaps are difficult to close, and reports suggest that translating knowledge into practice can take years and even decades. As such, mental health providers are increasingly seeking to understand the strategies and factors that contribute to implementation success or failure in an effort to accelerate the change process.

Modern mental health systems are currently striving to reduce gaps that exist between what is known to be effective and the services that are delivered in routine care.

This task involves developing a strong understanding of the implementation process as well as the roles that actors at different levels must play to effectively bring about practice changes. Future efforts to implement psychosocial EBP's should solicit the engagement of all key stakeholders and adopt a systems perspective to reduce inequities in care and make accessible the broadest range of evidence based services possible.

Acute inpatient units vary greatly, but a prototypic contemporary unit has the following characteristics: It has approximately 15 – 25 patients, whose hospital stay averages 14 days. The spectrum of psychopathology, for the purposes of the capstone project, is limited to geriatric patients (aged 65 and older) with diagnoses and symptoms of the various mood disorders (major depression, bipolar disorder, psychosis, etc). The unit is locked. The staff encompasses several professional disciplines (and often students from some or all of these disciplines): nursing, psychiatry, social work, occupational therapy, clinical psychology, and pharmacy. These mental health personnel offer a variety of treatments: pharmacological, individual, group and family psychotherapies, milieu therapy, occupational and activity therapy, and ECT. The pace of the unit is often frenetic; the turnover (of both patients and staff) is rapid; the staff tension and dissension is high; the psychotherapy is fragmented and almost non-existent.

Psychotherapists who lead outpatient therapy groups function autonomously: their skill and their decisions, determine the course, the procedures, and the outcome of the group. Life is far different for the leader of the inpatient therapy group. The psychiatric unit offers a variety of therapies, which often overlap and compete with one another for patients, scheduling time, staffing, funding, and training and supervision resources. Consequently, it is not the group therapist, but the administrative staff who

make such crucial decisions about the inpatient group, as the frequency and duration of meetings, size, composition, co-therapy assignments, supervision, optional or mandatory attendance policy, and so on. The destiny of the inpatient group is heavily shaped by contextual and administrative factors.

Greater attention to mental health problems among older adults in primary care is critically needed, especially given the role that mental health problems have on physical health, service use, and longevity. Before an older adult's mental health issues can be addressed by a healthcare professional, someone must recognize that there is an issue to be addressed. Several studies have documented under-detection of depression by primary care providers, and therefore, the patient receives no treatment. Even among those in whom symptoms are detected, under-treatment or inappropriate treatment is frequently, and referral to psychotherapy is rare. Enhanced detection and treatment of depression in geriatric primary care patients, including greater awareness of and referral to specialty mental health resources, can make substantial inroads to reducing enduring and substantial unmet mental health needs in late life and provide for more efficient and effective medical care and clinical outcomes.

Many factors need to be considered when implementing group programs. The needs of service users need to be considered with evolving group programs based on need offered. Nurse facilitators need to be equipped with the knowledge and skills necessary to facilitate groups, understanding the impact they can have on group cohesion and understanding the difficulties that may arise. A balance in the type of groups offered is needed, and while discussion groups are of the utmost importance, there is also a need for activity-based groups.

Inpatient Group Therapy

It is a major clinical fact of life for the inpatient group therapist that, unlike the outpatient therapy group, the inpatient group is not free standing, but is always part of a larger therapeutic system.

The contemporary acute psychiatric unit offers, in addition to group therapy, a number of other therapies: psychotropic medication, individual therapy, milieu therapy, activity therapy, occupational therapy, family therapy, and ECT. These therapies are interdependent: decisions made about one therapy may influence any or all of the other therapies.

The evidence supporting the efficacy of group therapy, and the prevailing sentiment of the mental health profession, are sufficiently strong that it would be difficult to defend the adequacy of the inpatient unit that attempts to operate without a small group program.

Interactional groups, analytic groups, multi-family groups, goals groups, movement therapy groups, art therapy groups, massage therapy groups, transitions groups, relaxation groups, guided fantasy groups, dance therapy groups, music therapy groups, horticulture therapy groups, medication education group, future planning group, therapeutic community group, living skills group, crafts group, human sexuality group, discharge planning group, problem solving group, rap groups, awareness training groups, motor skills group, assertiveness training group, behavioral effectiveness group, focus group, psychodrama group, men's group, women's group, structured exercise group, family living group, decision making group, emotional identification group, task groups, and activity groups are all examples of the types of groups that can be incorporated into

an inpatient unit program. A medication education group, lasting 60 minutes, once weekly, can be led by nurses who provide information about the effects and the side effects of medication, and help patients talk about their fears about taking medication. Goals setting groups can be held twice weekly, and includes all of the patients of a team, who meet to set personal goals for themselves for that week. And finally, therapeutic community meeting should be held once daily, and is an easy group for any nurse to lead.

Prestige Of The Inpatient Group

If the unit administrators consider the group program to be unimportant, or even counter-therapeutic, there is little likelihood of the group's being an effective therapy modality. No inpatient group therapist can lead a successful group if the other members of the unit treatment team devalue group therapy. Staff skepticism initiates a process in which the unit team members operate in a fashion that causes their beliefs to be realized. Either explicitly or implicitly, they communicate their sentiments to the patient community and adversely influence the patients' expectations toward the group therapy experience. An unfavorable set of expectations can undermine psychotherapy. A substantial body of research demonstrates that the greater the patients initial belief that therapy will help, the better the ultimate therapy outcome. The effect is more powerful in group rather than individual therapy because of the contagion effect. Some group members who are skeptical and pessimistic about therapy rapidly convey their sentiments to other members; furthermore, they serve as "culture bearers" and demoralize succeeding generations of new members.

A successful unit program values group therapy, and builds the program around it. All admitting physicians are aware that the patients that they admit will automatically

enter the unit group therapy program, and that they, the physicians, must schedule their individual therapy hours accordingly.

The Composition Of The Inpatient Group

Psychiatric units use two basic approaches to group composition. Some units use the level model, in which relatively well-functioning patients are assigned to a “higher level” group, and the relatively regressed, psychotic ones, are assigned to a “lower level” group.

Other units use the team model. In this model, the unit is divided into two or three teams, to one of which all newly admitted patients are assigned in rotation; and each team meets as a therapy group. The team therapy group will thus, be very heterogeneous, and contain at any given time, patients at all levels of functioning, from the chronic regressed psychotic patients, to those who are relatively integrated but undergoing a severe life crisis.

The Frequency Of Group Meetings

Rapid patient turnover presents a major problem in the group therapy program on any acute unit. If the group therapist is to develop any group stability, then group meetings have to be held as frequently as possible. If the average length of stay on a twenty-two-bed unit is seven to fourteen days, then the composition of the group that only meets twice per week will be radically different from meeting to meeting. The group that meets daily, will of course, have a changing membership, but there will be enough carryover of members from one meeting to another to provide some measure of group stability.

Unit administrators offer several reasons why groups meet infrequently. Some units report that they cannot hold groups more than twice per week because of rotating nursing schedules. Some units that are understaffed report that they cannot offer frequent groups because of lack of staff and limited nursing time. Although scheduling problems on a busy “revolving door” unit may be significant, it seems that attitudes toward group therapy are the primary determinant of group therapy frequency. If the clinical leaders of a unit value and endorse therapy, then the insurmountable scheduling problems suddenly dissolve; and individual therapy demands and patients, nurses, and physicians schedules, all easily accommodate to the group therapy schedule. Although co-leaders may be preferable, some units have learned they are not indispensable. A well-trained leader can solo satisfactory.

Psychiatric nurses, the mental health professionals who traditionally lead the majority of groups, have mixed feelings about the role of group leader. First, many have had no formal group therapy training and feel inadequate and threatened in the role. Many psychiatric nurses have led groups for many years and have become highly skilled therapists.

Research Related Barriers In Creating An Evidence-Based Practice Setting

Concerns continue to surface about utilization of EBP in mental health care. Barriers to the implementation of EBP, comes up repeatedly in the psychiatric literature. Lack of training, lack of time, and lack of resources are the main deterrents to implementation strategies, compounded by the general difficulties of testing out clinical questions and hypotheses that one encounters in mental health care. Other barriers appear to be more exclusive to mental health, such as the limited validity of psychiatric

diagnosis, disregard of the human context in the process or care, the inappropriateness of RCTs in the field of psychiatry, and the competing claims between different schools of thought (Hannes, 2010). The hierarchy of evidence within the evidence based movement, where the RCT is promoted as the most reliable and robust source of evidence, has focused attention and funding on efficacy research; and effects of psychotherapy are claimed to be much harder to prove than effects of biological treatments (Hannes, 2010).

Implementation needs to be supported by a theory or model of care; i.e. the primary nurse model of care. Nurses need to see this as an important intervention in improving the care of their patients and their (nursing staffs) overall engagement. There needs to be a commitment of time, and nurses must be committed to making a change in their daily workflow, as each nurse-led group requires 15 minutes of preparation time, 45 minutes of group time, 15 minutes to debrief, and 60 minutes to chart.

Primary Nurse Model Of Care Delivery System

Primary nursing is the perfect care delivery model for mental health nursing because of the emphasis on relationships and relationship building between the nurse and the patient. The primary nurse model supports decision-making and autonomy for the nurse, thus supporting professional nursing practice. In this model, the registered nurse assumes total care for the patient during the entirety of the inpatient hospitalization, and drives the treatment plan as part of a therapeutic and collaborative relationship between the nurse, patient, and members of the interdisciplinary treatment team.

Implementation of the primary nursing can be directly linked to important outcomes such as improved patient experience; emotional safety; earlier identification of

changes in patient's condition; reduced workloads for clinicians as they care for the same patients; and better communication among disciplines and with physicians.

Primary nursing is a relationship-based with therapeutic presence, autonomous, evidence-based, and collaborative delivery care model. Primary nursing is a system for delivering nursing care that is based upon the four elements: responsibility for; relationship and decision-making; work allocation and assignments; communication with the healthcare team; and leadership. The primary nursing role is based upon responsibility, accountability and authority: the responsibility to develop a therapeutic relationship, the accountability to the patient, family and members of the health-care team and the authority to develop and implement an individualized plan of care for the patient.

Primary Nurse Model Of Care – Organizational Objectives

From the organizations perspective, there are many benefits that come with the implementation of the primary nurse model of the care. The primary nurse model of care allows nursing to practice consistency, which enhances patient and family satisfaction. It provides for greater continuity of care, which translates into better clinical outcomes for the patient. And, it gives nurses greater autonomy in practice.

Summary of Outcomes as Related to Evidence-Based Practice

Depression presents as a significant challenge for humankind, and by the year of 2020, depression will be the second most significant cause of injury and disease globally (Feely & Long, 2009). In the United States, depression is viewed and treated through the lenses of the medical model.

Mental illness in late life is a serious public health concern. Aside from sizable emotional and social consequences, mental illness in late life leads to increased disability,

poorer health outcomes, increased mortality risk, greater use of medical services, and reduced treatment compliance. Despite recent advances in mental health treatments for older adults (age 65 and older), less than one-third of older individuals with a mental health or substance use disorder receive treatment. Compared with younger adults (aged 18 – 64), older individuals are three times less likely to report receiving any form of mental health treatment.

When older individuals do seek treatment for mental health problems, they present to primary care physicians (PCPs) who often under-detect their psychopathology and attribute depression and other mental health problems to normal aspect of aging or medical disease. Moreover, research examining physician prescribing and referral patterns has shown that when physicians do detect psychological problems in older adults, they heavily rely on pharmacotherapy and are much less likely to refer older patients for psychotherapy, compared with younger patients. PCPs fail to detect and treat or refer fifty percent of patients with mental health problems, with an even greater number of mental health problems going undetected and untreated in older patients.

In a recent study, physicians were found to assess for depression in only 14% of older patient visits; formal depression assessment tools were used in only 3 out of 399 patient visits (Karlin & Fuller, 2007). Complicating detection of depression in primary care is the fact that somatic symptoms resemble symptomatology of medical illness or natural consequences of aging, and older patients are often unlikely to explicitly state that they need treatment for depression.

Beyond recognizing the problem, there must be a willingness to do something about it. The older adult may believe that the problem is part of normal aging, and

therefore, to be endured, not treated; may be embarrassed; may not know where to turn; and may not know that there are effective treatments.

The personal experience of depression cannot ever be completely comprehended by others, as it is a spectrum of thoughts, feelings, and behaviors that is described differently by each person who is living the symptoms. Mental health nurses have the opportunity to accompany people through their journey from despair to healthy coping. Their therapeutic presence, coupled with human-care qualities and skills, influences the outcome of this painful journey in a positive and connecting manner (Feely & Long, 2009).

The negative stigma of those with mental health problems is beginning to lift. The World Health Organization launched a worldwide campaign, to promote mental health care in which advocacy against stigma and discrimination is one of the top agenda (Chan, 2007).

Mental health nursing as a healthcare discipline is guided by standards and principles of practice, and these principles need to be tested and supported by evidence (Chan, 2007). The universal elements of quality mental health care in the inpatient setting can be characterized as having a strong nurse-patient relationship and having a structured therapeutic milieu.

The establishment of a quality nurse-patient relationship is considered important in most nursing situations; however, in mental health nursing, the interpersonal interaction is the core of practice, making the therapeutic relationship a fundamental element of mental health care. The therapeutic relationship employed in mental health care has been associated with therapeutic outcomes across a range of clinical settings and

patient populations (Dziopa & Ahern, 2009). Ironically, despite the therapeutic relationship being vital to treatment outcomes, the formation of a quality therapeutic relationship between the mental health nurse and patient is not an instinctive occurrence and requires great skill to be established.

An ethnographic study by Cleary et al. (2011) describes twelve themes for mental health nursing. These themes, listed in order of prevalence, are power relations; pragmatism; therapeutic use of self; nursing responsibility for the whole unit; nurses putting themselves on the line; nurses working collectively; non-therapeutic use of self; positively reframing practice; observation complexities; unit permeability; patient self-management of risk; and giving medication.

Nurses use their whole self therapeutically in many situations, including making choices about their words, silence, pace of response, and physical proximity to patients. In conjunction with the therapeutic use of self, nurses in acute mental health units put themselves on the line, physically, emotionally, and mentally, sometimes on a minute-by-minute basis.

Additional interventions include monitoring and promoting nutrition, elimination, sleep-rest patterns, and physical comfort, especially pain control; enhancing physical function and social support; and maximizing autonomy and personal control (Flood & Buckwalter, 2009). For example, the nurse can include the depressed older adult in making daily schedules and setting short-term goals. Other helpful interventions include structuring and encouraging daily participation in relaxation therapies and other pleasant activities; providing practical assistance, for example with problem solving; providing

emotional support through empathic, supportive listening; and encouraging pleasant reminiscences.

There is compelling evidence to support the efficacy of collaborative care for depression in older adults, rather than psychotherapy alone. On the basis of a review of 97 intervention studies, one researcher-practitioner expert panel (Flood & Buckwalter, 2009), strongly recommended interventions based on the depression care management (DCM) model in older adults. Common components include diagnosing depression through validated screening instrument and providing psychotherapy or antidepressant medications according to evidence-based guidelines (Flood & Buckwalter, 2009). Treatment is reassessed periodically through a validated severity instrument to determine how well the older adult is responding and to adjust treatment if appropriate. A trained social worker, nurse, or other practitioner educates patients, tracks outcomes, facilitates psychotherapy, and monitors antidepressants prescribed by a physician.

A focused, structured therapy group, which provides structured activities and support is considered an effective therapy for severely psychotic inpatients (Hsiao et al., 2004). In order to maximize the development of policies and services designed to meet the real needs of service users, geriatric mental health patients' voices need to be heard. One way in which to access the perspectives of these people on how they value psychotherapy is through appropriate and well-designed research. Inpatient group therapy realizes two essential benefits: (1) patients are provided with an opportunity to learn social skills to deal with interpersonal problems; and (2) patients interact more with other patients during their hospitalization, thus helping to decrease their sense of isolation and loneliness (Hsiao et al., 2004).

Evidence-Based Solution

Psychotherapy and psychopharmacology not only represent different treatment approaches, but also are based on distinct models of behavior. They can and should coexist and complement each other, with the ultimate treatment rationale being efficacy, not ideology. Depression has been the most studied of the spectrum of mental illnesses, and evidence is beginning to surface with the use of psychological treatments for other mental health concerns.

Treatment of depression in the elderly is an important concern of both research and practice. Approximately 7 – 11% of the American population aged 65 and older suffer from depression, making the treatment of depression in the elderly an important concern of both research and practice. Yet, few mental health providers in private practice see elderly patients, and the preferred mode of treatment for this age group is pharmacological. However, the use of antidepressants may be contraindicated for a large number of elderly people because they may already be taking multiple medications for medical illnesses that may interact with the psychotropic drugs.

For this reason alone, it is important to be able to provide alternative treatments such as group therapy. Yet, despite a vast literature suggesting the utility of group therapy with the elderly, there are few empirical studies assessing treatment efficacy. Group therapy rather than individual therapy has been advocated for elderly patients, both for its cost-effectiveness and to counteract the isolation and loneliness presumed to be common in old age. Group therapy and psychopharmacology not only represent different treatment approaches, but also are based on distinct models of behavior.

Nevertheless, they can and should co-exist and complement each other. The ultimate treatment rationale is efficacy, not ideology.

Capstone Project Progress

IRB approval was received in May 2014, and implementation of the project began at that time. Initially, the nurses were very enthusiastic, and highly participative in learning the process of leading a group on an inpatient unit. The DNP leader was very happy with their level of participation, and felt that a positive change in both patient and staff responses on a daily basis, was visible. I was excited, and anxiously anticipating being able to review the results of the May 2014 Press Ganey patient satisfaction surveys. The survey scores are posted on the fifteenth of every month.

As Capella University students, we had a summer break that lasted for a total of four weeks, from mid-June to mid-July 2014. When I returned to the clinical setting at the start of the Summer Quarter 2014, I was very disappointed to see that there were no surveys returned for the month of May 2014, and that the June 2014 surveys did not show any improvement in patient satisfaction at all. What I found out is that when I didn't show up to do groups, the staff did not take the ownership and responsibility of carrying on in my absence, which was very disappointing, as it speaks directly to staff engagement in the process.

For the entire Summer and Fall Quarters in 2014, I completely immersed myself into the project, and re-set expectations with the staff that I was teaching them, so that they could add to the therapeutic program. Rather than having the nurses sit in the group with me, as the co-leader, I made myself the co-leader and encouraged them to take the lead role. As a result, when Capella University students had the next break; in-between

the Summer and Fall Quarters; the staff nurses continued to run two groups per day; one in the morning and one in the evening. The July 2014 – March 2015 Press Ganey patient satisfaction scores continue to soar. In addition, the response rate has increased from an average of four surveys to fourteen surveys per month, so the data is more robust.

The staff has been surveyed at three-month intervals since the inception of the capstone project. They were surveyed in August 2014, and again in November 2014, and finally in February 2015 (see Appendix I). One more interval survey will be distributed in May 2015, prior to the end of the capstone, to get a full twelve-month picture of the projects successes and/or failures. The interval surveys thus far, show an incremental increase in staff satisfaction with their jobs, coupled with a direct observation of improvement in engagement with the patients and with co-workers and managers.

All measurements for both patient satisfaction and nurse engagement and satisfaction showed statistically significant increases. Overall rating of nursing care increased from a mean of 72.9 and a rank of 1 to a mean of 86.8 and a rank of 86. Nurses information regarding treatment program increased from a mean of 62.5 and a rank of 1 to a mean of 85.8 and a rank of 84. Friendliness/courtesy of the nurses increased from a mean of 81.3 and a rank of 5 to a mean of 90.2 and a rank of 58. Nurses introduction to the unit/program increased from a mean of 62.5 and a rank of 1 to a mean of 85.8 and a rank of 84. Nurses prompt response to requests increased from a mean of 75 and a rank of 5 to a mean of 85.2 and a rank of 84. Overall nursing care received increased from a mean of 75 to a mean of 91.7.

Nurses overall satisfaction with their jobs increased from 5% rating a 4 or higher in May 2014 to 70% rating a 4 or higher in February 2015, with 30% of those rating a 5 on the satisfaction scale.

Adding nurse led groups to the therapeutic milieu program showed a direct correlation between an improvement in patient satisfaction as well as an increase in nurse engagement. The goal was to add one nurse-led group. The DNP learner actually added two nurse-led groups because both nursing shifts wanted to be involved in the change process.

Patients want to spend therapeutic time with nurses and nurses want to be able to spend time in a therapeutic manner with patients. Building an inpatient unit program must include structured group activities that involve all staff at all levels.

Conclusions

Depression in the elderly causes significant morbidity and mortality, increases suicide rates, and causes significant impairment of physical and social functioning. It remains under-diagnosed and undertreated despite the fact that treatment can significantly improve quality of life and health. Management of depression in the elderly involves a comprehensive assessment, addressing co-morbid conditions and psychosocial interventions. Both pharmacotherapy and psychotherapy are effective interventions. Because of the high rates of recurrences, it is equally important to prevent future episodes with maintenance treatment.

Mental health care is an essential but often forgotten component of health care. Experts agree that “system” doesn’t describe the state of services designed to treat mental illness. There is little coordination of care and various agencies in health, education,

mental health, addiction, disability, and law enforcement often work at cross-purposes. Families have no central place to turn to for help, there is no coordinated plan for learning about and accessing services for desperately needed support, and providers are in short supply. At the same time, reimbursement for mental health services, from both public and private insurers, frequently falls short of providing the most-needed services, which typically involve continuous care that can extend for years.

With increases in life expectancy, and an aging baby boomer generation, the number of Americans aged 65 and older is expected to triple by 2040. We are already facing a mental health system that has failed our geriatric population for decades, and it will only get worse if we do not address the problems of inadequate and underuse of services from an evidence based perspective, to meet the needs of the current and future geriatric patient with mental health issues.

Barriers such as mental health policy, mental health parity, stigma, an overreliance on medication therapy, and underutilization of adjunctive therapies such as group psychotherapy, have contributed to the unraveling of the mental health care system in America. In addition, a shortage of adequately trained geriatric and mental health clinicians including nurses, exists, and is contributing to the push to medicate everyone for everything. More emphasis is needed in refocusing inpatient geriatric mental health treatment back to the nurse as a therapeutic tool, functioning in the structured therapeutic milieu. Reintroducing nurse-led groups is a first step in distributing the balance.

Establishing the efficacy of psychosocial treatments for geriatric depression is an important endeavor for several reasons. Although diagnosable mood disorders such as major depression are relatively less frequent among older versus younger adults,

depressive symptoms and adjustment disorders with depressed mood are quite prevalent.

Depressive experiences are a significant mental health concern for older adults.

Examining the efficacy of psychosocial interventions, like group therapy, is important

because some depressed older adults will not or cannot accept pharmacological

treatments. Treatment options for these people must be established.

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APPENDIX A. STATEMENT OF ORIGINAL WORK
Academic Honesty Policy

Capella University's Academic Honesty Policy ([3.01.01](#)) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person's ideas or works.

The following standards for original work and definition of *plagiarism* are discussed in the Policy:

Learners are expected to be the sole authors of their work and to acknowledge the authorship of others' work through proper citation and reference. Use of another person's ideas, including another learner's, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)

Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else's ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University's Research Misconduct Policy ([3.03.06](#)) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.

Statement of Original Work and Signature

I have read, understood, and abided by Capella University's Academic Honesty Policy ([3.01.01](#)) and Research Misconduct Policy ([3.03.06](#)), including the Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the *APA Publication Manual*.

Learner name and date	<u>Leslie G. Caesar, MSN, RN-BC</u>	<u>March 15, 2015</u>
Mentor name and school	<u>Dr. JoAnn Manty – Capella University</u>	

**APPENDIX B. EVALUATION AND SYNTHESIS TABLE FOR
CONDUCTING AN EVIDENCE REVIEW**

Citation	Design/Method	Sample/Setting	Major Variable Studied And Their Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth To Practice
Craske, M. (2003). Treatment of generalized anxiety disorder in older adults. <i>Journal of Counseling and Clinical Psychology, 71:1, 31-40.</i>	Eligible participants had a principal diagnosis of Generalized Anxiety Disorder according to <i>Diagnostic and Statistical Manual of Mental Health Disorders</i> (4 th ed; American Psychiatric Association, 1994) criteria.	Participants were recruited through hospital-affiliated health education programs, senior centers, and the media, and included a total number of 498 people being screened, with a total of 91 people being invited to participate.	12 sessions of Cognitive Behavioral Therapy (CBT) 12 sessions of Group Therapy (GD) 12-week waiting period with no therapy (WL)	Anxiety and worry; Depression; Quality of life.	Data were analyzed using SAS release 8.1 and compared tests of randomization and the experimental manipulation as well as tests of study hypotheses using chi-square tests.	CBT group was clearly superior to WL group in reducing generalized anxiety in older adults.	Need for study with a more diverse pool of participants, as these results may not be generalizable due to the fact that most participants were white females.
Gould, R. (2012). Cognitive behavioral therapy for depression in older people: A meta-analysis and meta-regression of randomized controlled trials. <i>Journal of the American Geriatrics Society, 60(10), 1817-1930.</i>	Online literature databases and registers were searched for randomized controlled trials (RCTs) of Cognitive Behavioral Therapy (CBT) for depression in older people. Random effects meta-analysis and meta-regression were conducted	Participants from the community and inpatient and outpatient clinical settings	Older people with major or minor depression, dysthymia, or depressive symptoms Critically review the quality of RCTs of CBT with active and non-active controls and other treatment pharmacotherapy or other forms of psychotherapy	Evidence-based outcome measures of depression	485 studies were identified of which 23 were selected after screening for inclusion criteria.	CBT was significantly more effective at reducing depressive symptoms than Treatment As Usual (TAU) or being on a waiting list but not compared with active controls.	More high quality RCT's comparing CBT with active controls need to be conducted before strong conclusions can be drawn about the efficacy of CBT for depression in older people.
Karlin, B. & Fuller, J. (2007). Meeting the mental health needs of older adults: Implications for primary care practice. <i>Geriatrics, 62:1, 26-35.</i>	Literature review of databases in English between 1986-2003 using the search terms therapeutic alliance, therapeutic relationship, working alliance; and nurse-patient relationships	Papers chosen for inclusion in the review were those with a research focus on the elements and potential benefits/costs of therapeutic relationships in nursing	Therapeutic working relationships with geriatric people with mental illness		The absence of randomized controlled trials, supporting the effectiveness of the therapeutic relationship, has been seen as proof of its lack of efficacy Outcome studies are incompatible with psychotherapy research because	Historically, mental health nurses have seen therapeutic relationships as fundamental to their practice. Therapeutic relationship skills and technical therapeutic skills are portrayed as opposite ends	People greatly value the therapeutic relationship and its contribution to recovery. More structured approaches to psychological therapy, such as cognitive behavioral therapy, may

					standardized treatments are assigned on the basis of psychiatric diagnosis rather than individualized assessment Comparative studies may be a poor method of evaluating the superiority of treatment methods	of the a continuum	prove to be increasingly relevant to the future practice of mental health nursing. The combination of relationship and process may prove to be the most effective treatment for people with mental illness.
Hanrahan, N., Aiken, L., & Hanlon, A. (2010). Relationship between psychiatric nurse work environments and nurse burnout in acute care general hospitals. <i>Issues in Mental Health Nursing, 31:198-207.</i>	Cross-sectional observational design from the Commonwealth of Pennsylvania A secondary analysis linked nurse survey data and hospital data to examine associations among organizational factors of the nurse practice (work) environment and psychiatric nurse burnout.	Psychiatric Nurse Sample (n = 353) Hospital Sample (n = 67)	Explanatory Variables Outcome variables	Nurse demographic and work characteristics ; hospital characteristics ; organizational factors of the nurse practice environment; staffing: patient to nurse staffing ratio	Regression Models	Significant relationship between nurse practice work environments and lower psychiatric nurse reports of emotional exhaustion and depersonalization	This study provides some of the first evidence that the quality of the inpatient psychiatric nurse work environment is associated with occupational stress of psychiatric nurses.
Tuvsesson, H., Eklund, M., & Wann-Hansson, C. (2011). Perceived stress among nursing staff in psychiatric inpatient care: The influence of perceptions of the ward atmosphere and psychosocial work environment. <i>Issues in Mental Health Nursing, 32:441-448.</i>	Cross-sectional survey conducted at 12 psychiatric acute inpatient wards in southern Sweden.	Registered Nurses and Nursing Assistants from 13-16 bed psychiatric adult inpatient care units	Perceived stress as felt by the nursing staff working in psychiatric inpatient care Possible differences between nurses and nurse assistants Associations among individual characteristics, the ward atmosphere, the psychosocial work environment, and perceived stress	Three self-report questionnaires targeting perceived stress, the ward atmosphere, and the psychosocial work environment	Descriptive statistics were used to analyze characteristics of the participants and to investigate the response distribution from the Perceived Stress Scale. The Mann-Whitney U-test was used to analyze differences between groups, and Spearman rank correlations were used to assess bivariate relationships among subscales	There were statistically significant correlations between Role Clarity and Organizational Climate and Perceived Stress. There were statistically significant correlations between – Involvement, Order and Organization, and Program Clarity – and Perceived Stress.	The findings present valuable insights into the working conditions, Perceived Stress, of nursing staff in psychiatric inpatient care. A possible way of preventing stress among the nursing staff is to focus on patient activity and mutual engagement among patients and staff.

Evaluation and Synthesis Table for Conducting an Evidence Review

Citation	Design/Method	Sample/Setting	Major Variable Studied And Their Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth To Practice
Cleary, M., Hunt, G., Horsfall, J., & Deacon, M. (2012). Nurse-patient interaction in acute inpatient adult mental health units: A review and synthesis of qualitative studies. <i>Issues in Mental Health Nursing</i> , 33, 66-79.	Meta-analysis of qualitative studies which studied nurse-patient interaction in acute inpatient adult mental health units Electronic searching was conducted through CINAHL, PsychINFO, Ovid Medline.	1199 studies identified, with a total of 23 studies included in the final review after all exclusions	Interactions between nurses and patients in the adult psychiatric inpatient environment	Findings were read, data were extracted, coded manually, analyzed, and scrutinized to discern unifying concepts or themes	The resultant ideas and concepts were situated within broad inclusive categories	Twenty eight themes fit within six categories: sophisticated communication, subtle discrimination, managing security parameters, ordinary communication, reliance on colleagues, and personal characteristics important to patients	Shows meaningful nurse connections with patients Disputes that claims that mental health nurses do not contribute to the therapeutic environment
Feely, M. & Long, A. (2009). Depression: A psychiatric nursing theory of connectivity. <i>Journal of Psychiatric and Mental Health Nursing</i> . 16, 725-737.	Qualitative approach using Classical Grounded Theory A combination of purposeful sampling and theoretical sampling	People living with depression or caring for individuals with depression	The total sample group comprised 17 people The focus group consisted of three men and four women	Focus groups and interviews	Simultaneous process of data collection, coding, and analysis were conducted	Connectivity between patients and nurses provides a framework that nurses can use to better understand and respond to the life experience of people living with depression	Adds to the body of experiential knowledge
Flood, M. & Buckwalter, K. (2009). Recommendations for mental health care of older adults – Part 1 – An overview of depression and anxiety. <i>Journal of Gerontological Nursing</i> . 35(2), 26-34.	Qualitative					Assessment Intervention Practice Guidelines	Key assessment points as well as therapeutic interventions were discussed
Gould, R. (2012). Cognitive behavioral therapy for depression in older people: A meta-analysis and	Online literature databases and registers were searched for randomized controlled trials (RCTs) of Cognitive	Participants from the community and inpatient and outpatient clinical settings	Older people with major or minor depression, dysthymia, or depressive symptoms Critically	Evidence-based outcome measures of depression	485 studies were identified of which 23 were selected after screening for inclusion criteria.	CBT was significantly more effective at reducing depressive symptoms than Treatment As Usual (TAU)	More high quality RCT's comparing CBT with active controls need to be conducted

meta-regression of randomized controlled trials. <i>Journal of the American Geriatrics Society, 60(10), 1817-1930.</i>	Behavioral Therapy (CBT) for depression in older people. Random effects meta-analysis and meta-regression were conducted		review the quality of RCTs of CBT with active and non-active controls and other treatment pharmacotherapy or other forms of psychotherapy			or being on a waiting list but not compared with active controls.	before strong conclusions can be drawn about the efficacy of CBT for depression in older people.
Karlin, B. & Fuller, J. (2007). Meeting the mental health needs of older adults: Implications for primary care practice. <i>Geriatrics, 62:1, 26-35.</i>	Literature review of databases in English between 1986-2003 using the search terms therapeutic alliance, therapeutic relationship, working alliance; and nurse-patient relationships	Papers chosen for inclusion in the review were those with a research focus on the elements and potential benefits/costs of therapeutic relationships in nursing	Therapeutic working relationships with geriatric people with mental illness		The absence of randomized controlled trials, supporting the effectiveness of the therapeutic relationship, has been seen as proof of its lack of efficacy Outcome studies are incompatible with psychotherapy research because standardized treatments are assigned on the basis of psychiatric diagnosis rather than individualized assessment Comparative studies may be a poor method of evaluating the superiority of treatment methods	Historically, mental health nurses have seen therapeutic relationships as fundamental to their practice. Therapeutic relationship skills and technical therapeutic skills are portrayed as opposite ends of the a continuum	People greatly value the therapeutic relationship and its contribution to recovery. More structured approaches to psychological therapy, such as cognitive behavioral therapy, may prove to be increasingly relevant to the future practice of mental health nursing. The combination of relationship and process may prove to be the most effective treatment for people with mental illness.

APPENDIX C. GERIATRIC PSYCH – NURSING OVERALL TREND GRAPH
(11/2011 – 01/2014)

QuickTime™ and a
decompressor
are needed to see this picture.

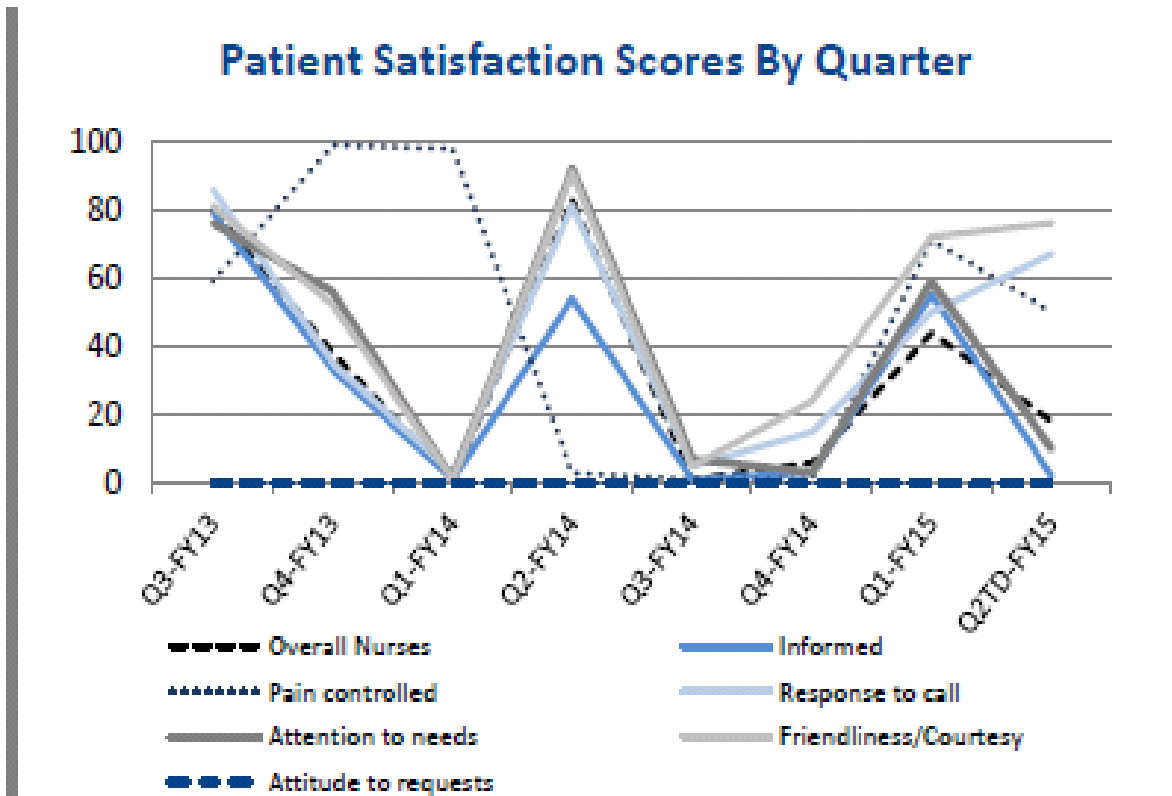
**APPENDIX D. GERIATRIC PSYCH – STANDARD OVERALL CARE GRAPH
(11/2011 – 01/2014)**

QuickTime™ and a
decompressor
are needed to see this picture.

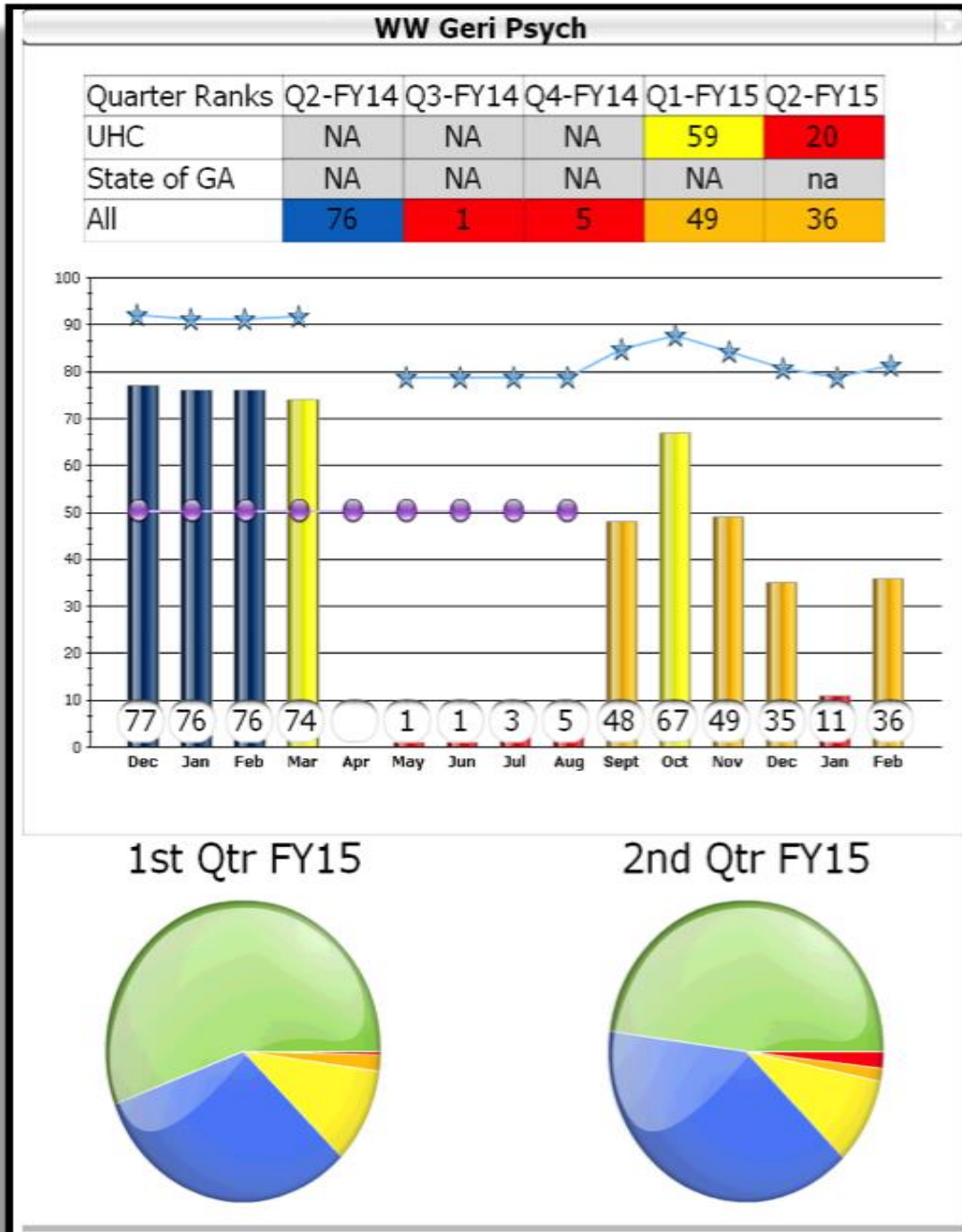
**APPENDIX E. GERIATRIC PSYCHIATRY INPATIENT UNIT – NURSING
 QUALITY INDEX – FOUR QUARTER TREND (05/2013 –
 01/2015)**

Unit Nursing Quality Index: Geriatric Psychiatry Inpatient															
Geriatric Psychiatry Hospital	FY13	FY14	FY15	Q3-FY13	Q4-FY13	Q1-FY14	Q2-FY14	Q3-FY14	Q4-FY14	Q1-FY15	Q2TD-FY15	8-Qtr Trend			
	Target	Target	Target	May-13	Aug-13	Nov-13	Feb-14	May-14	Aug-14	Nov-14	Jan-15				
Pt Sat: Overall Nurses	50	50	50	80	38	1	83	1	6	44	18	2 of 8			
Pt Sat: Nurse Kept You Informed	50	50	50	79	33	1	54	1	3	55	2	3 of 8			
Pt Sat: How Pain Was Controlled	50	50	50	59	99	98	3	1	1	71	50	5 of 8			
Pt Sat: Promptness Responding to Call	50	50	50	86	35	3	81	5	15	50	67	4 of 8			
Pt Sat: Attention Special/Personal Needs	50	50	50	76	56	1	92	7	3	59	10	4 of 8			
Pt Sat: Friendliness / Courtesy of Nurses	50	50	50	81	52	1	91	5	24	72	76	5 of 8			
Pt Sat: Nurses' Attitude toward Requests	50	50	50									0 of 0			
HAPU	0.00%	0.00%	0.00%	0.00%	0.00%	14.29%		0.00%	0.00%	0.00%	0.00%	6 of 7			
UAPU	0.00%	0.00%	0.00%	0.00%	0.00%	14.29%		0.00%	0.00%	0.00%	0.00%	6 of 7			
HAPU Stage II & Above	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%	0.00%	7 of 7			
Falls per 1,000 Patient Days	N/A	N/A	7.27	9.72	9.07	12.24	0.00	16.85	3.05	7.62	3.38	1 of 2			
Falls w/ Injury per 1,000 Patient Days	N/A	N/A	1.28	1.22	2.27	0.00	0.00	4.49	0.00	1.27	0.00	2 of 2			
Physical Restraint Prevalence	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%			6 of 6			
RN Certification	24.34%	27.29%	28.61%	18.75%	18.75%	13.33%	12.50%	13.33%	18.75%	18.75%	14.29%	0 of 8			
RN Education (BSN or Higher)	46.70%	43.59%	44.78%	42.11%	45.00%	44.44%	44.44%	36.84%	41.18%	36.36%	40.00%	0 of 8			
RN Engagement (Overall Score)	70.8			59.3								0 of 1			
8-Qtr Trend Legend: # Qtrs meeting target											>50%	50%	<50%	# of Indicators at Target	6 of 13

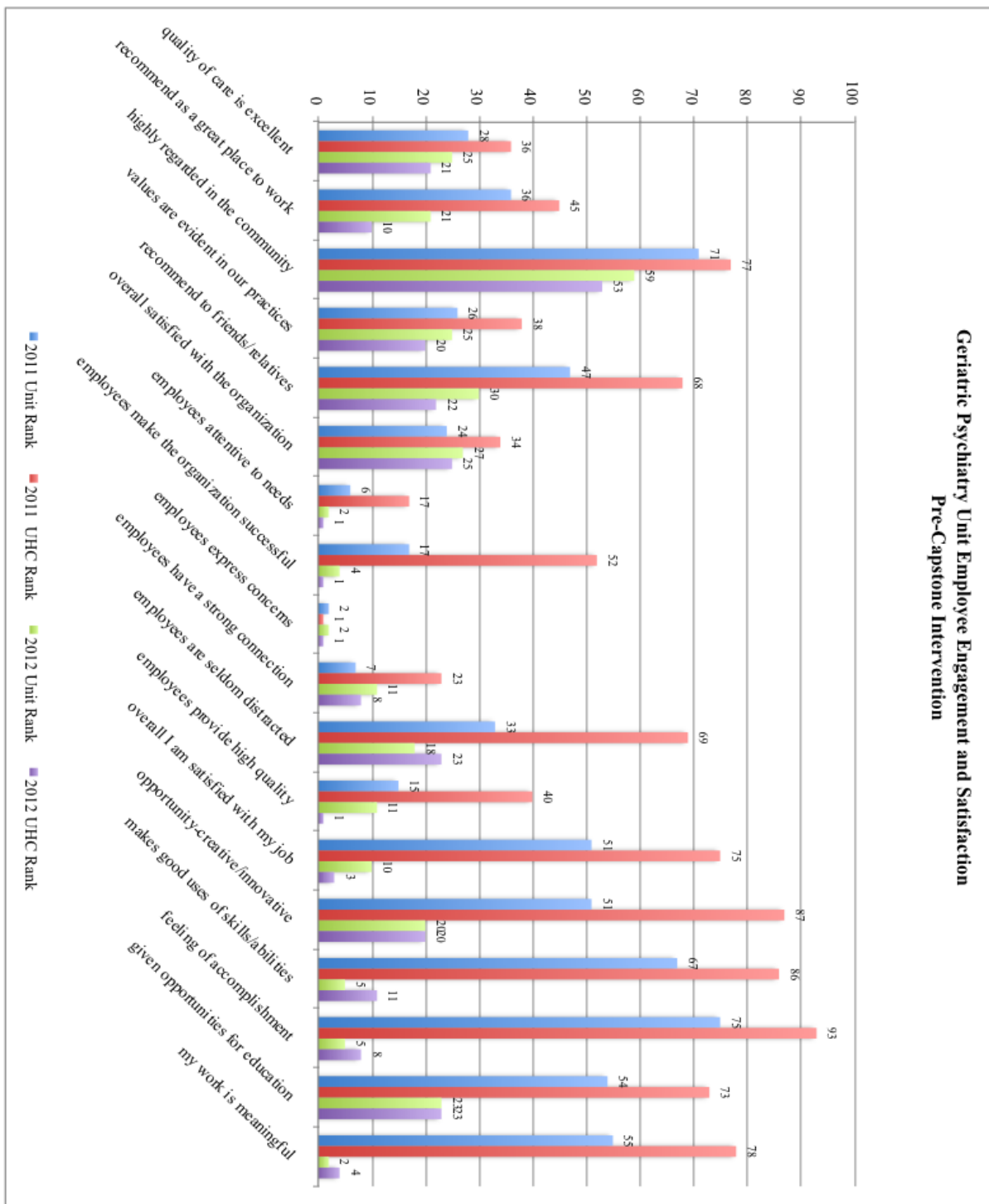
**APPENDIX F. GERIATRIC PSYCHIATRY INPATIENT UNIT – NURSING
INDICATORS PATIENT SATISFACTION (05/2013 – 01/2015)**



APPENDIX G. GERIATRIC PSYCHIATRY UNIT MONTHLY PATIENT SATISFACTION TREND REPORT (12/2013 – 02/2015)



APPENDIX H. EMPLOYEE PARTNERSHIP REPORT



APPENDIX I. EMPLOYEE SATISFACTION INTERVAL SURVEY

Employee Satisfaction Interval Survey

You are being asked to complete this survey as part of an ongoing assessment and evaluation that is being conducted by the Capella University DNP leader. Please answer all questions honestly. All survey answers are anonymous and will not be used in any way, other than to gauge your opinion of your work as it relates to leading groups and actively participating in the therapeutic milieu. This survey will be given to you at three month intervals from the inception of the capstone project – August 2014, November 2014, February 2015, and May 2015. All questions should be answered utilizing a Yes/No format, with the exception of the last question.

1. Did you feel adequately prepared to lead a group?
2. Did you require more training to feel comfortable leading a group?
3. Do you feel confident about leading groups with patients?
4. Do you feel that you are more connected to the care of your patients?
5. Do you enjoy the work that you do?
6. Do you feel that you are helping your patients improve during their hospitalization?
7. Are you confident that you can continue the group once the DNP leader leaves?
8. On a scale of 1 – 5, with 1 being completely dissatisfied with your job and 5 being completely satisfied with your job, how do you rate?