BUILDING ON A CULTURE OF PATIENT AND FAMILY CENTRED CARE

IN THE MENTAL HEALTH SETTING

By

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Abstract

Providence Health Care (PHC) is a faith-based care provider that operates sixteen facilities in Vancouver, Canada. PHC is beginning the journey towards patient and family centred care at all of its sites and programs. This inquiry engaged patients, families, staff, physicians and leaders to explore how a culture of patient and family centred care could be nurtured within the Mental Health Program at PHC. Results identified five main themes and four recommendations to build on PHC’s patient and family centred approach. Organizational implications and suggestions for future inquiry are proposed to further build on patient and family centred care initiatives with the goal of the PHC mental health program providing exemplary treatment and world-class leadership in patient and family centred care.
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Table of Contents

ABSTRACT ........................................................................................................................................... 2

ACKNOWLEDGEMENTS ...................................................................................................................... 3

TABLE OF CONTENTS ....................................................................................................................... 4

LIST OF FIGURES ............................................................................................................................... 6

CHAPTER ONE: FOCUS AND FRAMING ............................................................................................ 7

SIGNIFICANCE OF THE INQUIRY .................................................................................................... 9

ORGANIZATIONAL CONTEXT ....................................................................................................... 10

SYSTEMS ANALYSIS OF THE INQUIRY .......................................................................................... 13

CHAPTER SUMMARY ....................................................................................................................... 17

CHAPTER TWO: LITERATURE REVIEW ............................................................................................ 18

PATIENT AND FAMILY CENTRED CARE .......................................................................................... 18

CULTURE AND CHANGE WITHIN HEALTHCARE ......................................................................... 24

CHAPTER SUMMARY ....................................................................................................................... 31

CHAPTER THREE: RESEARCH APPROACH AND METHODOLOGY .................................................. 33

INQUIRY APPROACH ................................................................................................................... 33

PARTICIPANTS .................................................................................................................................. 35

INQUIRY METHODS .................................................................................................................... 37

ETHICAL ISSUES .......................................................................................................................... 47

CHAPTER SUMMARY ....................................................................................................................... 49

CHAPTER FOUR: FINDINGS AND DISCUSSION ............................................................................... 51
List of Figures

Figure 1. System influences on patient and family centred care ..........................13
**Chapter One: Focus and Framing**

Most of us feel better when we are seen and met with authentic presence and regard, without condescension or contrived intimacy. We feel good when we are treated as capable, when we are related to as if we have the capacity to actually undertake the hardest work in the world, when a lot is being asked of us, but in ways that build on our own intrinsic capacities and intelligences (Kabat-Zinn, 2005, p. 357).

Providence Health Care (PHC) is a Roman Catholic faith-based care provider that operates sixteen facilities in Vancouver, Canada. PHC is beginning the journey towards patient and family centred care at all of its sites and programs (Providence Health Care, 2013, Who We Are, para. 4). Patient and family centred care\(^1\) is defined by PHC as an “approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, the people we serve and their families” (Providence Health Care, 2013, Who We Are, para. 4). How patient centered care is anticipated to work within the area of mental health required further exploration (L. Heppell, personal communication, August 13, 2013)\(^2\)

I have been with PHC since 1994, and at the time this inquiry was launched, I was in the role of registered dietitian and program coordinator of an eating disorders program within the mental health department. I reported to the Professional Practice Leader of Nutrition Services, who reported to the Director of Professional Practice and Nursing, who subsequently reported to the Vice President, Patient Safety and Innovation and Chief of Professional Practice and Nursing. Through my work as a clinician and program coordinator, I had come to understand that to continually provide the best care experience, and to successfully address ever-increasing

\(^1\) In the literature of patient and family centred care, the word patient is used interchangeably with person, client and

\(^2\) All personal communications in this report are used with permission.
complexities and challenges, we needed to develop much stronger relationships with patients and families.

The purpose of this inquiry was to shape an environment for change through the establishment of collaborative relationships with patients, families and health professions, exposing and clarifying different perspectives, and co-creating new knowledge through action and reflection (Stringer, 2007, p. 41). My role as an action researcher within my organization was one of a collaborative problem-solving relationship between myself, as the researcher, and the organization, which aimed at both solving a problem and generating new knowledge (Coghlan & Brannick, 2010). Through these collaborative relationships, I hoped to “inspire others to perceive, believe, or act in different ways” (Glesne, 2011, p. 23), building on a culture of patient and family centred care within the Mental Health Program at PHC.

This inquiry engaged patients, families, staff, physicians and leaders within the Mental Health Program at PHC to explore how a culture of patient and family centred care could be nurtured within the Mental Health Program of PHC through the following question: How can a culture of patient and family centred care be nurtured that meets the aspirations of stakeholders within the mental health program at PHC? The sub-questions included:

1. How do the patients, families, leaders and staff of the mental health program of PHC define patient and family centred care?
2. What are the current practices of patient and family centred care in the mental health program of PHC?
3. What is the vision the stakeholders of PHC’s mental health program have for an ideal culture of patient and family centred care within the mental health setting?
4. What support is needed to implement further practices of patient and family centred care within the mental health program of PHC?

5. What implications might these findings have for other mental health service organizations that are seeking to enhance their culture of patient and family centred care?

**Significance of the Inquiry**

Patients as Partners, a recognized initiative of the B.C. Ministry of Health, believes patients and their families have a “unique perspective on the health care system that is different from the provider, health care worker, or administrator” (Impact BC, n.d., Patients as Partners, About, para. 3). This was first outlined in the 2007 *Primary Health Charter*, and was and continues to be both a policy and philosophy of the British Columbia Ministry of Health. The guiding principle was stated as follows: “patients, their families and/or caregivers should always be partners in health care: collaborating with health care professionals to improve their health as an individual, and having a voice in how health care is delivered in BC” (Impact BC, n.d., Patients as Partners, para. 2).

Patient and family engagement offers many benefits. Studies have shown that patients who are more engaged in their own health care have better health outcomes, are safer and have an improved experience of care (Chambers, 2009). Health care providers reported an improved experience in care delivery when they worked with patients at the centre of care and the system itself saved money when people were healthier and safer (Fancott, n.d.).

Engagement with patients and their families can have a positive effect on how services are planned, organized, and delivered (Fancott, n.d.). When patient and family centred care was
adopted, better patient outcomes, wiser use of resources and greater patient and family satisfaction were evident (Baas, 2012).

By conducting this inquiry, there was the potential to engage stakeholders in a discussion of how a culture of patient and family-centred care could be fostered within the mental health program of PHC. The stakeholders in this inquiry included patients and families, staff, physicians, and leaders of the mental health program and other senior leaders at PHC. Research highlighted the need for patient and family engagement to be “meaningful, embedded within each organization and understood and valued by staff” (Chambers, 2009, p. 3).

If this inquiry had not move forward, the organization would have relinquished an opportunity to receive meaningful feedback about service delivery directly from the most important stakeholder, the user, and as a result, missed opportunities to further enhance the current level of care. This had the potential to negatively impact patients’ and families’ experience of care, service delivery, and health outcomes.

Investigating how a culture of patient and family-centred care could be fostered within the mental health program had and continues to have the potential to build on PHC’s patient and family-centred approach and ensure PHC is responsive to the needs of patients and families, continually adapts, and takes advantage of opportunities that enhance patient care for the long term.

**Organizational Context**

PHC is a large organization with sixteen sites, 738 inpatient beds, 686 residential beds, numerous outpatient programs, and approximately 9,000 employees. PHC operates in partnership with Vancouver Coastal Health, the Provincial Health Services Authority and the
University of British Columbia. PHC falls within the Vancouver Coastal Health region but is governed by its own, independent Board of Directors and is accountable to patients and residents, Vancouver Coastal Health, the BC Ministry of Health, the Board of Directors and BC taxpayers (Providence Health Care, 2013, Governance).

PHC’s organizational leadership structure is comprised of PHC Society members, Board of Director members, a Chief Executive Officer and eleven Vice Presidents (VP). The mental health program within PHC reports through the operations leaders, professional practice leaders, or a physician leader, to a director, and on to either the VP of Acute Clinical Programs, VP of Patient Safety and Innovation and Chief of Professional Practice and Nursing, or VP of Medical Affairs. The reporting structure depends on employee discipline. For example, a nurse working in the mental health program would report to the operations leader, who reports to the director of mental health, who subsequently reports to the VP of Acute Clinical Programs. A psychiatrist working in the mental health program would report to a physician leader, who subsequently reports to the VP of Medical Affairs.

When this inquiry began, PHC had identified five strategic directions in its 2012 – 2015 Strategic Plan. These included: care experience; infrastructure redevelopment; innovation; people; and quality and safety. This inquiry had the potential to contribute to PHC’s strategic direction, the care experience. The care experience spoke to the organization having a “person and family centred care . . . approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among healthcare providers, the people we serve and their families” (Providence Health Care, 2013, Person and Family Centred Care, para. 1)
As the effects of involving patients are likely to be complex, affecting different aspects of services in different ways (Crawford, et al., 2002), this inquiry narrowed the target area to the mental health program - one of PHC’s stated populations of emphasis (Providence Health Care, 2013, Who We Serve, para. 3).

PHC offers a diverse range of inpatient and outpatient mental health services. These services are located at various sites around Vancouver, BC and include: Mental Health Wellness Outpatient Clinic; Provincial Adult Tertiary Eating Disorders Program; Complex Pain Program; Inner City Youth Outreach Program; hospital-wide consultation liaison psychiatry service; and four inpatient treatment units (60 beds). The staff of the PHC mental health program includes 60 psychiatrists and 200 nurses and allied health employees located within the 16 sites operated by PHC.

When this inquiry began, the mental health program at PHC had already made great progress on its journey towards implementing patient and family centred care. The mental health program included patient and family representatives at a monthly quality meeting where projects were discussed to improve the overall quality of care provided to patients and families. As well, a patient and family centred care project began in September 2013 in partnership with staff nurses of the inpatient mental health treatment units. This project had a goal of improving patient outcomes by enhancing family involvement in the care of their family member being treated for mental illness. This project was modeled after a successful venture of enhancing family involvement in the care process of one of the inpatient psychiatry units at PHC. This family involvement project was credited for being one of the reasons the unit had a 97% overall patient
satisfaction score, ten percentage points above the provincial average for similar units in BC (J. Duff, personal communication, August 9, 2013).

**Systems Analysis of the Inquiry**

System thinking is a discipline of seeing the structures and patterns of interdependency that underlie complex situations (Senge, 2006, p. 68). When examining the inquiry of patient and family centred care within mental health, there were many systems to consider. As illustrated in Figure 1, at the core of the diagram is the perspective of patients and families. This is followed by the internal context of organizational, healthcare provider, and procedural perspectives. The next layer within this system diagram is the external context of societal, provincial, and federal perspectives.
Figure 1. System influences on patient and family centred care

From an organizational perspective, PHC was and continues to be very supportive of encouraging patient and family centred care within all areas of PHC, and has devoted one of the five strategic directions entirely to the cause. There was, however, an identified need to examine more fully the incorporation of patient and family centred care into the mental health program (L. Heppell, personal communication, August 13, 2013).

In Figure 1, the internal context also makes reference to the healthcare provider perspective. Traditional healthcare systems are based on a provider-centred approach, with the
provider being in control of everything that happens to a patient (Sodomka, Spake, & Rush, 2010). In traditional mental health service delivery, the “professionals hold the power and make decisions about the care and treatment of the people with mental illness” (Sommerseth & Dysvik, 2008, p. 262). Psychiatric patients are traditionally seen as unable to collaborate in their own care due to mental impairment, and are encouraged to surrender care decisions entirely to professionals. Typically, this biomedical approach has been found to dominate, with the patient and family centred perspective often missing (Sommerseth & Dysvik, 2008). Research suggested the dominance of the medical model, where decisions rested with psychiatrists, and contributed to healthcare workers being unable to practice in a patient and family centred manner (O’Donovan, 2007).

There are also procedural logistics to consider when examining the context of patient and family centred care within the mental health program. These include issues such as heightened confidentiality and locked treatment units. Confidentiality is one of the basic principals of healthcare practice (McHale, 2009). An individual with a mental illness may be particularly “concerned with maintaining the confidentiality of their health-care information because of the prospect of discrimination/stigmatization consequent upon their mental disorder” (McHale, 2009, p. 944). The issue of confidentiality brings up many questions in relation to patient and family centred care. For example, “when should confidentiality be breached in the interests of the patient? (and) when should, if at all, information be disclosed to families and carers?” (McHale, 2009, p. 944).

Locked treatment units have been in place to “minimize and contain risk in mental health care” (Cleary, Hint, Walter & Roberston, 2009, p. 644). Such risks included leaving the unit to
harm themselves or others and “unwelcomed visitors bringing in contraband” (Cleary, et al., 2009, p. 646). Some disadvantages to locked treatment units are noted in the literature. These included increased stigmatization for patients and their caregivers, decreased patient autonomy, and decreased visiting opportunities for families (Cleary, et al.).

It was also important to view this inquiry from a societal context. Research showed strongly negative attitudes towards people with mental health issues: an American national survey indicated that 75 percent of the public viewed individuals with mental illness as dangerous (Pescosolido, et al., n.d.). According to this research, this negative view had been influenced by negative images of psychosis, poor social skills, and poor personal appearance (McDaid, n.d.). This societal context may impact the public's ideas of the meaning of patient and family centred care within mental health. For example, one study indicated only 64 percent of participants believed individuals with mental health issues were able to make decisions regarding their own health care (Pescosolido, et al., n.d.).

At the provincial level, as previous mentioned, the British Columbia Ministry of Health has an initiative called “Patients as Partners” (Impact BC, n.d., Patients as Partners, para. 1). This is both a policy and philosophy with the guiding principle that patients and families/caregivers are partners in health care: collaborating with health care professionals on their health, and having a voice on healthcare delivery in the province (Impact BC, n.d., Patients as Partners, para. 2).

Federally, there are two major government initiatives involving patient and family centred care. The Canadian Foundation for Healthcare Improvement (n.d.) adopted patient and family centred care and improving patient-and family-centred experience and outcomes as one of
its key initiatives (Canadian Foundation for Healthcare Improvement, n.d., About Us, Frequently Asked Questions, para. 7). The Mental Health Commission of Canada released the *National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illnesses*, with a “purpose to guide system planners, policy makers and service providers in planning, implementing and evaluating mental health care services that recognize and address the unique needs of family caregivers” (MacCourt, 2013, p. 2).

**Chapter Summary**

In summary, it can be seen from the above that patient and family centred care was and continues to be much on the minds of the health care field and of mental health care systems more specifically. This inquiry provided the opportunity to assist PHC in enhancing this approach within its mental health program. A review of the literature that aligns with this research inquiry is provided in the next chapter.
Chapter Two: Literature Review

This literature review examines key topics related to the inquiry: How can a culture of patient and family centred care be nurtured that meets the aspirations of stakeholders within the mental health program at PHC? The sub-questions included:

1. How do the patients, families, leaders and staff of the mental health program of PHC define patient and family centred care?
2. What are the current practices of patient and family centred care in the mental health program of PHC?
3. What is the vision the stakeholders of PHC’s mental health program have for an ideal culture of patient and family centred care within the mental health setting?
4. What support is needed to implement further practices of patient and family centred care within the mental health program of PHC?
5. What implications might these findings have for other mental health service organizations that are seeking to enhance their culture of patient and family centred care?

A thorough review of the literature provided a strong foundation, built a framework for the key concepts, and shaped the focus of the current inquiry. The first topic examines the literature related to patient and family centred care. The second section evaluates the concept of culture and change within healthcare.

Patient and Family Centred Care

Defining patient and family centred. The term patient and family centred care is frequently used in the literature, but there is little consensus on its meaning (Morgan & Yoder, 2012). When reviewing the historic evolution of the term “patient centred”, these authors traced
the concept back to Florence Nightingale who stressed the focus on the patient rather than on the disease, and Carl Rogers, an American psychologist, who created the notion of person centeredness in the early 1940’s (Morgan & Yoder, 2012). In 2001, patient centred care was brought into mainstream health care as improving patient centeredness became one of the six aims of the Institute’s of Medicines (IOM) Health Care Quality Initiative (2001) which stated that health care should be safe, effective, patient-centred, timely, efficient and equitable. This document defined patient-centred care as

health care that establishes a partnership among practitioners, patients and their families (when appropriate) to ensure that decisions respect patients’ wants, needs and the preferences and that patients have the education and support they need to make decisions and participate in their own care. (p. 41)

This definition stressed the importance of relationships among health care providers, patients, and families specifically related to decisions about their treatment.

Since 2001, the definition of patient centred care has “continuously evolved in the literature and in recent years has been greatly emphasized in policy initiatives” (Groene, 2011, p. 532). Johnson, Abraham and Shelton (2009) defined patient and family centered care as “an approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families . . . (and) a framework within which to begin examining policies, program, and practices” (p. 125). Other literature also supported this broad definition of patient and family centred care. O’Donovan (2007) described patient and family centred care as a “range of activities from patient involvement in individual care to public involvement in health policy decisions” (p. 542). A patient and family centred care organization will not only have patients and family included in decision making on their own delivery of care, but also on “all aspects of policy and procedure development, new program
development and institutional design” (Baas, 2012, p. 535). Baas (2012) also advocated for a more philosophical definition of patient and family centred care as “patient and family centred care should be considered as a philosophy or mission of a health care facility” (p. 534).

The definition of patient and family centred care cited most frequently in the literature came from the Institute for Patient and Family Centered Care (2013): “Patient- and family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families” (The Institute for Patient and Family Centered Care, 2013, Frequently Asked Questions, para. 1). According to the Institute for Patient and Family Centered Care the four concepts essential for patient and family centred care are: “dignity and respect; information sharing; encouraging participation of patients and family; and collaboration at the individual and institutional level” (The Institute for Patient and Family Centered Care, 2013, Frequently Asked Questions, para. 2)

As illustrated above, the definition of patient and family centred care is a “multidimensional concept” (Edvardsson, Koch & Nay, 2009, p. 236) that shifts the focus from the clinician to the person for whom care is being delivered and can encompass all levels of care delivery, including planning, treatment, policy development, and philosophy.

**Significance and benefits of patient and family centred care.** The benefits of patient and family centred care are well documented in the literature. Research suggested that patient centred care and/or patient and family centred care was associated with increased patient engagement, compliance, satisfaction, and health outcomes and a decreased length of stay, cost, and adverse events (Charmel & Frampton, 2008; Fredericks & Bunting, 2010; Groene, 2011; Jin,
Sklar, Oh, & Li, 2008; Mirzai, et al., 2013; Shaller, 2007; Stewart, et al., 2000). Research found that the failure to be patient centered (as perceived by the patient) was related to higher rates of referral and diagnostic tests which “counter a common misconception, that being person centered means responding to every whim of the patient, thereby increasing expenses to the health care system” (Stewart et al., 2000, p. 803).

The literature also identified specific benefits of patient-centered care on mental health outcomes. Dobscha, et al., (2009) found an improvement in depression symptoms and Chenoweth, et al. (2009) found patient-centred care reduced agitation in people with dementia in residential care. Stewart et al. found that patient centred care was associated with improved mental health (2000).

**Patient and family centred care in mental health.** Literature suggested, while the concept of mental health services based on patient and family centred care was widely understood, it rarely existed in practice (Ruddick, 2010; Sommerseth & Dysvik, 2008). Sommerseth and Dysvik (2008) recommended a paradigm shift was needed within mental health care - a focus away from health professions and towards empowerment of individuals with mental illness, with the individuals taking responsibility and becoming active collaborators in decision-making. In traditional service provision, these authors have found that a biomedical approach dominated, wherein professionals held the power and made decisions about the care and treatment of the people with mental illness and the patient’s perspective was seldom equated to the professional’s perspective, resulting in a power imbalance (Sommerseth & Dysvik, 2008). The authors explained that this power imbalance was further deepened, since many people with
mental illness were vulnerable and withdrawn, and had low expectations about their own contributions (Sommerseth & Dysvik, 2008).

New research has surfaced stating that globally, the relationship within health care is transitioning from “being a paternalistic one to a patient-centered one” (Lee & Lin, 2010, p. 1811). While other literature argued that within the concept of patient-centered care, “shared decision making can be flexible and can integrate paternalistic and informative models” (Moreau, et al., 2012). For example, if a patient requested the health care professional to make decisions about his/her care, this would qualify as patient centred. The authors found that what mattered most to patients were the physicians’ relational skills of listening, informing, advising, and supporting patients’ choices (Moreau, et al., 2012).

Research suggested that personal growth from a mental illness was more likely in the presence of an individual who valued the patient, was non-judgmental, open, honest, and made the effort to understand the patient’s world, all aspects of patient centred care (Ruddick, 2010). The relationship individuals form with others, including mental health professionals, has been shown to be the most important factor in helping patients cope with a mental illness (Ruddick, 2010). Patient and family centred care within mental health has the potential to create a milieu that is built on valuing and including patients and families, which in turn empowers individuals (Morgan & Yoder, 2012; Ruddick, 2010). Empowerment encourages autonomy and self-confidence, two important factors for self-growth in vulnerable individuals (Morgan & Yoder, 2012).

The literature identified some barriers to patient and family centred care in mental health. Ruddick (2010) suggested that the tendency in mental health services to apply medical labels had
the potential to attract judgment, negative connotations and/or discrimination. Being genuine may also be difficult in mental health as care providers balance the demands of the client’s family, opinions of other professions and ethical codes of practice (Ruddick, 2010). Ruddick (2010) also suggested that empathy might also be challenging, especially when working under pressure or in non-supportive environments, as healthcare workers may become more self-centred rather than patient centred in an effort of self-preservation. The author further explained that developing self-awareness was pivotal in the process of becoming patient centred and required an ability to reflect on one’s values and beliefs that guided behavior (Ruddick, 2010).

Other research identified the physical and cultural health care environment as a barrier to patient and family centred care (Morgan & Yoder, 2012). Traditional health care settings were created based on systems of efficiency and architectural design, and organized around care providers rather than around patients (Morgan & Yoder, 2012).

O’Donovan (2007) also identified some issues of applying principles of patient and family centred care within the mental health setting. This author identified the behaviours typical of a mental health unit (i.e. strict enforcement of rules, lack of choice, and coercion by threatening discharge, transfer to a secure unit or removal of privileges) failed to equate to patient and family centred care (O’Donovan, 2007). Hopton (1997) agreed that health professionals’ obligation to fulfill the mental health act and the involuntary detention of individuals can inhibit the health professionals’ ability to be honest, transparent and engage in shared decision-making, all important aspects of patient centred care. However, Johansson and Lundman (2002) suggested that patient and family centred care has a place in involuntary care, since individuals and their families have the right to information and to participate in their care.
Livingston, Nijdam-Jones and Brink (2012) also found that patient centered care was possible to achieve in “settings that prioritize risk management” (p. 358).

**Transitioning towards patient and family centred care.** In order to bring about improvement in patient and family centred care and provide the optimal benefit for people with a mental illness, many authors considered the culture and leadership of the organization to be important (Cliff, 2012; Luxford, Safran & Delbanco, 2011; Sodomka, Spake, Rush, 2010; Sommerseth & Dysvik, 2008; Taylor and Rutherford, 2010). This cultural transformation as defined by Taylor and Rutherford (2010), was a means “to shape the views, perspectives, and behaviors of the individuals throughout their organization to achieve patient and family centered care” (p. 3).

Morgan and Yoder (2012) believed a culture that valued respect, empowerment, and choice for patients, families and staff was paramount and described the necessary elements to create a patient and family centered culture as: vision and commitment; organizational attitudes and behaviours; and, shared governance. Taylor and Rutherford (2010) applied Kouzes and Posner’s (2007) leadership framework of “model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart” (p. 3), to drive the cultural transformation towards patient and family centred care. Livingston, et al. (2012), found an important method for moving towards a patient centred approach was to evaluate “patients’ and providers’ perceptions, and understanding (of) the strengths and gaps in services from their perspectives” (p. 358).

**Culture and Change within Healthcare**

Culture matters because it is a powerful, latent, and often unconscious set of forces that determine both of our individual and collective behaviors, ways of perceiving, thought
patterns, and values. Organizational culture in particular matters because cultural elements determine strategy, goals, and modes of operating. (Schein, 1999, p. 14)

This inquiry examined how a culture of patient and family centred care could be fostered within the mental health program. To truly embrace patient and family centred care; there must be a cultural shift within the organization (Baas, 2012). A review of the literature provided the groundwork of culture and change within healthcare, and offered insights into the steps necessary to facilitate a culture shift towards patient and family centred care within the mental health program at PHC.

**Defining organizational culture.** Organizational culture is one of the most prevalent concepts in the fields of management and organizational theory (Ogbonna & Harris, 2000). The concept of organizational culture has a fairly recent origin with Pettigrew (1979) famed as the first to formally introduce the term organizational culture.

It is widely accepted in the academic literature that there is no singular, correct definition of culture (Bellot, 2011). That said, however, most recent research on culture cites Schein’s (1987) definition,

Organizational culture is the pattern of basic assumptions which a given group has invented, discovered or developed in learning to cope with its problems of external adaptation and internal integration, which have worked well enough to be considered valid, and therefore to be taught to new members as the correct way to perceive, think and feel in relation to those problems . . . it is the assumptions which lie behind values and which determine the behavior patterns and the visible artifacts such as architecture, office layout, dress codes, and so on. (p. 383)

Cameron and Quinn (2011) described the components of organizational culture as the implicit assumptions; the conscious contracts and norms or the rules and procedures that govern human interaction; the artefacts (i.e. the building, logos, mission statements); and explicit
behaviours of members of the culture (p. 19). Furthermore, Cameron and Quinn believed an organizational culture is reflected by what is valued, the dominant leadership styles, the language and symbols, the procedures and routines, and the definitions of success that make an organization unique (p. 22).

In terms of how culture is created, Schein (1990) believed culture is a learned behaviour, modeled by leaders that “permit group members to identify with them and internalize their values and assumptions” (p. 115). Schein (1990) further explained culture “perpetuates and reproduces itself through the socialization of new members entering the group” (p. 115).

Organizations, if large enough, will not only have an overarching culture, but also sub-cultures that develop within specialized groups and departments (Sovie, 1993). Sovie (1993) explained, “these sub-cultures also help to shape perceptions, attitudes and beliefs and influence how their members approach and execute their particular roles and responsibilities” (p. 69). When examining an organizational culture, it is important to take into account the sub-cultures of an organization.

Although the literature does not universally subscribe to one definition of organizational culture, Bellot’s (2011) review offered some consistency of thought on the major elements of organizational culture. Firstly, organizational culture exists. This statement is simple to declare, yet, important to acknowledge. Secondly, organizational cultures are inherently fuzzy in that they incorporate contradiction, paradoxes, ambiguities and confusion. This may be due to culture being “undetectable most of the time” (Cameron & Quinn, 1999, p. 19). The intangibilities and inconsistencies of culture lead to difficulty in conceptualizing the notion of culture. Thirdly, organizational culture is socially constructed, the product of groups not
individuals, and based on shared experiences. And lastly, “each organization’s culture is relatively unique, malleable, and subject to continual change (Bellot, 2011, p. 30). This topic of organizational culture change is explored in more detail below.

**Changing organizational culture.** Most research agreed that culture is developed over time and is in a state of constant change (Bellot, 2011). Cameron and Quinn (1999) theorized cultural change “involves multiple factors, is integrated with other types of change initiatives, and involves personal changes as well as organizational changes” (p. 17). In their model of organizational culture, Silvester, Anderson and Patterson (1999) suggested that culture changes when either individuals encounter new situations that challenge old assumptions, requiring them to formulate new beliefs; or individuals hear views or beliefs from other group members which help them to explain new situations. Thus, any change is “likely to be slow and will depend upon individuals being challenged by new situations and organizational events” (Silvester, et al., 1999, p. 19).

The literature offers inconclusive evidence on whether organizational culture can easily be changed. Some authors believed that changing organizational culture is possible, and suggested ways in which to do so. For example, Allen and Kraft (1987) identified eight key principles in ensuring successful organizational cultural change. These included: 1) involve people in the problems and programs that affect them; 2) use win-win, non-blaming approaches; 3) have clarity of goals, objectives, purposes, and tasks; 4) focus on results; 5) work from a sound information base; 6) be systematic, using multi-level change strategies 7) integrate concern for people and achievement; and 8) emphasis sustained culture change (p. 28). In a retrospective study, Allen and Allen (1987) found three factors, a sense of community, a positive
culture, and a shared vision to be important to the success of cultural change efforts. Cameron and Quinn (1999) strongly believed diagnosing and changing culture is a crucial factor in the long-term effectiveness of an organization and a neglect of culture may lead to failure of organizational change initiatives.

Fitzgerald (1988), on the other hand, suggested difficulty in intentionally changing organizational culture. The author stated “we can’t talk intelligently about changing cultures until we understand how to change underlying values and the people who reside in them” (p. 9). Fitzgerald further explained, “values, beliefs and principles are hard to change because of their verisimilitude” (p. 10), which requires more information on how the values themselves are structured. Ogbonna and Harris (2000) also acknowledged the difficulties with changing organizational culture and suggested a potential solution may involve focusing on leadership style.

**Leaders role in culture transformation.** Schein (1992) observed that organizational culture and leadership are intertwined. Bass and Avolio (1993) echoed this connection between culture and leadership by suggesting, “the culture affects leadership as much as leadership affects culture (p. 113). Bass and Avolio (1993) further stated leaders needed to be attentive to the “beliefs, values, assumptions, rites, and ceremonies embedded in the culture” (pp. 113-114) that can inhibit efforts of change within the organization. Schein (1993) stated,

The bottom line for leaders is that if they do not become conscious of the cultures in which they are embedded, those cultures will manage them. Cultural understanding is desirable for all of us, but it is essential to leaders if they are to lead. (Schein, 1993, p. 366)

In a changing organizational culture, the norms of interactions, the nature of roles, expectations, reward, and recognition systems may be altered, therefore, managers and staff need
to feel and see supportive behaviors from the senior leaders in the organization (Knox & Irving, 1997). Gilley, McMillan and Gilley (2009) found that specific leader behaviours, for example, the ability to motivate, communicate, and build teams, are predictors of successful implementation of organizational change. Bass and Avolio (1993) concurred with the role of leaders in cultural organizational change by suggesting the role of leaders is to modify key aspects of culture, when possible, in order to fit with new organizational directions. Ogbonna and Harris (2000) also agreed with the role of leadership within organizational change as they found organizational culture is “significantly influenced by the extent to which a leader is supportive of followers and includes followers in decision-making processes” (p. 783).

Schein’s (1990) work clearly defined the role of leaders in cultural transformation.

1. Leaders may unfreeze the present system by highlighting the threats to the organization if no change occurs, and at the same time, encourage the organization to believe that change is possible and desirable.
2. They may articulate a new direction and new set of assumptions, thus providing a clear and new role model.
3. Key positions in the organization may be filled with new incumbents who hold the new assumptions.
4. Leaders systematically may reward the adoption of new directions and punish adherence to the old direction.
5. Organization members may be seduced or coerced into adopting new behaviours that are more consistent with new assumptions.
6. Visible scandals may be created to discredit sacred cows, to explode myths that preserve dysfunctional tradition, and destroy symbolically the artefacts associated with them.
7. Leaders may create new emotionally charged rituals and develop new symbols and artefacts around the new assumptions to be embraced. (Schein, 1990, p. 117)

The literature establishes a clear link between organizational culture and leadership. The next section in this literature review will examine the significance of culture in the healthcare system.

**Significance of culture in healthcare.** Although most of the conceptual and
measurement work regarding organizational culture has been based on the traditional corporate structure, research has shown that it is adaptable to the healthcare sector (Bellot, 2011). Bellot believed the recognition and assessment of organizational culture is particularly valuable in health care, as it addresses the “therapeutic milieu thereby creating the potential to maximize service, quality, and outcomes for both healthcare providers and recipients of care” (p. 36).

According to Gregory, Harris, Armenakis and Shook (2009), the very nature of the healthcare delivery process requires empathy, compassion, and the development of nurturing relationships between caregivers and patients, therefore, the culture should support healthcare workers by reinforcing the values necessary to provide caring and compassionate patient care. Sovie (1993) also agreed that healthcare organizations should be particularly concerned with organizational culture because “the shared beliefs, values, and feelings that exist within an institution direct the perception of and the approach to the work that is to be done” (p. 72).

Sovie (1993) stated that it is a “major responsibility of each hospital’s leadership to create and maintain a culture that will enable the organization to execute its mission effectively and cope successfully with its environment, an environment besieged with change” (p. 69). Parmelli, Flodgren, Schaafsma, Baillie, Beyer, and Eccles (2011) affirmed, “the management of organizational culture is increasingly viewed as a necessary part of health system reform” (p. 2).

There is much debate in the literature as to whether organizational culture has an impact on healthcare performance. Parmelli, et al. (2011) identified an increased emphasis in the literature on the need to change organizational culture in order to pursue effective improvement of healthcare performance. However, a thorough literature review found no studies on the effectiveness of strategies to change organizational culture on healthcare performance (Parmelli,
et al., 2011). Scott, Mannion, Davies, and Marshall (2003) took a more cautious approach and concluded there is some evidence to suggest that organizational culture may be a relevant factor in health care performance, however, the relationship is difficult to prove.

Conversely, Mannion, Davies, and Marshall (2005) deduced from their research that organizational culture is associated with performance. Gregory et al. (2009) also found a positive relationship between group culture and patient satisfaction, providing empirical support for organizations that value teamwork, cohesion, and employee involvement, which will tend to outperform organizations that do not focus on these values. This research revealed culture influenced organizational effectiveness as measured by patient satisfaction; culture impacts employee attitudes as measured by employee satisfaction and physician satisfaction; and furthermore, employee attitudes had an influence on organizational outcomes such as expenses and patient satisfaction (Gregory, et al., 2009).

Chapter Summary

In summary, patient and family centred care is a multifaceted concept that shifts the focus from the clinician to the person for whom care is being delivered and encompasses all levels of care delivery, including planning, treatment, policy development, and philosophy. Research identified many benefits to patient and family centred care, and suggested a paradigm shift was needed within the mental health setting - a focus towards empowerment of individuals with mental illness, with the individuals taking a more active role in collaborating about their own care. The literature identified the physical and cultural environment of the mental health setting as a barrier to patient and family centred care in mental health. In order to bring about improvement in patient and family centred care and provide the optimal benefit for people with a
mental illness, many authors considered the culture and leadership of the organization to be important. However, the literature reviewed offers inconclusive evidence on whether organizational culture can easily be changed. The literature did establish a clear link between organizational culture and leadership, yet there was much debate in the literature as to whether organizational culture has an impact on healthcare performance.

In the next chapter, the inquiry approach, participants, methodology, and methods will be discussed. The action research process for this project along with the associated ethical considerations will be explained in full.
Chapter Three: Research Approach and Methodology

This section will review the approach, participants, methods and ethical considerations of the study. The main research question of this inquiry explores how a culture of patient and family centred care can be nurtured to meet the aspirations of stakeholders within the mental health program at PHC. The sub-questions include:

1. How do the patients, families, leaders and staff of the mental health program of PHC define patient and family centred care?

2. What are the current practices of patient and family centred care in the mental health program of PHC?

3. What is the vision the stakeholders of PHC’s mental health program have for an ideal culture of patient and family centred care within the mental health setting?

4. What support is needed to implement further practices of patient and family centred care within the mental health program of PHC?

5. What implications might these findings have for other mental health service organizations that are seeking to enhance their culture of patient and family centred care?

Inquiry Approach

The purpose of this action research study was to understand patient and family centred care within a mental health setting for the patients, families, staff, physicians and leaders at Providence Health Care. Action research was the approach taken as it is a collaborative problem solving approach between the researcher and the client with the intent to solve a problem and generate new knowledge (Coghlan & Brannick, 2010, p. 5). In action research, the researcher works through the cycles of observing, reflecting, and acting (Glesne, 2011). Reflection is the
activity which assimilates action and research (Coghlan & Brannick, 2010, p. 25).

Action research was a good fit for my topic of inquiry as this methodology is focused on the need to “understand the ways stakeholders perceive, interpret and respond” (Stringer, 2007, p. 19) to a culture of patient and family centred care within the mental health setting. By including the perspectives of key stakeholders as an integral part of the research process, I was able to collaboratively analyze the situation and provide understanding at a deep level that led to effective positive action in keeping with Stringer’s (2007) model of action research.

Action research is a framework that is grounded in qualitative research methods (Stringer, 2007, p. 19). Qualitative researchers often “seek to make sense of actions, narratives, and the ways in which they intersect” (Glesne, 2011, p. 1). I used qualitative methods: interviews; world café (Brown & Isaacs, 2005); and a focus group, to study patient and family centred care in the mental health setting with patients, families, staff, physicians and leaders directly. Data were derived from interviews with patients and families, a world café event with staff, physicians and operations leaders, followed by a focus group with senior leaders to provide additional information that “further clarifies or extends the understanding” (Stringer, 2007, p. 68) of patient and family centred care within the mental health setting.

An appreciative stance was used as the overarching framework of this action research inquiry to “develop an appreciative and participatory approach to research” (Schall, Ospina, Godsoe, & Dodge, 2004). This stance focused on “what already works within a system, rather than a focus on what is deficient” (Coghlan & Brannik, 2007, p. 47).

There are many advantages of using action research. Not only do research participants “acquire the individual capacity to engage in systematic research that they can apply to other
issues in other contexts, but they also build a supportive network of collaborative relationships” (Stringer, 2007, p. 21) providing them with ongoing support.

**Participants**

Action research seeks to engage all relevant stakeholders in the process of inquiry (Stringer, 2007). To effectively explore how a culture of patient and family centred care can be nurtured within the mental health program at PHC, it is important to include patients, families, staff, physicians and leaders within the mental health program at PHC.

**Interviews participants.** Participants for the interviews included patients and their families of the mental health program at PHC. An interview was selected to provide an environment for participants to safely discuss how they felt (Glesne, 2011, p. 123) about patient and family centred care within the mental health setting at PHC. Participants currently receiving services through four of the six sub-programs of the mental health program were recruited through their healthcare provider via a letter of invitation (see Appendix A). Two sub-programs of the mental health program were excluded, the Inner City Youth Program and Consultative Liaison Services. The Inner City Youth Program was excluded because this research focused on adults and the Consultative Liaison Service was excluded because this service was conducted in non-mental health, medical inpatient areas of PHC.

Seven interviews were conducted with patients and/or their families. To ensure a rich mix of individuals from a variety of different programs, a matrix sampling method was used. If both the patient and his/her family volunteered, they had the option of being interviewed together or separately. The exclusion criteria included patients less than 19 years of age, patients who do not speak English, patients who were deemed incompetent to give informed consent, and
previous patients I have treated, as I conducted the interviews. The interviews took place at PHC, at a time convenient for the participants. An honorarium of a ten-dollar Starbucks gift card was provided to the interview participants.

World cafe participants. Participants for the world café included staff, physicians, and operations leaders from the mental health program at PHC. The participant pool included 200 staff (nurses and allied health employees), 60 physicians (psychiatrists and internists) and three operations leaders. These numbers included full and part-time staff. All 263 individuals received an invitation to participate/consent form for the world café event (See Appendix B). To ensure a rich mix of individuals from each of the participant pools, and among the different mental health sub-programs, a matrix sampling method was used to choose up to twenty-eight participants from among those who volunteered. Individuals were pre-assigned table groupings for the world café event to ensure no participant was in a grouping with his/her direct reporting leader, creating a safe and respectful environment where all individuals felt comfortable to share their ideas and experiences.

The world café event took place during the week at a lunch hour to encourage the maximum availability of staff, physicians and operations leaders. A light lunch and refreshments was served.

Focus group participants. Participants invited for the focus group included the two senior leaders of the mental health program, and two leaders of the patient and family centred care strategic initiative at PHC, and eight leaders currently involved in the Providence Health Care, Care Experience Strategic Advisory Committee. These individuals were chosen by purposeful sampling as all had a known and demonstrated interest in patient and family centred
care initiatives within the mental health program at PHC (see letter of invitation/consent form in Appendix C). I facilitated the focus group and the discussions were recorded electronically. None of the participants were direct reports or direct leaders of each other or me. The focus group was held at a mutually agreed upon time to ensure maximum participation.

**Inquiry team members.** Members of the inquiry team included the Director of Research of the PHC Eating Disorder Program and a fellow learner from my Royal Roads University (RRU) cohort. I also received assistance from a transcriptionist and three change specialists from the Change Initiatives department at PHC. The inquiry team assisted me in pilot testing my research questions, tools, procedures, and recording approaches. The inquiry team also assisted with data analysis to optimize validity and minimize the potential of personal bias. The change specialists facilitated the discussions at the tables of the world café event performing as table hosts and data recorders. Members of the inquiry team assisted with set up of the world café and acted as observers at the event recording data that may not be captured by the table hosts. Neither the inquiry team members nor the change specialists had staff reporting to them or reported to leaders who were invited to the world café event. The transcriptionist transcribed the information that was audiotaped during the interviews and focus group. The transcriptionist and change specialists signed a confidentiality agreement (Appendix D). Both members of the inquiry team also signed a letter of agreement outlining confidentiality, responsibilities, and expectations (Appendix E).

**Inquiry Methods**

The inquiry methods are divided into three subsections: data collection tools, study conduct and data analysis. The data collection tools portion provides a general overview of the
three research methods chosen: interview, world café and focus group. The study conduct portion provides more detail on the research methods, and the final subsection describes the data analysis process for this inquiry.

**Data collection tools.** The data gathering tools used for this inquiry were: interviews with patients and/or their families; a world café large group method with staff, physicians and operations leaders; and a leadership focus group.

**Interviews.** Interviews were conducted with patients and/or their families of the mental health program at PHC. Interviews enabled participants to reflect on their experiences and “provides opportunities for participants to describe the situation in their own terms” (Stringer, 2007, p. 69). An interview allowed a safe environment for patients and/or their families to provide reflections, experiences, and their thoughts of an ideal vision of patient and family centred care. An outline of the questions used in the interviews is described in Appendix F. These questions were piloted using my inquiry team. The inquiry team also piloted the procedures, recording equipment, and protocols for the interview, as listed in the interview protocol (Appendix F).

**World café.** The world café was chosen for this inquiry, as it is “a simple yet powerful conversational process for fostering constructive dialogue, accessing collective intelligence and creating innovative possibilities for action” (Brown & Isaacs, 2005, p. 3). The world café enables access to collaborative intelligence and strengthens organizational relationships (p. 3), both important aspects of exploring how a culture of patient and family centred care can be nurtured within the mental health program at PHC.
The questions used in the world café are described in Appendix G. These questions were piloted using my inquiry team. A pilot study is useful in clarifying the research questions and to “test the language and substance of the questions . . . and whether new research questions arise” (Glesne, 2011, p. 56). Brown and Isaacs (2005) identified “the importance of carefully crafted questions for breakthrough thinking and effective action” (p. 90), and suggested a few practice sessions will greatly enhance one’s “ability to engage in conversational inquiry stimulated by dynamic questions” (p. 92). The inquiry team also piloted the procedures and protocols for the world café event, as listed in the world café protocol (see Appendix G).

**Focus group.** A leadership focus group was held to obtain a leadership perspective of patient and family centred care within the mental health setting. A focus group is a form of qualitative research that is conducted in a group interview format, however, instead of the usual exchange of questions and answers between the researcher and the individuals that one would commonly envision in an interview setting, the researcher ensures that specific topics of research interest are discussed by the entire group in hopes of extracting data and discussion that might otherwise be withheld in the traditional researcher-interviewee environment (Grumbein & Lowe, 2010). A focus group and not individual interviews was chosen for this action research study to encourage rich dialogue among the participants that may not otherwise have occurred in a one on one interview. The focus group was used to complement a mixed-method study (Schwandt, 2007) and triangulate the data (Stringer, 2007), as similar questions used in the world café were used in the focus group. In focus groups it is important to have thoughtfully prepared questions, with special attention paid to phrasing and sequencing of the questions (Schwandt, 2007). These
questions and the layout of the focus group were piloted using the inquiry team. The protocol and questions for the focus group are outlined in Appendix H.

**Study conduct.** The procedures for conducting this research are discussed in the following section and include: recruiting and orientating the inquiry team; recruiting and securing informed consent of participants; pilot testing and conducting the research methods; and performing the ‘hand-off’ session back to organization.

**Recruiting and orientating the inquiry team.** Potential inquiry team members were approached in the first stage of the study conduct. I recruited the Director of Research of the PHC Eating Disorder Program and a fellow learner from my RRU cohort. Both individuals did not have power over any of the participants. Upon agreeing to participate as an inquiry team member, I familiarized them with the research questions, background, and other roles. I also answered any questions they had, after which they signed a letter of agreement outlining confidentiality, responsibilities, and expectations (Appendix E).

**Recruiting and orientating the world café table hosts.** The world café table hosts were recruited through the Change Initiatives Program at PHC. I recruited three change specialists with experience in running a world café event. These individuals did not have power over any of the participants. Upon agreeing to participate as a world café table host, I orientated them to the table questions, background, and other roles. I also answered any questions they had, after which they signed a confidentiality agreement (Appendix D).

**Recruiting and securing informed consent of interview participants.** Participants currently receiving inpatient or outpatient services in the mental health program at PHC were eligible to receive a research letter of invitation (Appendix A) from their health care clinician.
Four sub-programs of the mental health program (Mental Health Wellness Outpatient Clinic; Provincial Adult Tertiary Eating Disorders Program; Complex Pain Program; and the Inpatient Treatment Units) were requested to recruit three patients each. The clinician asked if the patient would be interested in providing information about their experience of their care at PHC. If the patient agreed, the clinician gave the research letter of invitation (Appendix A) to the patient and asked for permission to provide the patients contact information to me, the research coordinator. The patients were informed that agreeing or not agreeing to participate in this research would not have any effect on future treatment. The exclusion criteria included patients who did not speak English, patients less than 19 years of age, patients who were deemed incompetent to give informed consent, and previous patients I had treated, as I conducted the interviews. The patient was asked if their family members would like to be included in providing important information about the patient and family care experience. The consent form (Appendix I) included space for the participants to fill out their contact information if they wished to participate. Individuals, who accepted the terms of participation and agreed to be part of the study, signed the informed consent form (see Appendix I). The consent form was signed and sent back to me, or brought to the interview session. I had blank copies of the consent form at the interview session in case the interviewees did not bring the form with them.

**Pilot testing and conducting the interviews.** The interviews were pilot tested with the members of my inquiry team. I hosted a mock interview to test the recording equipment, timing, and process. The goal of the mock interview was to obtain feedback and make improvements on the process (see appendix F for the interview protocol and questions).
I confirmed I had a signed consent form prior to the interview commencing. The interview was held at PHC. The interview process was explained including the use of a recording device (see Appendix F). They were advised that the recording device could be turned off momentarily if they need to edit a comment. The interviews lasted 30-45 minutes each. At the end of the interview, the participants was thanked and reminded that they would receive a copy of the interview transcript to review for accuracy and completeness. The participants were then asked to provide any edits to their transcript to confirm accuracy. An external transcriptionist, who signed the confidentiality agreement (see Appendix D), transcribed the data. I disclosed to the interviewees what would be done with the information gathered.

**Recruiting and securing informed consent of world café participants.** All staff, physicians and operations leaders from the mental health program at PHC were invited via email to the world café. The participants were invited through a research letter of information/consent form explaining the purpose of the study, how the information would be collected, confidentiality, security of the data, and how the results would be disseminated (see Appendix B). Individuals who volunteered to participate in the world café were chosen by a matrix sampling technique to ensure a rich mix of individuals from each of the participant pools, and among the different mental health sub-programs. These selected individuals, after accepting the terms of participation and agreeing to be part of the world café, signed the informed consent form (see Appendix B). The consent form was either signed and sent back to me, or brought to the world café. I had blank copies of the consent form at the world café event in case any of the participants did not bring the form with them.
Pilot testing and conducting the world cafe. The world cafe procedures and questions (Appendix G) were piloted by the inquiry team and change specialists. This included a mock run through of the world cafe event to test the procedures and timing and make improvements to the process.

The event was held in a location within PHC but separate from the regular work location of the participants to protect the confidentiality of those who volunteered to participate. Food, drink, tablecloths, paper, writing utensils, music and flowers were provided to simulate the cafe ambience. The world cafe event lasted 90 minutes.

At the beginning of the world cafe, participants were provided signed consent forms to the facilitator (see Appendix B). Participants were advised that their names would not be used in any documents either summarizing information or in the final report, and that all quotes would be anonymous unless the participant asks to have their name associated with the quote. As this was a large group method, participants were advised of the requirement to agree to keep confidential any information shared by participants and the identity of those participants from those who were not part of the world cafe. Finally, I reminded participants of the purpose of the research, where and how long the information would be kept, as well as how and when the information would be destroyed, all of which was provided in their letter of invitation (see Appendix B). A detailed outline of the world cafe protocol is outlined in appendix G.

Data from the world cafe was transcribed from the information recorded on flip charts by the table hosts, from the audio recording of the report out discussion, and from the information recorded by the observer. Participants received a copy of the world cafe transcript to review for accuracy and completeness. The participants were asked to provide any additions to their
transcript to confirm completeness. I disclosed to the participants how the information gathered was going to be used.

**Recruiting and securing informed consent of focus group participants.** The third research method of this inquiry was a leadership focus group. The participants for the focus group were emailed an invitation through a research letter of information/consent form explaining the purpose of the study, how the information would be collected, confidentiality and security of the data, and how the results would be disseminated (see Appendix C). A written informed consent was obtained as part of the enrolment process (see Appendix C). Consent forms were provided to participants along with their invitations, and at the start of the focus group in the event that the participants forgot to bring their signed consent forms.

**Finalization of questions, pilot testing and conducting the focus group.** The purpose of the focus group was to obtain a leadership perspective of patient and family centred care within the mental health setting. The focus group was pilot tested with the research inquiry team to thoughtfully review the questions, including the phrasing and sequencing of the questions, and to limit any biases and assumptions. I hosted a mock focus group to test the recording equipment, timing, and process. The goal of the mock focus group was to obtain feedback and make improvements on the process (see Appendix H for the focus group protocol and questions).

I confirmed I had a signed consent forms from all participants prior to the focus group commencing. The focus group was held at PHC but in an area away from the mental health program to ensure confidentiality. I offered cookies and refreshments to the participants to create a welcoming atmosphere. The focus group process was explained including the use of a recording device (see Appendix H). The focus group lasted 60 minutes (state actual time).
Data from the focus group were transcribed from the information recorded electronically. An external transcriptionist, who signed a confidentiality agreement (see Appendix D), transcribed the electronic data. Participants received a copy of the focus group transcript to review for accuracy and completeness. The participants were asked to provide any additions to their transcript to confirm completeness. I disclosed to the participants how the information gathered would be used.

Conducting the ‘hand-off’ session back to organization. A meeting was arranged with the PHC senior leadership team with the support of my organizational sponsor. The senior leadership team included the chief executive officer and vice presidents at PHC. The purpose of this meeting was to discuss the results and recommendations generated by this research on ways to further nurture a culture of patient and family centred care in the mental health program at PHC. This meeting also provided the opportunity to discuss the commitment of organizational leaders responsible for the follow up action.

Data analysis. Data analysis is the process of “distilling large quantities of information to uncover significant features and elements that are embedded in the data” (Stringer, 2007, p. 95). In all research methods chosen for this inquiry, data were analyzed by categorizing and coding (Stringer, 2007, p. 98). Procedures for categorizing and coding involve: reviewing the collected data; unitizing the data; categorizing and coding; identifying themes; organizing a category system; developing a report framework (Stringer, 2007, p. 99). As with all research techniques, it was important to ensure the research was trustworthy, authentic, valid and reliable.

To uphold trustworthiness, it was necessary to be transparent throughout this research process and to design the methods and questions in consultation with my inquiry research team.
to limit any biases and assumptions. To further ensure the research was credible and trustworthy it was necessary to take the time to reflect via journal writing and conversations with my inquiry team to, “look inside and gain awareness of the origins of... reactions” (Short, 1998, p. 83).

To promote authenticity, it was important to be: attentive to the data; intelligent in inquiry; reasonable in making judgments; and, responsible in making decisions and taking action (Coghlan & Brannick, 2010, p. 23). I took great care to create a safe environment for all participants to feel comfortable to share their ideas. This was done through thoughtful sampling procedures and by conducting the sessions in a curious, non-assuming stance in which the participants were seen as having expert knowledge in order to maximize the authenticity of the data generated from the sessions.

The technique of member checking was used to ensure validity, in which participants were given the opportunity to review the raw data, analyses, and reports resulting from the research (Stringer, 2007, p. 58). After the interview, the session was transcribed verbatim. This transcription was provided to the interviewee to review and provide any additional comments or clarification. At the end of the world café there was a report out by participants. This allowed an opportunity for participants to voice in their own words the key findings for each question as well as allow for additional input by participants. In addition, the data were summarized by question and was provided to the participants electronically in an effort to further validate the information. This offered participants an opportunity to provide any final comments or thoughts on the questions. After the focus group was complete, it was transcribed verbatim. Themes were extrapolated and documented based on an analysis of this verbatim transcript.
Data were triangulated using four methods of information gathered through the literature review, interviews, the world café, and the focus group. Using triangulation in tandem with journaling and the verbatim principle minimizes the possibility of researcher inaccuracy in interpreting the data. The verbatim principle also ensured participant perceptions were accurately captured, thereby enhancing the validity and reliability of the data (Glesne, 2011).

And finally, to ensure reliability, it was important to clearly identify the steps taken in this research inquiry, as “the results should be replicable by any person similarly placed” (Stringer, 2007, p. 192).

**Ethical Issues**

This research inquiry was reviewed and approved by the RRU and PHC Research Ethics Review Boards. As a researcher, I had the responsibility and accountability to ensure I conducted this research ethically to protect the physical, social, and emotional welfare of participants involved in this research project. In Canada, the *Tri-Council Policy Statement* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada [CIHR], 2010) stated that “respect for human dignity requires that research involving humans be conducted in a manner that is sensitive to the inherent worth of all human beings and the respect and consideration that they are due” (p. 8). In this policy, respect for human dignity is expressed through three core principles: Respect for Persons, Concern for Welfare, and Justice (CIHR, 2010).

**Respect for persons.** The principle of respect for persons recognizes the intrinsic value of human beings and the respect and consideration that they are due (CIHR, 2010). The essence
of this principle is that it is unacceptable to treat individuals solely as means to an end (CIHR, 2010). Respect for persons means respecting every individual's ability to give or refuse their consent to participate. Individuals who participated in this research study did so voluntarily, free of coercion or pressure to consent. If a prospective participant decided against participating or chooses to withdraw from this study, their decision was respected. An invitation clearly outlined any foreseeable risk and potential benefits of this inquiry, and explicitly stated that individuals were not required to participate in this research project. Sending the invitation and consent form well before the event allowed for the opportunity of potential participants to ask questions or seek clarification about the study, and allowed sufficient time to consider whether or not to attend. The plan was that participants were to be informed of any new information that may arise that affected the participants in this study. If the new information affected whether they wished to participate, the participants was asked whether or not they wished to continue in the study. No such information arose. Participants were also informed that once consent was given, it could also be withdrawn. Due to the large group nature of the two of the data collection methods being used, it was not possible to guarantee that any comments made by those who choose to remove themselves from the research before its conclusion could be removed from the records. No such requests to be removed from the study were received from any of the participants.

**Concern for welfare.** The principle of concern for welfare recognizes that research participation can affect the welfare of an individual or group in many ways (CIHR, 2010). Respecting the principle of concern for welfare means doing your best to ensure that participants are not exposed to unnecessary risks. Within this research inquiry, it was important to consider
the privacy and confidentiality of personal information. During and after data analysis any personal information obtained from participants was stored securely. Data in paper form was kept in a locked cabinet not accessible to anyone outside the study. Data in digital form was password protected. I took great care to create a save environment for all participants to feel comfortable to share their ideas. This was done through thoughtful sampling procedures to ensure no participants, facilitators or observers were in a reporting relationship to one another and that no patients and family members were in the same session with those professionals who provided services to them.

**Justice.** The principle of justice refers to the obligation to treat all people fairly and equitably (CIHR, 2010). I maximized respect for justice and inclusiveness by inviting all staff, physicians, and operations leaders within the mental health program at PHC for the world café event, and all senior leaders who had a known and demonstrated interest in patient and family centred care initiatives within the mental health program at PHC were invited to the focus group. Health professionals recruited patients and families. This minimized any neglect or discrimination against individuals whose opinions may have differed from my own.

**Chapter Summary**

Overall, the inquiry approach, participants, and methodology to institute this action research project were discussed in this chapter. An inclusive, yet diverse process of participant recruitment was chosen as patients, families, staff, physicians and leaders of the mental health program were invited to take part in this research study. The inquiry methods included individual interviews, a world café event, and a focus group. This chapter concluded with a discussion on the ethical issues; respect for persons, concern for welfare, and justice.
In the next chapter, the findings of the data collection will be discussed in detail. The researcher analysis will be enhanced by quotations of the participants from the interviews, world café, and focus group. Conclusions drawn from the data analysis and also supported by literature on ways to build on a culture of patient and family centred care within the mental health program will be highlighted.
Chapter Four: Findings and Discussion

This research was conducted with patients, families, staff, physicians and leaders within the mental health program at PHC. The research question was as follows: How can a culture of patient and family centred care be nurtured that meets the aspirations of stakeholders within the mental health program at PHC? The sub-questions included:

1. How do the patients, families, leaders and staff of the mental health program of PHC define patient and family centred care?
2. What are the current practices of patient and family centred care in the mental health program of PHC?
3. What is the vision the stakeholders of PHC’s mental health program have for an ideal culture of patient and family centred care within the mental health setting?
4. What support is needed to implement further practices of patient and family centred care within the mental health program of PHC?
5. What implications might these findings have for other mental health service organizations that are seeking to enhance their culture of patient and family centred care?

Findings

The following is a summation of the data collected from seven interviews with patients and/or family, a world café event with staff and physicians, and a focus group with leaders.

Response rates. Seven interviews were conducted with patients and/or their family. Of the seven interviews, only one patient chose to be interviewed with a family member. The gender composition of the interviews was mostly female (86%) with only one male (14%)
participating. Two interviewees (29%) were from the Chronic Pain Program, three (42%) from the Eating Disorder Program, and two (29%) from inpatient psychiatry.

Invitations for the world café event were sent out to 263 staff, physicians and operations leaders of the mental health program. Of those, 18 participants (7%) agreed to participate. Seventeen participants came to the event as one participant sent regrets due to illness. Of the 17 individuals who attended the world café event, 41% were nurses, 35% were allied health employees (psychologists, dietitians, social workers, case managers), 12% were psychiatrists/internists, and the remaining 12% were operations leaders. Female participants made up the majority with 82%.

For the focus group, 12 letters of invitation were sent out. Of those, six leaders agreed to participate in the focus group, for a 50% response rate. One participant could not attend due to unforeseen circumstances. Of the five leaders who participated, two were senior leaders from the mental health program and three were leaders from various departments of PHC. All participants were female.

In the reporting of findings below, quotations from the interview participants in this research project were coded as I-1, I-2, I-3, I-4, I-5, I-6, and I-7. The world café participants were coded as WC and the focus groups participants were coded as FG. Throughout this thesis all participants will be addressed by this coding system to protect anonymity.

**Thematic analysis.** A thematic analysis was preformed on all the research data, including patient and family interviews, a world café event with staff, and a leadership focus group. As stated by Glesne (2011), thematic analysis involves “coding and segregating data for further analysis and description” (p. 184). Five main themes were discovered: (1) infrastructure
and superstructure – a systems perspective; (2) philosophy; (3) clinician’s approach; (4) ethical considerations; and, (5) fitting the hospital experience into the patient’s broader life. Various sub-themes were defined and highlights included: environmental design; culture; transparency and communication; respecting patient’s rights and preferences; certification and involuntary admissions; and, involve the community as a whole. Each of the main themes and their associated sub-themes will be presented in this chapter along with the supporting evidence from the data that led to their identification.

**Theme one: Infrastructure and superstructure – a systems perspective.** From a systems perspective, the infrastructure (organizational structure) and superstructure (physical structure), of the organization in relation to patient and family centred care was a theme that triangulated across all three methods of data collection. This main theme was divided into three sub-themes: organizational/leadership role; environmental design; and, culture.

**Organizational/leadership role.** The participants identified the importance of clarity regarding the organization’s stance on patient and family centred care not only in mental health, but also throughout the organization. A participant from the world café event clearly articulated,

> From a global perspective, I think, ‘what's the organization's stance on [patient and family centred care] mental health?’ . . . part of it is how you roll it out organizationally. . . There should be a focus on a plan in terms of what does patient and family-centered care look like as an organization? Where are the areas of focus? (WC)

The analysis also revealed a role for leaders in patient and family centered care. One leader from the focus group expressed,

> If we in the leadership positions started to actually do rather than talk about family centered care and actually had a very strong definition and what that is? I think we will see a lot of changes. It has to happen on every level. . . you have to have the right people
at the right spot who embrace and engage it, and talk about it and live it, and breathe it, and it's just the way of doing business. (FG)

Participants also suggested having “concrete and reliable measures . . . How do we actually objectively measure whether or not we are moving towards this ideal of more patient-centered care?” (WC)

_Environmental design._ Participants recommended a physical space that supported a warm, welcoming, private, less institutional, and more homelike environment. One interviewee described, “It is really small in there . . . It's really confined . . . There were no windows . . . We need space. We need light. It felt like jail.” (I-3).

Participants identified the importance of designing space from a patient and family perspective and of having patients and their families involved in the environmental design. As one participant stated,

> From looking at it, at the balcony level, from a system’s perspective, I think that there are things that we can do that are patient and family centered to design and develop programs and services for mental health . . . take patients who are well, who have experienced illness, who have experienced the system, who can engage with us. (FG)

Participants also suggested incorporating technology into the environmental design, “being able to better reach those folks who can't necessarily come to us. We need to go to them. Multiple modalities of delivery of information i.e. Internet and Skype and all those other things that can make it a lot easier to connect these days.” (WC)

_Culture._ The culture of patient and family centred care within the organization was identified as important. One leader in the focus group described her vision of patient and family centred care as,
I think a lot of it has to do with just changing our culture of belief around [patient and family centred care], and really permeating it through . . . I live in anticipation of a day where people bring a meeting together and their first thought is, ‘Is a patient and family here?’ . . . For me that ideal state has a lot to do with the culture. (FG)

Participants in the world cafe also suggested that in order to change the culture and behaviours, there needed to be staff engagement,

Unless you get buy-in from the staff on what patient and family-centered care really is and how to provide that, I don't think you're going to be able to change too much because people get stuck in their own ways of practicing. (WC)

Balancing the needs of the patient and the caregiver came across as an important aspect of patient and family centred care. One participant explained, “when we talk about patient centered care, it's always having that focus of thinking about not your needs first but the patient's and yes we have needs as caregivers but we have to balance those with the needs of the patient” (FG). On the other hand, when examining balance of the needs of the patient, it was also suggested to keep in mind the needs of the clinicians and increasing staff morale, captured by the following statement: “Happy employees will be most productive and be motivated to provide best care” (WC).

In summary, theme one revealed the significance of the physical and organizational structure of PHC. Participants recommended a physical space that supported a warm, welcoming, private, less institutional, and more homelike environment and including patients and their families in the environmental design. In terms of the organizational structure, there was an identified need for clarity regarding the organization’s stance on patient and family centred care, a role for leaders to model patient and family centred care, and a suggestion for concrete and reliable measures to objectively evaluate steps taken. The culture of patient and family centred care within the organization was also identified as important, balancing both the
needs of the patient and clinician. Theme two addresses the overarching philosophy of patient and family centred care within the mental health setting.

**Theme two: Philosophy.** The participants’ data demonstrated the philosophy of patient and family centred care within the mental health setting was a well-discussed topic. This discussion included the following sub-themes: articulating a clear definition; inclusiveness; transparency and communication; and, reducing social stigma.

**Articulating a clear definition.** It was suggested that patient and family centred care means different things to different people. As one participant stated,

Some people are fully engaged and fully on board with that [patient and family centred care] concept and it works really well but there is still a couple of people at the table that are like, ‘I'm actually really uncomfortable with this’. So, because we don't have that common definition or understanding or knowledge of how it could work - we are not there yet. (FG)

The data suggested that having a common understanding or definition of patient and family centred care was important. As one participant explained,

From the systems perspective and for the providers of health care service it would be cool if we had some common understanding of what it [patient and family centred care] is and what that means and how to integrate it into how we design and develop programs and systems and clinical care. But because it's so inconsistent, sometimes we are on different pages because we don't have that common definition or understanding or knowledge of how it could work. (FG)

In terms of a definition of patient and family centred care, the most frequently cited component identified was placing the patient at the centre of care. One participant described her view as,

I have a mental picture of it [patient and family centred care] that the patient is the most inner circle and then the family is the next circle. . . . what patient-centered care means to me is that they're making it as personal and as relevant to you as possible. (I-4)
Another important component of a definition of patient and family centered care cited was the idea of treating the person as a whole. One interviewee explained,

I feel like it's a little bit self-explanatory. It allows each person to address their own struggles, and it emphasizes the fact that we're all individuals and we have our own strengths and our own things we need to work on, but that we also exist in this system, in a community, a family, or society. (I-7)

Including patients and families as part of team and “acknowledging each person's experience and level of expertise and knowledge” (FG) was another important notion identified. One participant stated, “From a patient/family perspective remember that we have expertise as well – we are able to present alternative options which will result in fewer consequences” (WC).

Participants agreed on using a broad definition to describe “family” and that the patient should identify who constitutes his or her family. One participant explained, “Obviously, even who your family is means different things for different people” (FG). It was also identified that the practice of having an all-encompassing definition of “family” and having the patient determine who is identified as family was orchestrated well at PHC (WC).

In summary, the prominent components of the definition of patient and family centered care were: to have a clear, consistent definition; include placing the patient at the centre of care; treating the patient as a whole, within a community; and, including the family as identified by the patient. One WC participant summarized these concepts well, and defined patient and family centered care as,

Health care professionals set the patient and his/her family at the centre of the care they provide. Families do not have to be related to the patient and are identified by the patient. Patients and families are a central part of a patient's treatment and the treatment is based on stated goals, hopes, and wishes of a patient and his/her family. Health care professionals provide information/options that are available to patients and families based on unbiased information/evidence that will best assist patients/families to make decisions for and about themselves. (WC)
**Inclusiveness.** Participants in all three methods of data collection identified the importance of having a philosophy of inclusiveness - including the current healthcare team, the patient and family, and community care providers. It was clear that including all health professionals, including the community care providers, as part of the team was an important aspect of patient and family centred care. Participant I-1 positively described an example,

> They had a huge team of people come in for my discharge, and everybody was on the same page in the community . . . everybody was brought in . . . my OT in the community and whatnot. Everybody got really detailed discharge summaries . . . My OT just kind of knew exactly what to do. Had that not have happened, it probably would've been a completely different situation. (I-1)

The value of a non-hierarchical team was discussed as an important philosophy of patient and family centred care. One participant summarized,

> An item that came up as well across the board was around hierarchy and using of titles. In looking at it from a team perspective versus trying to have the doctor, the nurse, allied health, dietitians, everybody being part of a team rather than the team looking at the doctor to make the final decision or to be able to say what will happen in terms of the care. (WC)

Similarly, one interviewee captured the desire for this inclusive approach and stated,

> There's the psychiatrist and then psychologist or whatever, I don't know. Somebody that works underneath them. The person that works underneath them is more interested or works more with you, but the person that's actually making the big decisions for you, really has little to no contact with you. You're feeling is that, the person who makes the big decisions has the littlest time with you, I guess, or knows you the least. (I-1)

> There was also overwhelming support to include the patient as part of the team. One participant positively reported,

> I really felt that I was part of the team- not the object of the team. . . . I became an asset to the team . . . here I feel that they welcome it [my experience] and they want that personal expertise that you bring and only you can bring. (I-4)
It was also clear that including the family as part of the care team was extremely important. As one participant explained, “Impact of Mental Health issues is on whole family – prognosis impacted by family dynamics” (WC). Furthermore, I-4 described, 

There's been so much literature produced and written that one of the most important predictors of a person's recovery from mental illness is the kind of support team they have around them. My having a really inclusive family-centred care, they're part of that support team and they're being educated and they're being able to be given tasks and especially if there was the odd follow up call with the discussion . . . so they could actually see how the progress was happening, and that what was going on was really movement. (I-4)

From the perspective of a family member, I-2 stated, “If she didn't have me here, she'd probably be down and out. I think family is very important to be around . . . family is so important in a time like this. You're away from your family, your friends”.

Some participants discussed the challenges of involving family, especially when the family is from out-of-town.

For someone being out of town, I wish there was more access for family to come support you in process, if my kids could visit . . . I'm doing family therapy and a lot of the therapy is in terms of my family and it would be nice to do one-on-one sessions with them. Right now, my husband and I are doing it over the phone. It's good, of course but it's not the same. You don't get to see that body language. Then that is another thing I think would be really great – Facetime. (I-3)

It appeared that not only including family as part of the care team was important, but also having the philosophy of valuing the family. I-5 explained, 

With this treatment I also learned the value of family . . . They are people who are supportive and they really love me . . . By knowing that, I feel like I'm not alone. That gave me opportunity to change my attitude and by changing my attitude helped me a lot to overcome this mental problem. (I-5)

Many ideas were suggested on ways to include the patient and his/her family into the team. Participants from the world café event suggested patient and family involvement at all
levels of care. For example, having patients and family involved in rounds and team meetings, writing their own treatment goals, having access to their clinical information and documentation, involving family in the certification process, and providing expertise and input into program planning and development (WC) were all mentioned.

Participants also described ways that including the family could become standard practice. One participant explained,

we were talking about processes or protocols . . . definitely involving the family should be part . . . if there is something on the collaborative care plan that says, family involvement . . . there should be some kind of protocol where it's part of the patient's record that family has been contacted or family was not contacted for these reasons . . . that we are talking to the patient about their families and how they want their families involved. We were attempting to make the connection, so whether the family chooses to be involved or not at least we have done our due diligence in a sense that we tried to involved them, and [the patient] chose or not these people to be involved but they want these people to be involved, . . . we have done that and acknowledged them, had that conversation. (FG)

Conversely, the data revealed a lot of discussion about how to include or not include family or friends who may not be supportive. As one participant stated,

Or at the same time that designated family member is, be it a friend . . . isn't the best person because he isn't the safest person to be around for multiple different reasons . . . with the patient population that we have here at St. Paul’s . . . there are all kinds of examples of that, where I may identify my family members being my crystal meth dealer, and that's the person I like the most in the world but what he wants from my care and what's really [helpful]... you know what I am getting at. (FG)

Another participant described the complicated issue of whether or not to involve a family member in the patient’s care. “If family is part of [the source of the] harm [we] need to ensure that they are not being a part of care planning- however if patient is returning to [the home] environment [we] need to balance how to involve these family members in the plan”. (WC).
Furthermore, there may be individuals who do not have anyone they can include as family/friends. As one participant explained,

There is a percentage of the population... that’s incredibly vulnerable... doesn't really have a family per se, or they don't identify as having a family, nor do they identify with having a vast and robust social network that they would consider to be their family. It's probably true of all patient populations, not just mental health, but... If you don't have anybody to ask and they don't identify with having a network, family centered care looks a little bit different. Patient centered I don't think does, but, who do you reach out to? (FG)

Many participants suggested education and support for family. As one participant explained, “Maybe some more support for loved ones, so they can understand or they can get that support themselves... I think that does in turn help the person” (I-1). World café participants suggested the idea of a designated team of resources to be with and support families through the entire journey: “Making sure that we actually have dedicated individuals or folks from teams that actually are there to support patients and families” (WC). Another suggestion included,

some kind of formalized system of education and information giving for families on a regular basis... about the Mental Health Act, certification, medications, crisis management plans, resources in the community, support... like a regular group and it be run by consumers, families with the aid of people maybe from different departments in different areas in mental health. (WC)

_Transparency and communication_. According to the data, transparency and communication were values identified by many participants. Transparency was discussed in regards to easier access to clinical information and documentation as well as a feeling of safety for the patient and family when there was an opportunity for open and frank dialogue (WC).

Communication was a well-discussed topic. “Just to have everybody on the same page and be consistent with me too, it's like... I take comfort in that. I don't have to educate
everybody” (I-1). Likewise, I-7 suggested more transparency in regards to communication but also had cautions to offer about this transparency, stating

I think a little bit more transparency in terms of . . . the communication among program staff is really good, almost too good. It's uncomfortable how you'll tell one-person one thing and the next day someone else will refer to it. At any given time we don't really know who knows what, so I think a little bit more transparency in terms of what's being reported in handover. Not every day or anything, just a general update of ‘This is what we know’. (I-7)

Many participants mentioned the importance of including the patient in the discussions. A participant in the world café event summarized this concept as follows,

The one that came up most often was from a patient's perspective wanting to be part of that conversation, but being part of that conversation means more than just getting the information. It's more of a two-way street where that patient can also provide their perspective on what they're feeling, what their understanding is of the information that's being relayed back to them. (WC)

Not only was it found important to include the patient in the discussions, but also the family. One participant stated,

It's also the family members being involved in the conversation and saying what the patient needs. Not in all cases could the patient provide their perspective or their needs in order to be most comfortable. That's where the family members would really be able to add value, so including them in all dialogue that happens. Dialogue, not just around the actual care delivery, but education around what is being done, what the discharge would look like, and when that patient goes home, what does the home environment need to look like for that patient to be successful in their discharge? (WC)

The listening skills of the healthcare provider were discussed as important. One participant in the leadership focus group explained, “It was about the communication. I was listening to the wife and to the husband as well and tried to make it work for him. So what was it that she needed at the time and what was it he needed at the time.” (FG) I-6 agreed with the importance of listening, “She listens to my concerns or fears or desires. She's open to discuss that.” When asked what constitutes good care, one participant responded,
I think for me, it's the communication. Being able to understand what's going on and who’s going to be doing it. Why it's being done and what's the outcome of it? So it's always that communication component. Talking with me, not at me, even if it's blood test, both engaging in conversation. (FG)

Another participant described a situation where she didn’t feel heard, “He didn't explain it really well, as well as I wanted him to explain. . . But I kept bugging and bugging and bugging until it was heard.” (I-2)

Participants in the world café suggested approaches for facilitating difficult conversations. Three main strategies were discussed: having a clear rationale; using negotiation; and empowering the patient. With difficult situations, it was suggested to provide a clear rationale as to why certain services or treatments are provided (WC). Using negotiation was described as follows,

The reality is that sometimes it is a bit of a negotiation when somebody's in a really acute stage of illness because you're not able to have a completely lucid conversation with them because of their illness. It's negotiating around and trying to get buy-in from the patient. (WC)

Further to this point, another world café participant explained,

In acute mental health 9/10 of our patients are certified under the Mental Health Act and are not here because they want to be, so that looks very differently because we were looking at the patient’s perspective and what they want and need. If you ask them, they want out of hospital because they're ill and they didn't have the insight. They haven't had meds yet and they're not showing any insight. . . . it is almost a bit of a negotiation at times saying, ‘If you take your meds and you do this, this and this, we can talk about a pass with your family this weekend,’ or whatever it is. (WC)

Empowering the patient was another technique discussed for dealing with difficult situations. One participant described,

In my program I know we focus a lot on empowering the patient, so focusing on what their goals are for their admission and empowering them, that by taking these steps, then we can put other things in place to help you achieve those goals. . . . what their goals are
for quality of life or for their future and always tying it back to what their personal goals are. (WC)

Reducing social stigma. In the view of many participants was the value of reducing shame and the social stigma around mental health and addictions. I-1 explained,

Ooh, if you see a psychiatrist, then you're crazy. Do you know what I mean? Just the stigma that goes along with all of the stuff too. If you're on any psychiatric meds, it's still a shame type thing for a lot of people. They don't talk about it, don't want to talk about it, don't want to get help for it. (I-1)

Education was suggested by many participants as a way to reduce social stigma.

“Education came to mind, building on what you were saying, in terms of breaking down the stigma and judgment” (WC). One patient suggested that providing education helps to build compassion and reduce stigmatization.

They [the public] just see them [people with mental health issues] as different and weird, and [people with mental health issues] could kill them. It's not the case at all. I think educating the public even more on what it means to be ill and how it's ... It's a real scary dark place for people. I think if people understood more about those illnesses, they would be a lot more compassionate. It's called the invisible disability. If they were in a wheelchair or lost a leg, you would see them a lot differently than if you knew that they had schizophrenia. (I-1)

Education was suggested not only for family members and the general public but also for healthcare professionals. One participant in the world cafe explained,

From a patient perspective and talking about staff being nonjudgmental is maybe a better understanding--for the entire program staff--of addiction because that's such a high percentage of our patients. Some of our staff are very open to those conversations and some are, frankly, quite judgmental about addiction . . . I think education for our staff around that would be helpful. (WC)

In summary, theme two highlighted the philosophy of patient and family centred care within the mental health setting and included the sub-themes of: articulating a clear definition;
inclusiveness; transparency and communication; and, reducing social stigma. The next theme addresses the clinician’s approach and how it related to patient and family centred care.

**Theme three: Clinician’s approach.** The clinician’s approach was an important aspect of patient and family centred care as was discussed numerous times across all three methods of data collection. The overarching theme of the approach of the clinician has been divided into three sub-themes: characteristics of clinicians; level of clinician experience; and, respecting patient’s rights and preferences.

**Characteristics of clinicians.** Many characteristics of the clinician were discussed by the participants. For example, making one feel safe was discussed several times. One participant described,

> I think it was her mannerism and the way that she made you absolutely feel really safe. I could be vulnerable. . . . The last one-on-one person I had I didn't connect with her as much. I didn't feel as safe. (I-6)

Compassion was another trait described as an important clinician characteristic. One participant explained,

> They are so compassionate and genuine. . . . You can tell that they really live their life like that. They are not just doing it to be nice to you and because they have to as part of their job. You can tell the things they say to you and how they interact with you, they truly live their lives like that. (I-3)

Participants from the world café event stressed the importance of a respectful relationship between caregivers and patients and using a “non-judgmental and non-blaming attitude” (WC).

Another participant had a suggestion for the clinician’s approach, sharing that “I think if they . . . weren't so technical . . . Just a bit more human.” (I-1)

The idea of the clinician being available and flexible was also a common perception, exemplified by the following statement:
Just knowing that someone is always here if you do need something or whatever, they are always there . . . I just needed someone, and I'm not used to asking for help, but I took a risk and went there and it was totally very validating, and a really positive experience. My whole time there, this whole program is amazing. (I-3)

This idea was echoed by a participant in the leadership focus group who shared,

One other idea that came up was being able to provide the small things to the patient and the family members, and that could be whenever they call, being available to them and not just when it's scheduled hours, but providing them the opportunity to come in at any point in time and being able to speak to anybody that is from the team around what's happening or just to have general questions answered as well. (FG)

Participants also discussed the importance of patient advocacy as a favourable clinician characteristic. Participant I-1 explained,

I see a psychiatrist almost being more of an advocate or caring about their patient or doing things that may be a bit beneath them for the better of their patient. If they need to get something done, just being a more approachable part of the team too . . . If they show a lot of care for their patients; they're wanting to do things that will make their patients better. (I-1)

Participant I-2 agreed with this sentiment, “They just keep plugging away, trying to find the source of the pain. . . She [the doctor] perseveres . . . Advocates for me. . . . Perseverance gives hope - Hope that there's light at the [end of the] tunnel.”

Level of experience. Various participants discussed the importance of the clinician’s level of experience.

I think it was the therapist and her experience. The way that she approached our sessions. Because I've been in other therapy and I think it was just the way that I could relate to her and she knew how to approach me. (I-6)

Another participant valued the clinician continuing to learn enhancing his/her level of experience. “It was a positive experience because I saw they're learning, growing and things are getting better for everybody. . . . Not just me. Everybody” (I-4).
Respecting patient’s rights and preferences. Participants agreed on the importance of respecting patients’ rights and preferences.

Respecting the patient's rights, so including everyday conversations and talking about what their traditions are, how those can be brought into the medical care environment, to not be judgmental towards the patient. From a medical standpoint, don't just look at the disease, but look at the patient as a person. (WC)

The idea of dignity and respect was also discussed. As one participant described,

‘Okay, wake up. Essentially, it's convenient for me to do my rounds now so wake up and talk to me and how are things going.’ I'll never forget that experience and how really disrespectful I felt it was . . . and a bit of a loss of dignity, somebody just coming through the curtain . . . it's your own personal space too. (FG)

Using a holistic stance was also something that participants discussed as an important aspect of the clinician’s approach. As one participant explained,

Made me feel safe . . . It was a holistic approach. It's not, ‘Here's some narcotics. Get better.’ You're to breathe, and how do you self soothe, and the meditation and the biofeedback. I left here with a lot of tools that I didn't have. (I-1)

Another participant agreed in using a holistic approach as a way of respecting patients’ rights,

Patients/clients have often expressed appreciation about access and information about adjunct/complementary/alternative treatments (i.e. individual psychotherapy, yoga, acupuncture, recreation therapy, music therapy, job search/support, occupational therapy support, and spiritual support). (WC)

In summary, theme three identified the significance of the approach of the clinician and included such qualities as compassionate, non-judgmental, persistent, respectful of patient’s rights and preferences, and the clinician’s level of experience. The next theme, will discuss the ethical considerations and challenges when building on a culture of patient and family centred care within the mental health setting.
Theme four: Ethical considerations. Participants discussed some ethical challenges when considering patient and family centred care within the mental health setting. These included: privacy and confidentiality; certification and involuntary admissions; and, locked treatment wards.

Privacy/confidentiality. Privacy and confidentiality came up as an issue for many participants, yet not unique to the mental health setting. As one participant explained,

"Maybe the first thing . . . is there are issues about privacy, it's fairly universal in a sense that you always want to maintain that so I don't know if it's necessarily different [in the mental health setting] but it's of more awareness (FG)."

A patient participant suggested increased transparency in terms of privacy/confidentiality and communication between healthcare providers.

"The communication among program staff is really good, almost too good. It's uncomfortable how you'll tell one person one thing and the next day someone else will refer to it. At any given time we don't really know who knows what, so I think a little bit more transparency in terms of what's being reported in handover (I-7)."

Privacy and confidentiality are a particular issue if the patient decides to not include his/her family in care. How does one practice family centred care when the patient does not want any family involved? One participant described, “Challenges arise if patient does not want to involve family – this is however, directed by patient even though it may not be therapeutic”. (WC)

Certification and involuntary admissions. Certification and involuntary admissions was a well-discussed subject across all three methods of data collection. One leader in the focus group explained,

"Never take the decision to certify a patient lightly. We legally have the right to do that, any physician and other designated individuals can do that but it is taking away a patient's rights. So, when we make that decision it needs to be clear and justifiable and we need to
be able to explain it to [the patient] and their family in terms of safety, and the provisions of the law. (FG)

Certification and involuntary admissions was discussed as unique to the mental health setting. As one leader articulated,

I think that [certification] does constitute a difference that other specialties don't have to deal with and I think our staff needs to be very aware of what this is because they [the patients/family] will challenge it. ‘Well, yeah, you talk about patient centered and I was put away against my will, how is that patient centered care?’(FG)

Interesting, however, when patients discussed certification and involuntary admissions, the issue wasn't about actually certifying or having an involuntary admission, but how the certification was implemented. As one patient participant explained,

I hadn't slept for two to four days and I was almost going psychotic because I was so tired and [the doctor] arranged for the admission here. It was to be a total voluntary admission. . . . in the end they certified me. Manic. I wasn't told. I wasn't given any of the paperwork. Nothing until I insisted on it four days after being in here. . . . I think there's certain protocols that have to be followed and that are very important because otherwise, I went around here feeling like a prisoner for the first three or four days. All my rights were taken away. I wasn't even told why this was happening to me. I wasn't told when, what my rights were, and what could be done about it. It was quite harsh. (I-4)

A participant from the leadership focus group agreed it is important to look at how certification is implemented.

I think one of the differences in mental health is that often our patients don't want to be here and often they don't have insight into why we are recommending certain treatments and why they need to be here. Sometimes that makes it difficult to institute the protocols. . . . When a person is angry or upset or they are resisting I try to understand what's behind it rather than reacting and not take it personally . . . I think that there needs to be, in terms of patient centered care a need to look at where is the patient at right now, where are they coming from, and if they are behaving in a way that isn't what you would expect or isn't consistent then step back, look at it objectively and try to understand where that's coming from, because otherwise we do them a dis-service. (FG)

Participants suggested including the patient and family in the certification process. As one participant explained,
[Certification] does require more explanation, and more of a concerted effort to speak with family and with patients whenever they are able to understand what it is that you are trying to tell them because sometimes you can speak to them about the need for committal, etcetera, but they won't get it until they are better. To speak with the family, and the importance of engaging with family and making efforts to let the patients know why we felt we needed to take, to make a certain decision. (FG)

Patients also suggested including family into the certification process.

I would like to see the collaborator- the family, the friends, to be consulted a little bit more because they're really excluded from the process. . . . I think if you have that collaborative person, part of that decision . . . you may get a little more cooperation out of the patient . . . [if] that person compensates in some way and needs chemical sedation, the family member should be immediately contacted. It's kind of like somebody moving from the ward down to ICU, you wouldn't just move them and not tell the family. (I-4)

I-4 further suggested providing written material to ensure patients and families understand their rights and responsibilities.

Everything you tell them, everything they sign and stuff - you give them a copy of. Because even if you have something and you're reading it, . . . the state you're in doesn't know if you're comprehending it or if you're going to remember it the next day. (I-4)

One participant described how an involuntary admission was helpful in the recovery process,

When I first came in I was cautious about talking. I was frightened with this environment and being a mental health involuntary patient. All of this scared me, so I was cautious about talking about myself. But, as soon as I changed my attitude and talked to the nurses and doctors about how I felt and being honest with them, I found that really helped me to get better and for them to get better treatment for me. Because, every time I was with them before I changed my attitude, they were pretty confused with me. They tried to find out about me but I always tried to run away. By opening up to them, they know much better about me so they can give much better treatment. (I-5)

Locked treatment wards. Some patient participants negatively discussed locked treatment units. I-3 explained, “It felt like jail . . . I didn't even feel like I was on recovery. It was like get me out of there . . . I did not have a good experience.” Conversely, other patient participants described a positive and helpful experience with locked treatment units. I-5 articulated,
You know, I was scared of the word involuntary. I am locked in, my freedom is restricted. Now, I have to follow the routine life. But, it really helped me . . . If I wasn't involuntary, if I was an out-patient, I wouldn't be able to step back from this issue. I would try to cope with it . . . but feel like I was avoiding my issue because I'm just trying to distract myself in order to avoid that issue. Here, it's routine, you don't have your freedom, it's restricted. So, that kind of gave me a lot of time to think about myself. (I-5)

One participant felt strongly about not using locked treatment units or seclusion room as coercion.

[The nurse] says you have to and I'm going back and forth and I said well, what if I don't? She says, ‘then we're going to lock you in seclusion’. I took the pills but seclusion rooms are not punishment rooms. I was not acting out more than saying what happens if I don't take it? (I-4)

World café participants discussed the benefits of removing seclusion rooms and in its place have “nurses work on de-escalation plans and techniques” (WC).

In summary, theme four discussed the ethical considerations of privacy, certification and locked treatment wards. When examining the issue of certification it is important to look at how certification is implemented and to include the family in the process. Privacy and confidentiality issues may arise when the patient does not want family to be involved. Both positive and negative views of locked treatment wards were discussed. The fifth theme will look at fitting the hospital experience into the patient’s broader life.

**Theme five: Fitting the hospital experience into the patient’s broader life.** The fifth theme triangulating across all methods of data collection was the notion of fitting the hospital experience into the patient’s broader life. The two sub-themes of: involve the community as a whole; and transition/discharge, are described below.

*Involve the community as a whole.* Participants described that if PHC truly wants to be patient centred, the organization cannot solely think of the patient within the boundaries of the
hospital setting. As I-7 explained, “we're all individuals and have our own strengths and things we need to work on, but we also exist in a system, in a community, a family, and a society.” I-7 further summarized the goal of mental health treatment as, “the awareness that we live within a system . . . who you are as a person, and what your goals are in life, and what's driving you. The whole thing is focused on developing yourselves as individuals within a community.”

One focus group participant explained the need for an increased connection between the hospital system and community agencies.

If we really want it to be patient and family centered . . . We would have to, in terms of our mental health population and our addictive population, enlarge our definition of a family . . . I know that we already work quite hard at establishing relationships with outside agencies, community based agencies but we might have to [try] even further . . . I know we're in an acute care hospital but some of these issues we deal with is the revolving door . . . we treat them, we get them all healthy and then they go back out there and they fall apart again. Maybe we need to think about . . . a way of pushing our boundaries into being more involved with community . . . Maybe that's what the next half of this century will look like for us, that we can't just merely say beyond these doors it's not our thing, that we can only do what we do with. But there is no point in doing all this well, if out there it's just an abyss. (FG)

Participant I-2 also agreed in including the community as a whole and the ramification of re-hospitalization if the community isn’t involved.

You're not just treating the person, you're treating [the person] as a whole - as the person, the person with friends, the person in community, the family in community, and then when you discharge someone, you're discharging them where, are they homeless? Discharge them to the street - they're going to be back in [the hospital] shortly. (I-2)

Transition/discharge. Participants described the challenges of transitioning from hospital to their home community. I- 3 explained,

It's hard to transition. I have three kids and to try and see what your daily life is going to be like, it's different here. I can't pretend I have three children here and do things . . . It worries me because you don't get to slowly transition . . . It's completely different because I'm not even in the same town. We don't have the same things. (I-3)
I-4 agreed with the challenges of transitioning from hospital to home.

I find that you go home and they expect that everything should be back running one-hundred percent. When I’ve been in the hospital and out of the groove and really focused on myself and getting well to suddenly be thrown back into a busy family and be expected to do it all, it really slows down any nurturing you had and it becomes even more difficult. (I-4)

There was also much discussion about how or whether to transition a patient back to an unhealthy environment. One participant explained,

Something that's critical is when we think about housing, after the patient's acute in-patient [stay], when we are thinking about where are we transitioning this person to, the patient centered thing to do is [to ask], ‘where would you like to live? How can we make that happen?’ Unfortunately the reality is, is you would like to live here but that's not available to you because of your history of x, y and z, or substance misuse. What is available to you is y and x, and they are atrocious, and I am sorry that's the only options that we have or a shelter. We want to be patient and family centered but unfortunately the reality the way the system is set up is you can't live in the hospital. We need to discharge you, but you have limited options and you actually in some circumstances don't have a say in the matter. It's an incredibly narrow scope. (FG)

As in previous themes, the value of including family was discussed. I-2 suggested a way to include the family in the discharge process,

They looked at me, and they see where I'm at, but I would like to see . . . [in the] future including family in discharge . . . to have a family meeting beforehand and say this is what we discovered and . . . can we sit together here and think how we could implement this? I think that that kind of a discharge meeting would be quite helpful. (I-2)

Participants from the world café event also agreed in a “formalized recognition of patient and family goals upon discharge” (WC). They further suggested,

Dialogue, not just around the actual care delivery, but education around what is being done, what the discharge would look like, and when that patient goes home, what does the home environment need to look like for that patient to be successful in their discharge? (WC)
Many participants suggested follow-up support after discharge from hospital. I-4 explained, “It doesn't really have to be complicated either. It can be a phone [call] just how things going . . . accountability is very important”.

A participant from the leadership focus group suggested a system of transition that is based on protocols and a wrap around service.

Well, imagine, patient and family centered. . . . You come in and it's very protocolized and it's clinically driven and it doesn't matter where you go, that is the clinical standard . . . You come into the system and rather than having to navigate the system because it's so complicated in mental health; there is a system that's actually designed around you and clinicians, psychologists, psychiatrists, nursing, social work, really wrap their services around the patient and put the wheels back on the patient and get them back out. I think we sometimes send people out with three wheels instead of four wheels. (FG)

By contrast, I-1 disagreed with using a system based on protocols,

It's about the person, not about the diagnosis or not about necessarily always the protocols or ... Just person centered, about the person . . . I think we're all individuals. One thing that works for one person may not work for the other person. (I-1)

In summary, theme five addressed fitting the hospital experience into the patient’s broader life. The sub-themes of involving the community as a whole and the challenges of transitioning patients from hospital to their home community were discussed.

**Summary of findings.** The thematic analyses presented in this chapter explored the issues and suggestions of the participants in regards to how a culture of patient and family centred care can be nurtured within the mental health program at PHC. Five main themes were discovered. The first theme, revealed the significance of a systems approach, including the infrastructure and superstructure of PHC. Participants recommended a physical space that supported a warm, welcoming, private, less institutional, and more homelike environment and including patients and their families in the environmental design. In terms of the organizational
structure, there was an identified need for clarity regarding the organization’s stance on patient and family centred care, a role for leaders to model patient and family centred care, and a suggestion for concrete and reliable measures to objectively evaluate steps taken.

The second theme, philosophy, included articulating a clear, consistent definition of patient and family centred care that incorporated components such as placing the patient at the centre of care; treating the patient as a whole, within a community; and, including the family as identified by the patient. The philosophy of inclusiveness was also important to the participants. For example, including all health professionals, the patient and family, and community care providers into the care team of the patient were mentioned repeatedly. Participants also appreciated a non-hierarchical team approach. Another identified value of patient and family centred care within the mental health setting was transparency and communication. For example, the listening skills of the healthcare provider were cited as crucial and approaches for facilitating difficult conversations were examined. It was also suggested to take steps to reduce social stigma around mental health and addiction issues.

The third theme identified the significance of the clinician’s approach and included such qualities as compassion, non-judgmental, persistent, being respectful of patient’s rights and preferences, and the clinician’s level of experience. Theme four identified the ethical issues present when integrating a patient and family centred approach into the mental health setting. Confidentiality, certification and locked treatment wards were debated. Theme five addressed fitting the hospital experience into the patient’s broader life. The importance of involving the community as a whole and the challenges of transitioning patients from hospital to their home
community were discussed. This information provided by the participants will inform the conclusions stated in the next section.

Conclusions

This research was conducted with stakeholders to inform PHC on how a culture of patient and family centred care can be nurtured within the mental health program. Through the research process and analysis of the findings from the interviews, a world café event, and a focus group, four conclusions were drawn that were also supported by literature. The purpose of the conclusions is to place the experiences and perspectives of the participants into a broader context, compare and contrast the findings with academic literature, and “suggest changes in organizational or programmatic practices implied by the research” (Stringer, 2007, p. 183). The following conclusions relate to the participants’ exploration of topics such as systems, inclusiveness, compassion, respect and dignity, and ethics.

**Conclusion one: A systems level approach is required for a culture of patient and family centered care to be strengthened within the organization.** The findings of this inquiry demonstrated a systems level approach is needed to facilitate a culture of patient and family centred care. This included a strong organizational stance, a clear, consistent definition of patient and family centred care, a warm, inviting infrastructure, and the use of concrete and reliable measures to monitor the impact of patient and family centred care initiatives.

This inquiry revealed a strong organizational stance on patient and family centred care is needed not only in mental health, but also throughout the organization. Research supports this finding. Organizations that have succeeded in fostering patient centered care have “gone beyond mainstream frameworks for quality improvement and have adopted a strategic organizational
approach to patient focus” (Luxford, Safran & Delbanco, 2011, p. 514). One of the key factors for achieving patient and family centred care at the organizational level is to clearly and constantly communicate a strategic vision of patient and family centred care (Shaller, 2007). Senge (2006) agreed, “Few if any, forces in human affairs are as powerful as shared vision” (p. 192).

A clear, consistent definition of patient and family centred care will help shape an organizational vision. As cited previously in this document, the definition of patient and family centred care cited most frequently in the literature is from the Institute for Patient and Family Centered Care (2013): “Patient- and family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families” (The Institute for Patient and Family Centered Care, 2013, Frequently Asked Questions, para. 1). PHC has adopted this definition. This inquiry further identified the following components within a definition of patient and family centred care: placing the patient at the centre of care; treating the patient as a whole, within a community; and, including the family as identified by the patient.

A systems level approach to patient and family centred care includes infrastructure design. Currently PHC is in the process of a major infrastructure redevelopment. This has an impact on the mental health program as the mental health patients currently housed in the hospital’s 100-year-old Burrard building will be moved into newly designed, more appropriate units in the Providence building (Providence Health Care Annual Report, 2013, Infrastructure Redevelopment, para. 6). The findings of this inquiry recommended a physical space that supported a warm, welcoming, private, less institutional, more homelike environment, and
inclusion of patients and their families in the environmental design. This conclusion is supported by the literature. Shaller (2007) found a supportive and nurturing physical space is an important key factor for achieving patient centered care at the organization level. Furthermore, Charmel and Frampton (2008) found that attributes of a patient centered care model included “an architectural and interior design that gives a ‘homelike’ feeling and encourages patient mobility, involvement of family in the care process, and space for both solitude and social activities” (p. 1).

This inquiry suggested the use of concrete and reliable measures to monitor the impact of patient and family centred care initiatives. Shaller (2007) agreed, stating that a significant element contributing to patient centred care at the organizational level is “systematic measurement and feedback to continuously monitor the impact of specific interventions and change strategies” (p. v)

**Conclusion two: An ideal vision of patient and family centred care includes a philosophy of inclusiveness.** This inquiry revealed a philosophy of inclusiveness is paramount to an ideal vision of patient and family centred care. This would include the comprehensive expertise of the patient, family, hospital and community health care providers. Traditionally, within the mental health setting, “the professionals hold the power and make decisions about the care and treatment of the people with mental illness” (Sommerseth & Dysvik, 2008, p. 261). According to the Centre for Addiction and Mental Health (2004), adopting a patient and family centered care philosophy requires a shift in organizational practices and in the attitudes and behaviors of individual providers from a model in which professionals are seen as the only people in possession of expert knowledge to a model that is based on knowledge exchange and partnership. (p. 2)
The literature reviewed supported involving the patient in their own care, as people know themselves best and should be considered to have a role as an active collaborator in decision-making (Sommerseth & Dysvik, 2008). However, “many people with mental illness are vulnerable and withdrawn and have low expectations about their own contributions” (Sommerseth & Dysvik, 2008, p. 265). The patient, therefore, requires information and training to develop his or her role as an active member in their own care (Sommerseth & Dysvik, 2008).

This inquiry identified the importance of including the family. Research identified many benefits of family involvement for the person with mental illness, including, reduced relapse rated, reduced hospital admissions, lower risk of mortality, and increased compliance with medication (MacFarlane, 2011). Buila and Swanke (2010) stated the mental health care provider should routinely seek out the input of caregivers and include them in the delivery of care. These authors found that the family provided an invaluable resource for the patient with mental illness, as they provided crucial information about the patient’s history, recent level of functioning and on-going support that enhanced the overall care provided. It would appear that being truly patient and family centred in the care for individuals with mental illness requires partnerships with families.

This inquiry also identified the challenges of transitioning patients from hospital to their home community and the importance of involving the community as a whole. Discharge planning is the “development of an individualized discharge plan for the patient prior to leaving hospital, with the aim of containing costs and improving patient outcomes” (Shepperd, Lannin, Clemson, McCluskey, Cameron, & Barras, 2013, p. 2). A structured discharge plan tailored to the individual patient resulted in a reduction in hospital length of stay and readmission rates, and
an increase in patient satisfaction (Shepperd et al., 2013). These authors also reported that discharge planning should ensure the organization and provision of community services. Zhang, Harvey and Andrew’s (2011) research also identified many benefits of involving the community in discharge planning as a lack of social and community support predicted a longer hospital stay and good community psychiatric care following discharge reduced hospital readmission rates.

An important element of discharge planning is the effectiveness of communication between hospital and community (Shepperd, Lannin, Clemson, McCluskey, Cameron, & Barras, 2013). Health care clinicians involved in the treatment of hospitalized patients need to ensure continuation of care through outpatient services (Nelson, Maruish, Axler, 2000). A patient and family centred perspective implies cooperation between different services and levels in mental health care (Sommerseth & Dysvik, 2008).

**Conclusion three: Compassion, respect and dignity are important aspects of patient and family centred care.** This inquiry revealed compassion, respect and dignity are important aspects of patient and family centred care. Mind (2004) found only 20% of hospital inpatients thought they were treated with respect and dignity. This is significant as the relationship patients form with others, including mental health professionals, has been reported as constituting one of the most important factors in helping them cope with distress in their lives (Faulkner & Layzell, 2000). Personal growth has also been reported in the literature as more likely in the presence of a patient who valued the client and was truly non-judgemental, open and honest, and made the effort to understand the client’s world (Ruddik, 2010). The literature also echoed the important personal attributes of health-care professionals found in this research
inquiry, such as being non-judgmental, respectful, patient, open, genuine, calm, and good listeners (Shattell, Starr, & Thomas, 2007).

The clinician being available and having the time was also an important discovery in this inquiry. This attribute of health care professionals taking the time and not looking rushed was supported in the literature (Shattell, Starr, & Thomas, 2007). Ruddick (2010) agreed with the importance of time,

time is significant in the development of therapeutic rapport and an empathic understanding of others . . . time is often in short supply in mental health care systems so spending time being with a client reinforces the fact that they are being valued. (p. 26)

Compassion, respect and dignity remain important when facilitating difficult conversations. In psychiatry, difficult conversations often revolve around mandatory treatment components. This research inquiry revealed three main strategies for dealing with difficult conversations: having a clear rationale, using negotiation, and empowering the patient. Research by Geller and Srikameswaran (2006) regarding mandatory treatment components also showed that patients understood the necessity of mandatory treatment components; however, did object to the manner in which they were delivered. For example, the mandatory treatment components needed to have a sound rationale, be consistently implemented, not take the patient by surprise, and maximize patient autonomy (Geller & Srikameswaran, 2006). Further research by Geller and others also found that both patients and care providers preferred a collaborative approach to directive interactions in psychiatric treatment delivery (Geller, Brown, Zaitsoff, Goodrich, & Hastings, 2003). A collaborative stance may be preferred because, as Geller and Srikameswaran (2006) reported, it is conducive to a less hierarchical relationship, maximizes client autonomy and responsibility, and removes the need for coaxing or coercion. The value of a non-
Hierarchical team was also discussed as an important philosophy of patient and family centred care within this inquiry.

Compassion, respect and dignity for the health care professional were also reported in the literature and in this inquiry to be important. For example, Charmel and Frampton (2008) identified a relationship between employee satisfaction and patient satisfaction, as the more staff felt cared for themselves, the better they can care for their patients.

**Conclusion four: Patient and family centred care within the mental health setting included some ethical considerations.** This inquiry identified some ethical challenges of patient and family centred care within the mental health setting. These included confidentiality, certification and locked treatment units.

Confidentiality is considered especially important in mental health care (McHale, 2009). An individual may be concerned with maintaining the confidentiality of their healthcare information due to possible discrimination or stigmatization and a lack of confidentiality may deter some from receiving help (McHale, 2009). Healthcare professionals are regularly faced with problematic questions of disclosure, a dilemma which led McHale to question, “when should, if at all, information be disclosed to families and carers?” (2009, p. 944). Buila and Swanke (2010) argued that the professional is bound by confidentiality, but it is imperative that efforts toward gaining permission to include caregivers be exhausted, leading these authors to observe that “patients will not provide consent if never asked to provide consent” (p. 149).

The Mental Health Act of British Columbia provides authority, criteria and procedures for certification for an involuntary admission and treatment (Guide to the Mental Health Act, 2005, Safeguarding Individual Rights, para. 1). This inquiry found that it was not so much being
certified, but how the certification was implemented that was important to patients. Research reported in the literature also showed this important distinction. Johansson and Lundman, (2002) cited one of the main problems in involuntary care was “how to handle the intrusion on the patient’s autonomy without violating his or her integrity (p. 640). Several other authors (O’Donovan, 2007; Olofsson & Jacobsson, 2001) observed that in certain circumstances, certification is necessary to maintain safety; however, some individuals may feel humiliated or fearful when there is a lack of information about their treatment or their rights as involuntary patients. The results of this inquiry suggested providing written material to ensure patients and families understand their rights and responsibilities. The literature supported this finding. For example, Johansson and Lundman (2002) reported that for the involuntary admitted patient, the freedom to choose is limited but the right to be given information must still be respected. Further, Attenborough, Cushing, Hanrahan, and Korszun, (2009) observed that there is an ethical importance of honesty, clarity and knowledge in explaining difficult situations, such as certification. As well, participants in this inquiry also strongly recommended including family into the certification process. This sentiment was echoed in the literature by Buila and Swanke (2010), supporting the inclusion of caregivers of patients with mental illness in decision-making, information exchange, and partnerships.

The rationale for locked treatment units is the provision of safety. The literature was clear in stressing the importance of balancing the safety and security of patients, staff and the public whilst respecting the rights and choices of individuals (Clearly, Hunt, Walter, & Robertson, 2009). Cleary et al. (2009) also reported that education should be routinely provided on patients’ legal status and rights and supplemented with easy to understand written material.
Another important aspect of locked treatment units related to patients having their own space and possibility to decide their own matters, without coercion. Koivisto, Janhonen, and Vaisanen’s (2004) research reported that coercion only “increased the antagonism between the patients and the staff (p. 272). The results of this inquiry agreed with this research, with participants arguing against the use of locked units as coercion.

Summary of conclusions. In summary, four conclusions were drawn from the analysis and supported by literature. Conclusion one highlighted a systems level approach is needed to facilitate a culture of patient and family centred care. This included a strong organizational stance, a clear, consistent definition of patient and family centred care, a warm, inviting infrastructure, and the use of concrete and reliable measures to monitor the impact of patient and family centred care initiatives.

Conclusion two revealed a philosophy of inclusiveness is paramount to an ideal vision of patient and family centred care. This included the comprehensive expertise of the patient, family, hospital and community health care providers. Conclusion four also identified the challenges of transitioning patients from hospital to their home community and the importance of involving the community as a whole.

Conclusion three revealed compassion, respect and dignity are important aspects of patient and family centred care. This included such aspects as the clinician being available and having the time for the patient and his/her family, and the importance of compassion, respect and dignity when facilitating difficult conversations. Compassion, respect and dignity for the health care professional were also reported in the literature and supported by this inquiry to be important.
Conclusion four identified some ethical challenges of patient and family centred care within the mental health setting. These included confidentiality, certification and locked treatment units. In particular, this inquiry and academic research found that it was not so much being certified, but how the certification was implemented that was important to patients. It was suggested to provide written material to ensure patients and families understand their rights and responsibilities, including family into the certification process, and limiting coercion.

**Limitations of the Research**

The data collection process of this research project had a variety of limitations. “Researchers should indicate any limitations that arose from the pragmatic realities of investigation” (Stringer, 2007, p. 179), in order to demonstrate trustworthiness of the data (Glesne, 2011). This inquiry was limited by self-selection bias, gatekeeper bias, and small sample sizes. These limitations are described below.

**Self-selection bias.** A self-selection bias may have existed in the method of participant recruitment. Individuals with an interest in patient and family centred care may be more inclined to accept the invitation to participate in the interviews, world café event or focus group. This could have biased the results of this inquiry, as individuals with less interest in patient and family centred care may not be represented. Additionally, there was a high representation of female participants and only one family member participant, which may have also biased the results of this inquiry.

**Gatekeeper bias.** Gatekeeper bias may have also existed in the method of patient and family recruitment. A gatekeeper is a “person who stands between the data collector and a potential respondent” (Encyclopedia of Survey Research Methods, Gatekeeper, para. 1). The
clinicians who provided patients and family members with letters of invitation for this research study acted as gatekeepers and potentially may have intentionally or unintentionally exerted control over which individuals had access to participate in a manner which bias the selection of participants for the interviews (Groger & Mayberry, 1999). This in turn could have biased the contributions from this stakeholder group. The impact or nature of this bias cannot be known; however it should not be overlooked as a potential limitation to the findings.

**Small sample sizes.** This inquiry aimed to have representation from a broad spectrum of inquiry stakeholders as patients, family, staff, physicians and leaders were invited to partake. There was, however, a relatively small sample size in each data collection method. For example only seven participants were interviewed, 7% of the mental health staff and physicians attended the world café event, and five individuals attended the focus group. With such a small number of participants, it is unlikely that a complete range of opinions were represented. Stringer (2007) stated in qualitative research, “It is not usually possible to include all the people who should be included” (p. 179), however, it is important to acknowledge this relatively small sample size may impact the results of the inquiry.

**Chapter Summary**

This chapter outlined the findings from the data collected from interviews with patients and family, a world café event with staff and physicians, and a focus group with leaders. Conclusions were derived from these results that were informed by the organizational context and review of academic literature. These conclusions guided the recommendations and the discussion of their implications discussed in detail in the next chapter.
Chapter Five: Inquiry Implications

This research was conducted with patients, families, staff, physicians and leaders within the mental health program at PHC. The research question was as follows: How can a culture of patient and family centred care be nurtured that meets the aspirations of stakeholders within the mental health program at PHC? The sub-questions included:

1. How do the patients, families, leaders and staff of the mental health program of PHC define patient and family centred care?

2. What are the current practices of patient and family centred care in the mental health program of PHC?

3. What is the vision the stakeholders of PHC’s mental health program have for an ideal culture of patient and family centred care within the mental health setting?

4. What support is needed to implement further practices of patient and family centred care within the mental health program of PHC?

5. What implications might these findings have for other mental health service organizations that are seeking to enhance their culture of patient and family centred care?

This chapter focuses on providing recommendations to the sponsoring organization. These recommendations were supported by both the research data and academic literature. Implications for the organization and for further research are also discussed in this chapter.

Recommendations

The following recommendations were determined based upon the results of this inquiry and relevant academic literature. Through this research process, four recommendations have been provided. These recommendations advise PHC on the direction they could take to move
further with the operationalization of patient and family centred care within the mental health setting.

Recommendation One: It is recommended that over the next year the PHC mental health leadership team, in collaboration with a cross-functional team of stakeholders, lead the engagement of the PHC mental health community in developing and communicating a clear vision that will provide a compelling focus for the future of patient and family centered care within the Mental Health Program at PHC. The mental health program at PHC has already made great progress on its journey towards patient and family centred care. The program includes patient and family representatives at a monthly quality meeting where projects are discussed to improve the overall quality of care provided to patients and families. The eating disorders program, a sub-program of mental health, also runs a monthly patient and family advisory committee meeting and has involved patients and families into program based patient journey mapping to improve the patient experience. The findings of this inquiry as well as relevant literature supports recommending the PHC mental health program develop a clear vision of patient and family centred care. This includes the use of concrete and reliable measures to monitor the impact of patient and family centred care initiatives. This recommendation includes several components, each discussed below.

Develop a clear vision of patient and family centred care within the mental health program. This inquiry’s results have led to the recommendation that the mental health program develop a clear vision of patient and family centred care. “Visions are about ideals . . . hopes, dreams and aspirations . . . the strong desire to achieve something great . . . ambitious . . . expressions of optimism.” (Kouzes & Posner, 2012, p. 130). Shaller (2007) found one of the key
factors for achieving patient and family centred care at the organizational level is to clearly and constantly communicate a strategic vision of care.

When developing a vision for patient and family centred care within the mental health program it is important to include staff in developing a shared vision. As Senge (2006) reported, “A shared vision, especially one that is intrinsic, uplifts peoples’ aspirations. Work becomes part of pursuing a larger purpose” (p. 193). Kouzes and Posner (2012) agreed, “Exemplary leaders don’t impose their visions of the future on people; they liberate the vision that’s already stirring in their constituents. They awaken dreams, breathe life into them, and arouse the belief that people can achieve something grand.” (p.131). These authors further described the importance of having individuals be a part of the process and engaging staff in a “collective dialogue about the future” (Kouzes & Posner, 2012, p. 117). “People commit to causes, not to plans . . . when people are part of something that elevates them to higher levels of motivation and morality, they develop a sense that they belong to something very special” (Kouzes & Posner, 2012, pp. 121-122).

From an organizational perspective, PHC has devoted one of the five strategic directions, The Care Experience, entirely to patient and family centred care. From this strategic direction, PHC has developed clear priorities of patient and family centred care initiatives for the organization. This inquiry’s results have led to the recommendation that the mental health program use their vision of patient and family centred care to tailor these organizational priorities for the mental health program. These priorities should be developed in consultation with staff and patient and family advisors and communicated throughout the program.
Use concrete and reliable measures to evaluate patient and family centred care

initiatives. The results of this inquiry also lead to the recommendation that feedback in the form of concrete and reliable measures to continuously evaluate specific interventions and change strategies be developed and implemented. The literature reviewed identified some ways to evaluate patient and family centred care initiatives. For example, Shaller (2007) recommended “the presence of a robust customer listening capacity that enables an organization to systematically measure and monitor its performance” (p. 11) such as patient experience surveys, complaints, walk-throughs, and implementation of patient and family advisory councils to gather systematic feedback from patients. Jenkinson, Coulter, and Bruster (2002) developed the Picker Patient Experience Questionnaire to gather feedback on patients’ experiences of health care in order to evaluate patient and family centred care initiatives and to determine priorities for quality improvement. These evaluation measures can be used in collaboration with results from the provincial wide surveys of patient-reported experience measures currently conducted by the BC Patient Reported Experience Measures Steering Committee (BC Ministry of Health, n.d., Patient Experience Survey Results).

In summary, recommendation one proposes the development and communication of a clear vision of patient and family centred care within the PHC Mental Health Program. This includes the use of concrete and reliable measures to monitor the impact of patient and family centred care initiatives.

Recommendation Two: It is recommended over the next year, the PHC Director of Mental Health and the PHC Head of the Department of Psychiatry/Physician Program Director, in collaboration with physicians, staff, patients and families, lead the development
of a Mental Health Act certification protocol for the Mental Health Program within PHC.

The results of this inquiry found there was an overall understanding of the necessity of certification for safety purposes, and that it was not so much being certified, but how the certification was implemented that was important to patients. Many suggestions arose from this inquiry as to how to certify an individual under the Mental Health Act while keeping consistent the values of compassion, respect and dignity. Several specific strategies have been identified as component parts of this recommendation and each will be discussed in turn.

*Provide written material as well as a verbal explanation to patients certified under the Mental Health Act.* For the involuntary admitted patient, the freedom to choose is limited but the right to be given information must still be respected (Johansson & Lundman, 2002). Research showed that education should be routinely provided on patients’ legal status and rights and supplemented with easy to understand written material (Cleary, Hunt, Walter, & Robertson, 2009). The findings of this inquiry, supported by research reported in the literature, have led to the recommendation that PHC provide verbal and written material to a patient when certified under the Mental Health Act (British Columbia Ministry of Health, 2005) to ensure patients and families understand their rights and responsibilities. PHC staff routinely provides verbal explanation of the certification process. Providing written material as well to patients and their designated family members in the form of a brochure outlining the certification process and the patient’s legal rights should be considered. This information could also be provided on the PHC intranet and PHC external website for ease of access for patients, families and staff.

*Include the patient’s family in the certification process.* It is also strongly recommended that family be included in the certification process. In British Columbia, under the
Mental Health Act, notification of a designated family member in the case of an involuntary admission to hospital is mandatory (BC Ministry of Health, 2005, Section 7.1 Rights Information, Advice to a Near Relative, p. 42). The results of this inquiry have highlighted the need for a formalized way to document when a designated family member has been contacted. Family should be defined by the patient and can represent any identified supportive person(s). A participant from the focus group summarized this recommendation nicely, there should be some kind of protocol where it's part of the patient's record that family has been contacted or family was not contacted for these reasons . . . that we are talking to the patient about their families and how they want their families involved. We were attempting to make the connection, so whether the family chooses to be involved or not at least we have done our due diligence in a sense that we tried to involved them, and [the patient] chose or not these people to be involved but they want these people to be involved, . . . we have done that and acknowledged them, had that conversation. (FG)

This sentiment was echoed in the literature by Buila and Swanke (2010), supporting the inclusion of caregivers of patients with mental illness in decision-making, information exchange, and partnerships. MacCourt (2013) in the National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illnesses also suggested including families as partners in the mental health treatment team and informing a designated family member in the case of an involuntary admission to hospital.

*Compassion, respect and dignity remain important when facilitating difficult conversations such as certification.* In psychiatry, difficult conversations often revolve around mandatory treatment components. The results of this inquiry have led to the identification of five main strategies for dealing with difficult conversations while maintaining compassion, respect, and dignity: (1) have a clear rationale, (2) implement consistently, (3) do not take the
patient by surprise, (4) empower the patient by maximizing patient autonomy, and, (5) use a collaborative approach.

This research inquiry revealed two of the above strategies for dealing with difficult conversations: having a clear rationale and empowering the patient. Research by Geller and Srikameswaran (2006) regarding mandatory treatment components concurred with having a clear rationale and empowering the patient by maximizing patient autonomy and suggested two other strategies for dealing with difficult conversations: implement consistently and do not take the patient by surprise (Geller & Srikameswaran, 2006). Further research by Geller and others provided evidence for the fifth strategy of using a collaborative approach as this research found that both patients and care providers preferred a collaborative approach to directive interactions in psychiatric treatment delivery (Geller, Brown, Zaitsoff, Goodrich, & Hastings, 2003).

In summary, recommendation two advocates for the development of a Mental Health Act certification protocol for the PHC Mental Health Program. Within this protocol, it is suggested to provide written and a verbal explanation to patients certified under the Mental Health Act; include the patient’s family in the certification process; and, incorporate the values of compassion, respect and dignity when facilitating difficult conversations such as certification.

**Recommendation Three:** It is recommended that over the next year the PHC mental health program leadership team, in collaboration with physicians, staff, patients and family representatives, pilot an initiative to further promote the value of inclusiveness throughout the care team, including health professionals, the patient, family, and community. The literature reviewed identified that improving the patient experience and involving patients in their care are linked to improved health outcomes, such as being better able to manage complex
chronic conditions, reduced anxiety and stress, and shorter lengths of stay (Balik, Conway, Zipperer, & Watson, 2011). This inquiry’s results also uncovered that these desirable outcomes require not only the support of health professionals and family members, but also the broader community. This recommendation has prompted the following two specific suggestions for action, which are discussed below.

**Include the patient and their identified family in the care team.** The results of this inquiry strongly supported including the patient as part of the care team and this was further supported by the literature reviewed. For example, Buila and Swanke (2010) found in their research the importance of including the family in assessment, treatment planning, and mental health care implementation. Their findings demonstrated that families are important contributors to the care and treatment of the patient with mental illness as they offer practical support to the patient and have valuable knowledge and insight essential to the assessment and treatment of their loved one. MacCourt (2013) in a report for the Mental Health Commission of Canada recommended mental health service providers routinely encourage the involvement of families, while respecting the confidentiality and privacy of the patient. MacCourt further explained,

> Where a relative chooses not to involve family caregivers, ensure that the reasons are explored, discussed and documented, and that service providers provide general information about the trajectory of the illness, common symptoms and management of symptoms so that the caregiver has the basic information required to support the family member without compromising confidentiality. (p. 24)

Many ideas were suggested on ways to integrate the patient and his/her family into the team. Participants from the world café event suggested patient and family involvement at all levels of care. For example, having patients and family involved in rounds and team meetings, writing their own treatment goals, having access to their clinical information and documentation,
as well as involving family in the certification process, and providing expertise and input into program planning and development (WC) were all mentioned. Current processes should be examined to determine how this type of involvement could be enhanced.

**Include appropriate agencies and individuals in the community as part of the acute care team.** This inquiry identified the challenges of transitioning patients from hospital to their home community. Discharge from hospital may be problematic as the patient’s current living situation may not be appropriate, or the patient may require additional community supports to successfully live in that community. If a patient is discharged to an unsupportive home environment, re-hospitalization may occur. This can result in what one participant identified as the “revolving door” (FG) phenomenon. The focus group participant further explained,

> I know we're in an acute care hospital but some of these issues we deal with is the revolving door . . . we treat them, we get them all healthy and then they go back out there and they fall apart again. Maybe we need to think about . . . a way of pushing our boundaries into being more involved with community . . . Maybe that's what the next half of this century will look like for us, that we can't just merely say beyond these doors it's not our thing, that we can only do what we do with. But there is no point in doing all this well if out there it's just an abyss. (FG)

This inquiry had led to the recommendation that involving community care providers, not only in the discharge process, but also throughout the inpatient stay be actively pursued. Community care providers have important knowledge about patients’ level of functioning, strengths and challenges as well as information about community programs and services. Nelson, Maruish, and Axler, (2000) supported involving community health care clinicians with the hospitalized patient to ensure continuation of care through outpatient services. Sommerseth and Dysvik (2008) stated that a patient and family centred care approach implies cooperation between different services and levels in mental health care. Given these findings, it is
recommended that the mental health program continue to build and foster relationships with community care providers and include the community as a part of the hospital care team. This will have many benefits including obtaining collateral information about the patient and developing a shared ownership for finding appropriate community programs and services post discharge.

In summary, recommendation three advises the mental health program to pilot an initiative to further promote the value of inclusiveness throughout the care team. This would involve encouraging the patient, family, and community care providers to be involved, not only in the discharge process, but also throughout the treatment progression. It is recommended that the mental health program continue to build and foster relationships with patients, families, and community care providers and include them as a part of the hospital care team.

**Recommendation Four: It is recommended over the next decade the PHC mental health program leadership team promote and support the engagement of staff, in collaboration with patients and families, in further research and innovation on patient and family centred care initiatives with the goals of providing exemplary treatment and becoming a world-class leader in this approach to care.** The PHC mental health program has established a foundation for becoming a world-class leader in patient and family centred care. The actions recommended within the previous three recommendations will further strengthen that foundation, as will the active commitment to engage in the conduct and dissemination of further research, the focus of this last recommendation. Steps have begun in this direction. For example, recently, the program has supported research and innovation with a group of mental health program dietitians receiving research funding to conduct practice-based research in the
area of patient and family centred care. As well, PHC is co-sponsoring the 2014 International Conference on Patient and Family Centred Care and many mental health program employees are attending, some of who are presenting workshops and poster presentations.

The commitment to innovation, growth and development was highlighted as important in this inquiry. One participant explained, “It [treatment] was a positive experience because I saw they [the staff] are learning, growing and things are getting better for everybody. Not just me. Everybody.” (I-4). A participant from the focus group theorized,

From the systems perspective and for the providers of health care service it would be cool if we had some common understanding of what it [patient and family centred care] is and what that means and how to integrate it into how we design and develop programs and systems and clinical care. (FG)

A patient participant further articulated support for research,

Obviously any type of treatment program comes from empirical findings, and theoretical, and all that, but I think a big part of it is doing exactly this, talking to people who have been through it or who are going through it, and finding out what works and what doesn't work, and taking that seriously, doing something about it, not just being like, "Yeah, I hear that," and then nothing happening, but actually implementing the changes that the consumers are suggesting or advocating for. (I-7)

It is recommended that the mental health program at PHC continue to build on these initiatives and provide further opportunities for staff, physicians, leaders, patients and families to be involved in research and knowledge exchange of patient and family centred care endeavors. According to Choi and Ruona (2011), fostering a learning culture encourages individuals to be engaged with the process and enhances individual capabilities to participate in and make genuine contributions, thereby enhancing the organization’s capacity to make successful changes. An excellent opportunity to initiate this recommendation is through the sharing of the results of this inquiry at Ground Rounds, a staff session across the mental health program.
Senge (2006) stated,

Through learning we re-create ourselves. Through learning we become able to do something we never were able to do. Through learning we re-perceive the world and our relationship to it. Through learning we extend our capacity to create, to be part of the generative process of life. There is within each of us a deep hunger for this type of learning. (pp 13-14)

In summary, recommendation four promotes the PHC mental health program engagement in further research and innovation on patient and family centred care initiatives. Encouraging a learning culture offers many benefits, including enhancing the organization’s capacity to make successful changes, with the goals of providing exemplary treatment and becoming a world-class leader in this approach to care. The next section, will discuss the organizational implications of executing the four recommendations.

Organizational Implications

This inquiry provides the mental health program of PHC four recommendations listed earlier in the chapter. These recommendations require consideration from the senior leaders of the mental health program to determine next steps as the program builds on a culture of patient and family centred care. Should the recommendations be accepted, there are a variety of implications that will affect change management processes as the PHC mental health program introduces initiatives to further enhance a culture of patient and family centred care. These implications are discussed below.

Leading organizational change. The literature suggested several factors contributing to the successful implementation of change (Burke, 2008; Choi & Ruona, 2011; Fernandez & Rainey, 2006). These included: establishing the need for change; providing a strategy for
implementing change; building internal readiness for change and overcoming resistance; and sustaining the change.

As a first step in any organizational change, it is important to establish the need for change. Burke (2008) stated, “If people in the organization see or feel no need for change, they are not likely to embrace the idea” (p. 743). Fernandez and Rainey (2006) suggested leaders must persuasively communicate the need for change. In introducing the need for change, Weisbord (2012) suggested the importance of leaders to focus on positive change, “not to diagnose and heal sickness, but to help people find dignity, meaning, and community in work. Those are the conditions that sustain productivity” (p. 265). This would suggest emphasizing the positive aspects of patient and family centred care when introducing the need for change.

The second factor important in leading organizational change is providing a strategy for implementing change. Fernandez and Rainey (2006) suggested this often begins with “crafting a compelling vision of change providing overall direction for the change process” (p. 169). Burke (2008) agreed with the importance of creating a vision statement to provide clear direction for the organization change effort, as “without direction, both in terms of who we are and who we want to be in the future, desired organization change will not occur” (p. 747). The literature highlighted the role of leadership to guide the change process with “persistence . . . clarity of direction, passion, and vision” (Burke, 2008, p. 750).

The third factor necessary in leading organizational change is to build internal readiness for change and overcome resistance (Fernandez & Rainey, 2006). Organizational readiness for change is considered a “critical precursor to the successful implementation of complex changes in healthcare settings” (Weiner, 2009, p. 67). Lewin (1947) first described the concept of
building internal readiness for change as “unfreezing” which included the process of altering employees’ belief and attitudes about change in a way that they perceive the change as both necessary and likely to be successful. Weiner (2009) agreed with the importance of establishing organizational readiness for change and defined readiness for change as the “organizational members’ shared resolve to implement a change (change commitment) and shared belief in their collective capability to do so (change efficacy)” (p. 67). Weiner (2009) postulated when organizational readiness for change is high, employees are more likely to initiate change and the result is a more effective implementation.

Weiner (2009) offered some suggestions to increase organizational readiness for change, including “consistent leadership messages and actions, information sharing through social interaction, and shared experience” (p. 67). Choi and Ruona (2011) suggested that individuals are more likely to have higher levels of readiness for organizational change when they are empowered, included to participate, and given an opportunity to express any resistance to change. Choi and Ruona (2011) further described the leader’s stance of authenticity, congruence, responsibility, openness, and trust as important during the change process.

The fourth factor important in leading organizational change is sustaining the change. According to Burke (2008) this phase of change requires the organization to deal with unanticipated consequences, maintain the change momentum as the natural movement toward equilibrium has to be countered, and identify and implement new initiatives that will “renew organizational members’ energy, spark new ways of thinking, and continue to propel the organization farther down its path of change” (p. 758). Fernandez and Rainey (2006) advised to
make the change long lasting, “the organization must incorporate the new policies into daily routines” (pp 169-173).

It will be crucial for the leaders of the mental health program to take into consideration these four factors for successful organizational change as the program initiates change processes to develop patient and family centred care approaches within the mental health program.

**Significance of partnerships in advancing patient and family centred care.** This inquiry identified the challenges of transitioning patients from hospital to their home community and the importance of involving the community as a whole. The mental health program will need to strengthen its connection and relationship with community services to ensure optimal care of individuals with mental health issues. This will require a shift in thinking as generally both acute care and community treatment providers only consider their role in provision of services within their own setting. This will require a more holistic view of mental health treatment – something the PHC mental health program can take a leadership role in facilitating.

Anderson and Ackerman Anderson (2001) stated, “Change leaders must build bridges across functions, processes, stakeholder groups, and change initiatives to ensure collaboration, information sharing, and shared accountability for enterprise outcomes” (p. 122). A connected, supportive community of organizations will foster an increased provision of care for individuals with mental health issues. Baker (2003) stated that collaborative relationships are critical to the long-term success of an organization. Many benefits to collaborative relationships included increased innovation, enhanced organizational learning, and increased employee satisfaction (Baker, 2003).
In order to promote further research and innovation on patient and family centred care initiatives with the goals of providing exemplary treatment and becoming a world-class leader in patient and family centred care, the mental health program will need to partner with other organizations. Anderson and Ackerman Anderson (2001) stated it is important to “build and sustain relationships between organizational entities to enhance mutual and system-wise effectiveness” (p. 122). This will provide an opportunity for collaboration on patient and family centred care innovative initiatives, outcome measures, information sharing, and research.

**Importance of culture in fostering efforts of patient and family centred care.** To bring about improvement in patient and family centred care and provide the optimal benefit for people with mental illness, many authors considered the culture of the organization to be important (Cliff, 2012; Luxford, Safran & Delbanco, 2011; Sodomka, Spake, Rush, 2010; Sommerseth & Dysvik, 2008; Taylor and Rutherford, 2010). In order to truly embrace patient and family centred care, the mental health program of PHC will require a review of the culture within the mental health program. As one leader in the focus group described,

I think a lot of it has to do with just changing our culture of belief around [patient and family centred care], and really permeating it through... I live in anticipation of a day where people bring a meeting together and their first thought is, ‘Is a patient and family here?’... For me that ideal state has a lot to do with the culture. (FG)

The mental health program at PHC, not only has an overarching culture, but also sub-cultures that develop within the specialized programs within the mental health program. Sovie (1993) explained, “these sub-cultures also help to shape perceptions, attitudes and beliefs and influence how their members approach and execute their particular roles and responsibilities” (p. 69). When examining the culture of the mental health program, it is important to take into account these sub-cultures.
The research reviewed agreed that culture is developed over time and is in a state of constant change (Bellot, 2011). In their model of organizational culture, Silvester, Anderson and Patterson (1999) suggested that culture changes when either individuals encounter new situations that challenge old assumptions, requiring them to formulate new beliefs, or individuals hear views or beliefs from other group members which help them to explain new situations. Thus, any change is “likely to be slow and will depend upon individuals being challenged by new situations and organizational events” (Silvester, et al., 1999, p. 19). If the mental health program accepts the recommendation to develop a vision of patient and family centred care, the culture will need to be examined and potentially re-shaped. In a retrospective study, Allen and Allen (1987) found three factors to be important to the success of cultural change efforts: a sense of community, a positive culture, and a shared vision. Cameron and Quinn (1999) strongly believed diagnosing and changing culture is a crucial factor in the long-term effectiveness of an organization and a neglect of culture may lead to failure of organizational change initiatives. The mental health program at PHC is in a great position to build on the culture of patient and family centred care as this inquiry identified this program has many key ingredients of a positive culture. The literature suggested a culture that valued respect, empowerment, and choice for patients, families and staff was paramount and necessary elements to create a patient and family centered culture (Morgan & Yoder, 2012).

The leaders of the mental health program play a critical role in cultural change. Gilley, McMillan and Gilley (2009) found that specific leader behaviours, for example, the ability to motivate, communicate, and build teams, are predictors of successful implementation of organizational change. Schein (1990) believed culture is a learned behaviour, modeled by
leaders who “permit group members to identify with them and internalize their values and assumptions” (p. 115). The mental health program at PHC is fortunate to have skilled, knowledgeable leaders to steer this cultural change.

**Organizational response.** These recommendations have been shared with my organizational sponsor, Leanne Heppell, PHC Vice President responsible for patient and family centred care initiatives throughout the organization. She is very excited about the recommendations and is eager to share the findings, conclusions and recommendations with her staff, the director responsible for the care experience strategic direction. I have also met with the leaders of the mental health program, PHC Director of Mental Health and PHC Head of the Department of Psychiatry/Physician Program Director to review the recommendations. They were very supportive of all the recommendations and keen to institute them. They requested I present the findings and recommendations of this inquiry at Ground Rounds, a research and education session for the physicians and staff of the mental health program, and have encouraged me to apply for research grants to participate in further research and innovation in patient and family centred care within the mental health program at PHC.

**Implications for Future Inquiry**

This inquiry investigated how a culture of patient and family centred care can be nurtured that meets the aspirations of stakeholders within the mental health program of PHC. The results outlined four recommendations for building on a culture of patient and family centred care within the mental health program. Future inquiries could be directed toward PHC’s interest in strategically moving forward with these recommendations and other patient and family centred care initiatives. By conducting a longitudinal research inquiry, there is the opportunity to capture
the shift in culture and monitor the impacts of an increasing patient and family centred care approach. For example, does increasing patient and family centred care approaches affect patient outcomes, patient satisfaction with care, readmission rates, length of stay, or staff satisfaction?

Fortunately, PHC as an organization, and the mental health program are very supportive of patient and family centred care initiatives and are well positioned to explore these additional areas of inquiry.

Chapter Summary

This research project offered insights to further improve the current level of patient care delivery by enhancing a culture of patient and family centred care. Four recommendations are provided in this chapter to build on PHC’s patient and family centred approach and ensure the mental health program is responsive to the needs of patients and families, continually adapts, and takes advantage of opportunities that enhance patient care for the long term. Future research ideas are proposed to further build on patient and family centred care initiatives with the goal of the PHC mental health program providing exemplary treatment and world-class leadership in patient and family centred care.

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Appendix A: Letter of Invitation For Patients and Families

BUILDING ON A CULTURE OF PATIENT AND FAMILY CENTRED CARE IN THE MENTAL HEALTH SETTING

My name is Kim Williams and I am a dietitian within the mental health program at Providence Health Care (PHC). I am researching how a culture of patient and family centred care can be nurtured within the mental health program as part of the requirement for a Master of Arts in Leadership Degree at Royal Roads University.

You are being invited to participate in this research, as you or your family member are currently receiving services from the mental health program, and have unique knowledge and experience that can help increase our understanding the care experience.

I was wondering if you would be interested in meeting with me, as I would like to hear your thoughts about integrating patients and their families into mental health treatment processes.

The interview would be arranged at St. Paul’s Hospital, at a time convenient to you. The interview would last approximately 45 minutes and would be audio recorded with your permission. As a thank-you for your time, you will be given a $10 Starbucks gift card.

Participation in this study is entirely voluntary. You may decide to participate or not to participate, or you may withdraw from the study at any time. Your involvement (or non-involvement) in this study will not affect your care at PHC. None of your health care professionals will see your comments. I will send you a copy of the transcribed interview so you can confirm your comments. At that point, you would be able to make changes – or withdraw your comments completely.

If you wish to arrange an interview, please fill out your contact information on the following page and hand back to your (or your family member’s) clinician or contact me via phone or email as indicated below.

I look forward to speaking with you soon!

Regards,

Kim Williams
Thank you for your willingness to participate in this study!

Contact Information:

Name ____________________________

Phone number ______________________

Email address ______________________

Or

Inpatient Unit ______________________
Appendix B: Consent Form for Staff

BUILDING ON A CULTURE OF PATIENT AND FAMILY CENTRED CARE IN THE MENTAL HEALTH SETTING

Who is conducting the study?

My name is Kim Williams and this thesis research project is part of the requirement for a Master of Arts in Leadership Degree at Royal Roads University. My credentials with Royal Roads University can be established by contacting Dr. Brigitte Harris, Director, School of Leadership, at [telephone number] or [email address]

Members of the research team will include: the Director of Research of the PHC Eating Disorder Program, Dr. Josie Geller; and fellow learner from my Royal Roads University cohort, Liz Jolley, Professional Practice Leader, PHC Respiratory Services.

Purpose of the study

The objective of my research project is to explore how a culture of patient and family centred care can be nurtured within the mental health program at PHC. Patient and family centred care includes important aspects of care such as collaboration, information sharing, dignity and respect.

You are being invited to participate in this research as you currently work within the Mental Health Program at Providence Health, and I believe you have important experience to help increase our understanding of how to build on a culture of patient and family centred care within the mental health setting.

This phase of my research project will consist of a world café event and is estimated to last one and a half hours.

If you say “yes”

If you agree to participate in this research, you will be invited to a world café event. The world café will consist of three tables each with different questions about patient and family centred care. The participants at each of the tables will be prearranged so that no participant will be with other participants that are in a reporting relationship to each other.
Participation in the world café event will require 90 minutes of your time. The world café will be recorded by the table hosts (Change Specialists from PHC Change Initiatives) on flip charts and transcribed so that we can analyze and code the content. The type of data recorded will be a description of the conversation at each table. The café report-outs and plenary dialogue will be audio recorded and transcribed so that we can analyze and code the content. No identifying information will appear on the transcript.

An example of a question to be discussed at one of the tables is “What are the practices of patient and family centred care that are really working well in the mental health program of PHC?”

**Study results**

I will be submitting my final report to Royal Roads University in partial fulfillment for a Master of Arts in Leadership Degree. Upon acceptance, the thesis will be published and archived in the Royal Roads University Library and in the Thesis Canada Portal of Library and Archives Canada. I will also be sharing my research findings with Providence Health Care Senior Leadership Team and the Mental Health Program Leadership. I may also submit an abstract to a conference or article for publication to an appropriate journal.

**What are the benefits and risks of participating?**

The participants may not directly benefit from this study; however, investigating how a climate of patient and family centred care can be fostered within the mental health program has the potential to build on PHC’s patient and family centred approach and ensures PHC is responsive to the needs of patients and families, continually adapts, and takes advantage of opportunities that enhance patient care for the long term. There are no known risks (besides giving of your time) to participating in this research study.

**Real or Perceived Conflict of Interest**

Please be aware that you are not required to participate and, should you choose to participate, your participation would be entirely voluntary. If you do choose to participate, you are free to withdraw without prejudice. If you do not wish to participate, simply do not reply to this request. Your decision to not participate will also be maintained in confidence. Because of the group nature of the world café, your identity and the contributions you make will not be completely anonymous or confidential but will be known by the other participants. However, each participant will be required to agree to keep all such information confidential and to not discuss it with any individuals who were not in attendance at the world café session. As well, because of the group nature of this session, if you participate and later decide to withdraw, any comments you contributed will not be able to be deleted from the record. I disclose this...
information here so that you can make a fully informed decision on whether or not to participate in this study.

**How will your privacy be maintained?**

Participants will be encouraged to conduct a dialogue with their peers. The table hosts will create a document with the participants’ ideas. At the close of the café, the hosts will verbally report out on what they heard. This verbal report will reflect the document created by the table participants. The café report-outs and plenary dialogue will be audio recorded and transcribed so that we can analyze and code the content. I will work to protect your privacy throughout this study. All information I collect will be maintained in confidence with hard copies (e.g., consent forms) stored in a locked filing cabinet in my work office.

Electronic data (such as transcripts or audio files) will be stored on a password-protected storage device on my work computer. Information will be recorded in hand-written format, transcribed and, where appropriate, summarized, in anonymous format, in the body of the final report. At no time will any specific comments be attributed to any individual unless specific agreement has been obtained beforehand. Only the principal investigator and the transcriptionist, who has signed a confidentiality agreement, will have access to the recordings. All documentation will be kept strictly confidential. The data will be stored for the timeline of five years after the approval of the final report by Royal Roads University in accordance with their guidelines. Once the digital recordings have been transcribed the recordings will be erased and deleted from the recording device. After five years all paper copies of transcribed data will be shredded.

Your confidentiality will be respected. Information that discloses your identity will not be released without your consent. All documents will be identified only by code number and kept in a locked filing cabinet. Participants will not be identified by name in any reports of the completed study. We encourage all participants to refrain from disclosing the contents of the discussion outside of the world café event; however, we cannot control what other participants do with the information discussed.

**Will you be paid for taking part in this study?**

We will not pay you for the time you take to be in this study. However, as this event is over the lunch hour, a light lunch and refreshments will be served.

**Who can you contact if you have questions about the study?**

Please feel free to contact me at any time should you have questions or concerns regarding the project and its outcomes [email address] or [telephone number].

If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, you may contact the Research Subject Information Line in the
UBC Office of Research Services at [telephone number] or if long distance e-mail [email address] or call toll free [telephone number].
PARTICIPANT CONSENT AND SIGNATURES

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you choose not to participate in this research project, this information will be maintained in confidence.

If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without prejudice.

Your signature below indicates that you consent to participate in this study and indicates that you have received a copy of this consent form for your own records.

__________________________  __________________________
Signature of Participant     Name (please print)

Date: _____________________

Thank you for your willingness to participate in this study.
Appendix C: Consent Form for Leaders

BUILDING ON A CULTURE OF PATIENT AND FAMILY CENTRED CARE IN THE MENTAL HEALTH SETTING

Who is conducting the study?

My name is Kim Williams and this thesis research project is part of the requirement for a Master of Arts in Leadership Degree at Royal Roads University. My credentials with Royal Roads University can be established by contacting Dr. Brigitte Harris, Director, School of Leadership, at [telephone number] or [email address].

Members of the research team will include: the Director of Research of the PHC Eating Disorder Program, Dr. Josie Geller; and fellow learner from my Royal Roads University cohort, Liz Jolley, Professional Practice Leader, PHC Respiratory Services.

Purpose of the study

The objective of my research project is to explore how a culture of patient and family centred care can be nurtured within the mental health program at PHC. Patient and family centred care includes important aspects of care such as collaboration, information sharing, dignity and respect.

Your name was chosen as a prospective participant because you are either a leader of the PHC Mental Health Program or a leader responsible for the patient and family centred care initiatives at PHC.

This phase of my research project will consist of a focus group and is estimated to last one hour.

If you say “yes”

If you agree to participate in this research, you will be invited to a focus group.
Participation in the focus group will require 60 minutes of your time. The focus group will be audio taped and transcribed so that we can analyze and code the content. No identifying information will appear on the transcript.

An example of a question to be discussed in the focus group is “What are the practices of patient and family centred care that are really working well at PHC?”

Study results

I will be submitting my final report to Royal Roads University in partial fulfillment for a Master of Arts in Leadership Degree. Upon acceptance, the thesis will be published and archived in the Royal Roads University Library and in the Thesis Canada Portal of Library and Archives Canada. I will also be sharing my research findings with Providence Health Care Senior Leadership Team and the Mental Health Program staff. I may also submit an abstract to a conference or article for publication to an appropriate journal.

What are the benefits and risks of participating?

You will not directly benefit from participating in this study; however, investigating how a climate of patient and family centred care can be fostered within the mental health program has the potential to build on PHC’s patient and family centred approach and ensures PHC is responsive to the needs of patients and families, continually adapts, and takes advantage of opportunities that enhance patient care for the long term. There are no known risks (besides giving of your time) to participating in this research study.

Real or Perceived Conflict of Interest

Please be aware that you are not required to participate and, should you choose to participate, your participation would be entirely voluntary. If you do choose to participate, you are free to withdraw without prejudice. If you do not wish to participate, simply do not reply to this request. Your decision to not participate will also be maintained in confidence. Because of the group nature of the focus group, your identity and the contributions you make will not be completely anonymous or confidential but will be known by the other participants. However, each participant will be required to agree to keep all such information confidential and to not discuss it with any individuals who were not in attendance at the focus group session. As well, because of the group nature of this session, if you participate and later decide to withdraw, any comments you contributed will not be able to be deleted from the record. I disclose this information here so that you can make a fully informed decision on whether or not to participate in this study.

How will your privacy be maintained?

The dialogue of the focus group will be audio taped and transcribed. I will work to protect your privacy throughout this study. All information I collect will be maintained in
confidence with hard copies (e.g., consent forms) stored in a locked filing cabinet in my work office.

Electronic data (such as transcripts or audio files) will be stored on a password-protected storage device on my work computer. Information will be recorded in hand-written format, transcribed and, where appropriate, summarized, in anonymous format, in the body of the final report. At no time will any specific comments be attributed to any individual unless specific agreement has been obtained beforehand. All documentation will be kept strictly confidential. Data will be stored for 5 years; audio recordings will be deleted following transcription.

Your confidentiality will be respected. Information that discloses your identity will not be released without your consent. All documents will be identified only by code number and kept in a locked filing cabinet. Participants will not be identified by name in any reports of the completed study. We encourage all participants to refrain from disclosing the contents of the discussion outside of the focus group; however, we cannot control what other participants do with the information discussed.

**Will you be paid for taking part in this study?**

We will not pay you for the time you take to be in this study.

**Who can you contact if you have questions about the study?**

Please feel free to contact me at any time should you have questions or concerns regarding the project and its outcomes [email address] or [telephone number].

**Who can you contact if you have questions about the study?**

If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, you may contact the Research Subject Information Line in the UBC Office of Research Services at [telephone number] or if long distance e-mail [email address] or call toll free [telephone number].
PARTICIPANT CONSENT AND SIGNATURES

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you choose not to participate in this research project, this information will be maintained in confidence.

If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without prejudice.

Your signature below indicates that you consent to participate in this study and indicates that you have received a copy of this consent form for your own records.

_____________________________  ______________________
Signature of Participant                 Name (please print)

Date: ______________________

Thank you for your willingness to participate in this study.
Appendix D: Confidentiality Agreement

BUILDING ON A CULTURE OF PATIENT AND FAMILY CENTRED CARE IN THE MENTAL HEALTH SETTING
Privacy and Confidentiality

AGREEMENT

Between

Kim Williams

(Researcher)

and

(Name of Transcriptionist/World Café Table Host)

This agreement is part of a research thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF ARTS in LEADERSHIP- Health at Royal Roads University conducted with the approval of Providence Health Care Research Ethics Boards.

As an individual providing transcriptionist support for this Research Project:

1. I understand that I am responsible for maintaining the privacy and confidentiality of all information I am exposed to from data collection sessions &/or data analyses.
2. I understand that I will have access to raw research data in a form that could be used to identify the individual(s) to whom it relates. I will not disclose any information to any other person and am bound by all terms and conditions of the present agreement.
3. Information and data collected and contained in the research records I create through transcription will not be used or disclosed for any purpose other than the prescribed project.
4. I understand that Kim Williams (Researcher) is the sole owner of all data transcribed for this project.
Appendix E: Inquiry Team Member Letter of Agreement

BUILDING ON A CULTURE OF PATIENT AND FAMILY CENTRED CARE IN THE MENTAL HEALTH SETTING

In partial fulfillment of the requirement for a Master of Arts in Leadership Degree at Royal Roads University, Kim Williams (the Student) will be conducting an inquiry research study at Providence Health Care to explore how a culture of patient and family centred care can be nurtured to meet the aspirations of stakeholders within the mental health program at Providence Health Care. My credentials with Royal Roads University can be established by calling Dr. Brigitte Harris, Director, School of Leadership, at [telephone number] or email [email address]

Inquiry Team Member Role Description

As a volunteer Inquiry Team Member assisting the Student with this project, your role may include one or more of the following: providing advice on the relevance and wording of questions and letters of invitation, supporting the logistics of the data-gathering methods, including observing, assisting, or facilitating an interview, world café or focus group, taking notes, or analyzing data, to assist the Student and Providence Health Care’s organizational change process. In the course of this activity, you may be privy to confidential inquiry data.

Confidentiality of Inquiry Data

In compliance with the Royal Roads University Research Ethics Policy, under which this inquiry project is being conducted, all personal identifiers and any other confidential information generated or accessed by the inquiry team member will only be used in the performance of the functions of this project, and must not be disclosed to anyone other than persons authorized to receive it, both during the inquiry period and beyond it. Recorded information in all formats is covered by this agreement. Personal identifiers include participant names, contact information, personally identifying turns of phrase or comments, and any other personally identifying information.

Personal information will be collected, recorded, corrected, accessed, altered, used, disclosed, retained, secured and destroyed as directed by the Student, under direction of the Royal Roads Academic Supervisor.
Inquiry Team Members who are uncertain whether any information they may wish to share about the project they are working on is personal or confidential will verify this with Kim Williams, the Student.

**Statement of Informed Consent:**

I have read and understand this agreement.

________________________  __________________________  _____________
Name (Please Print)  Signature  Date
Appendix F: Protocol for the Interview

BUILDING ON A CULTURE OF PATIENT AND FAMILY CENTRED CARE IN THE MENTAL HEALTH SETTING

Set Up

Before the start of the interview, the room will be checked for a comfortable temperature and water, coffee, or tea will be prepared. A blank consent form will be on hand. Upon arrival the participant will be welcomed in the following way. At no point during the research process will the participants be coerced to participate or deceived in any way.

Opening Commentary

Welcome (name of participant) to this interview for the purposes of gaining unique insights into how the mental health program at PHC can build on a culture of patient and family centred care. I am a Masters in Leadership Health student at Royal Roads University completing a thesis requirement with the PHC.

Your time and participation is greatly appreciated. You have been chosen for this interview due to your personal insight, knowledge and expertise. Thank you for signing a consent/confidentiality form (participant to sign form if they have not already).

You will be asked a series of questions that support dialogue on the topic of this research project. Your answers will not be right or wrong. They will be your valuable insights into the topic. The session will last approximately an hour. You can choose to withdraw at any time. All your information will be kept confidential and recorded anonymously and you will be given an opportunity to look over the transcribed data for accuracy within one week of the interview.

This interview will be digitally recorded and I may make some notes to guide the process. You may ask that the digital recorder be turned off for a few minutes at any time during the interview, and then turned on again when you are ready. Are you ok with this? All data recordings will be transcribed by an external transcriptionist who has signed a confidentiality agreement. The recorded data will be transferred to the transcriptionist directly from myself and no one else will have access to the recordings.

The data collected from this interview will be analyzed for themes along with the other interviews I will conduct. As this research will also be published, a copy of this thesis will reside in the RRU library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal, and the ProQuest/ UMI database.

All data collected will be kept at my work office in a secure place, on my password-protected computer and on a USB so that no external viewer can decipher the participants’
identity. The data will be stored for the timeline of five years after the final report has been approved by Royal Roads University in accordance with their guidelines. Once the digital recordings have been transcribed the recordings will be erased and deleted from the recording device. After five years all paper copies of transcribed data will be shredded. Continuing consent will be requested if the final thesis is used to launch future research projects.

I will ask you a series of questions one at a time with ample time between for discussion. Once a question has been explored thoroughly I will give you a brief summary of the discussion and move on to the next question. As this is a semi-structured approach other topics/questions on peer work may arise that we can also address. I am interested in hearing your stories and ideas on the topic area so will encourage you to share your thoughts.

The questions you will be asked in the interview are as follows:

1. When it is at its best, what does patient and family centred care mean to you?
2. In your experience, what are the practices of patient and family centred care that are really working well in the mental health program of Providence Health Care?
3. Tell me about a time when you and/or your family member felt included in your treatment in the mental health program. What was it about that time that made it so memorable to you? If you don’t have a time in mind, what would you envision inclusion of you or your family member into your treatment would look like?
4. When done well, what are the benefits of patient and family centred care?
5. Are there practices of patient and family centred care you would have liked to experience in the mental health program of Providence Health Care?

Closing

Upon completion of the interview the participant will be asked if they have anything else they would like to contribute before we close. I do not anticipate any adverse feelings as a result of the interview, but if the participates due have some feelings that require attention, I will direct the participant to their health care provider. The data will be transcribed within a week of the interview. At that point the participants will have an opportunity to look over their own transcript. They will have one week to look over their transcript and return it back to me. They can return it back to me by email at [email address] or by mail at [address].
Appendix G: Protocol & Questions for the World Café

BUILDING ON A CULTURE OF PATIENT AND FAMILY CENTRED CARE
IN THE MENTAL HEALTH SETTING

Set Up

Before the start of the world café, the room will be set up with tablecloths, paper, writing utensils, music and flowers to simulate the café ambience. The room will be checked for a comfortable temperature. Catered sandwiches, water, coffee, or tea will be provided. Upon arrival, the participant will be welcomed and confirmed that the consent form has been signed. A blank consent form will be on hand. The participants will be offered to help themselves to a catered lunch and shown which table they will be starting the world café at. At no point during the research process will the participants be coerced to participate or deceived in any way.

Timeline for world café of 90 minutes

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to the session</td>
<td>10 minutes</td>
</tr>
<tr>
<td>First rotation</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Move to next table</td>
<td>3 minutes</td>
</tr>
<tr>
<td>Second rotation</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Move to next table</td>
<td>3 minutes</td>
</tr>
<tr>
<td>Third rotation</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Report out by table hosts</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Further discussion</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Closing remarks</td>
<td>10 minutes</td>
</tr>
</tbody>
</table>

Opening Commentary

Welcome to this world café discussion forum. I am a Masters in Leadership Health student at Royal Roads University completing a thesis requirement with the PHC.

The purpose of this café is to bring our peers together to engage in rich dialogue and gain unique insights into how the mental health program at PHC can build upon a culture of patient and family centred care.

The following change specialists are assisting as table hosts and taking notes on flip charts. (Introduce the change specialists) My fellow research inquiry members will be introduced, and assurances given that they have signed a confidentiality agreement.

Your time and participation is greatly appreciated. Thank you for signing a consent/confidentiality form (participant to sign form if they have not already).
Thank you for expressing your interest in taking part in the world café component of my research. Using qualitative action research methods, my goal is to develop recommendations to PHC on how the mental health program can build on a culture of patient and family centred care. The information gathered from this world café will be used in combination with other data gathered from interviews and a focus group to produce a final report.

You will participate in this world café event with fellow staff members of the mental health program at PHC, each of whom brings diverse backgrounds. Your participation is completely voluntary and you will have the right to withdraw at any time.

All data collected will be kept in my work office in a secure place, on my password-protected computer and on a USB so that no external viewer can decipher the participants’ identity. The data will be stored for the timeline of five years after the approval of the final report by Royal Roads University in accordance with their guidelines. After five years all paper copies of transcribed data will be shredded. Continuing consent will be requested if the final thesis is used to launch future research projects.

You will be asked a series of questions that support dialogue on the topic of this action research project. Your answers will not be right or wrong. Your thoughts and ideas will be valuable insights into the topic. The session will last approximately ninety minutes. You can choose to withdraw at any time. All your information will be kept confidential and you will be given an opportunity to look over the transcribed data for accuracy within one week of the world café group. The report out town hall discussion will be audio recorded. Please do not identify yourself or others you may know by name to respect confidentiality.

The data collected from this world café will be analyzed for themes along with the other data I have collected. A copy of this thesis will reside in the Royal Roads University library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal and the ProQuest/UMI database.

We hope that you find our café one where you can actively engage in a safe and welcoming environment. As this is a large group method, there is a requirement that to agree to keep confidential any information shared by participants and the identity of those participants from those who were not part of the world café.

Process

• There are three tables in this café, each with a different question

• Each round will consist of ten minutes of discussion. I will signal to the café that there is one minute left for the discussion. When the music starts to play that is your cue to move to the next table (clockwise movement). There will be three minutes for you to arrive at the next table. Please move to your next table as a group.
• Each table has a host. The role of the host is to engage in the conversation as a participant and to capture key themes of the discussion on the flip chart paper. The host will remain at the table and share the essence of the conversation for the guests arriving for the next round.

We hope that you find this experience fun and we look forward to the rich and engaging discussions.

The questions at each of the café tables will be as follows:

1. What are the practices of patient and family centred care that are really working well currently in the mental health program of Providence Health Care?

2. What is your vision of an ideal climate of patient and family centred care within the mental health setting?

3. What are the benefits and rewards of patient and family centred care? and What are the challenges/barriers to patient and family centred care that you would most like to see resolved?

Turn on digital recording devices. Once the three rounds of dialogue have taken place, all participants will be involved in a town hall discussion to summarize the findings, seek clarification and validation of the data generated, and examine a fourth question, *What opportunities exist within PHC’s mental health program to optimize support of the successful implementation of further practices of patient and family centred care?*

**Closing**

Upon completion of the world café the participants will be asked how they feel about the process. After the data is transcribed the participants will have the opportunity to look over their comments to make sure what they said was captured accurately. These summaries will be transcribed and sent to all participants for member checking.
Appendix H: Protocol and Questions for the Focus Group

BUILDING ON A CULTURE OF PATIENT AND FAMILY CENTRED CARE
IN THE MENTAL HEALTH SETTING

Set Up

Before the start of the focus group, the room will be checked for a comfortable temperature and water, tea or coffee will be prepared. The room chairs will be set up in a circular format with a table in the centre. There will also be two digital recorders to record the session. Blank consent forms will also be on hand. Upon arrival the participants will be welcomed in the following way. At no point during the research process will the participants be coerced to participate or deceived in any way.

Timeline for focus group of 60 minutes
Opening remarks/questions 5 minutes
Questions 7-8 minutes per question. Total 50 minutes
Closing remarks 5 minutes

Opening Commentary
Welcome to this focus group for the purposes of gaining unique insights into how the mental health program at PHC can build upon a culture of patient and family centred care. We know each other from our work at the PHC. I am a Masters in Leadership Health student at Royal Roads University completing a thesis requirement with the PHC.

The fellow inquiry team member who is assisting with note taking on flip charts will be introduced, and assurances given that she has signed a confidentiality agreement.

Your time and participation is greatly appreciated. Thank you for signing a consent/confidentiality form (participant to sign form if they have not already).

Thank you for expressing your interest in taking part in the focus group component of my research. Using qualitative action research methods, my goal is to develop recommendations to PHC on how the mental health program can build on a culture of patient and family centred care. The information gathered from this focus group will be used in combination with other data gathered from interviews and a world café to produce a final report.

You will participate in a focus group with fellow PHC leaders, each of whom brings diverse backgrounds. I will be facilitating and arrangements have been made to ensure that this room remains private and free from interruptions for the time that we are here together. Your
participation is completely voluntary and you will have the right to withdraw at any time. The focus group format will be fluid as long as only one person speaks at a time.

All data collected will be kept in my work office in a secure place, on my password-protected computer and on a USB so that no external viewer can decipher the participants’ identity. The data will be stored for the timeline of five years after the approval of the final report by Royal Roads University in accordance with their guidelines. Once the digital recordings have been transcribed the recordings will be erased and deleted from the recording device. After five years all paper copies of transcribed data will be shredded. Continuing consent will be requested if the final thesis is used to launch future research projects.

You will be asked a series of questions that support dialogue on the topic of this action research project. Your answers will not be right or wrong. Your thoughts and ideas will be valuable insights into the topic. The session will last approximately an hour. You can choose to withdraw at any time. All your information will be kept confidential and you will be given an opportunity to look over the transcribed data for accuracy within one week of the focus group.

This focus group will be digitally recorded and flip chart notes will be taken by my fellow inquiry team member. Are each of you ok with this? I will inform the participants at this point that if they require the digital recorders to be turned off momentarily, they can let me know at any point during the focus group and can also ask that any notes taken on the flip charts be changed, added to, or deleted. All data recordings will be transcribed by an external transcriptionist who has signed a confidentiality agreement. The recorded data will be transferred to the transcriptionist directly from myself and no one else will have access to the recordings.

The data collected from this focus group will be analyzed for themes along with the other data I have collected. A copy of this thesis will reside in the Royal Roads University library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal and the ProQuest/UMI database.

The questions that will frame the focus group session will be as follows:

1. When it is at its best, what does patient and family centred care mean to you?
2. What are the practices of patient and family centred care that are really working well currently in the mental health program of Providence Health Care?
3. What is your vision of an ideal climate of patient and family centred care within the mental health setting?
4. What are the benefits and rewards of patient and family centred care?
5. What are the challenges/barriers to patient and family centred care that you would most like to see resolved?
6. What opportunities exist within PHC’s mental health program to optimize support of the successful implementation of further practices of patient and family centred care?
Process

The focus group will be free flowing like a dialogue focused on the above questions. Silence will be honoured and if needed myself as the facilitator will guide the participants on to the next question when the group seems to be finished with the last. I will encourage quiet people to take a turn sharing their knowledge. If conflict or tension arises I will mediate it by stating that we are bound to come across some difference of opinions and I encourage everyone to keep learning and sharing in a respectful manner.

Closing

Upon completion of the focus group the participants will be asked how they feel about the process. When the data is transcribed they will be told they will have the opportunity to look over their comments to make sure what they said was captured accurately.
Appendix I: Consent Form for Patients and Families

BUILDING ON A CULTURE OF PATIENT AND FAMILY CENTRED CARE IN THE MENTAL HEALTH SETTING

Who is conducting the study?

My name is Kim Williams and this thesis research project is part of the requirement for a Master of Arts in Leadership Degree at Royal Roads University. My credentials with Royal Roads University can be established by contacting Dr. Brigitte Harris, Director, School of Leadership, at [telephone number] or [email address]

Purpose of the study

The objective of my research project is to explore how a culture of patient and family centred care can be nurtured within the mental health program at PHC. Patient and family centred care includes important aspects of your care such as collaboration, information sharing, dignity and respect.

You are being invited to participate in this research in order to increase our understanding of how to build on a culture of patient and family centred care within the mental health setting. Participation in this study is entirely voluntary. You may decide to participate or not to participate, or you may withdraw from the study at any time.

Your involvement (or non-involvement) in this study will not affect your care at PHC. None of your health care professionals will see your comments.

If you say “yes”

If you agree to participate in this research, you will be invited to meet with Kim Williams to complete an interview that addresses your thoughts about integrating patients and their families into mental health treatment processes. The interview will be arranged at St. Paul’s Hospital, at a time convenient to you. Participation in the interview will require 45 minutes of your time. The interview will be audiotaped and transcribed so that we can analyze and code the content. No identifying information will appear on the transcript.
An example of an interview question you will be asked is “Can you think of a time when you and/or your family member had a really positive experience with treatment? What was it about that time that made it feel positive?”

**Study results**

I will be submitting my final report to Royal Roads University in partial fulfillment for a Master of Arts in Leadership Degree. Upon acceptance, the thesis will be published and archived in the Royal Roads University Library and in the Thesis Canada Portal of Library and Archives Canada. I will also be sharing my research findings with Providence Health Care staff. I may also submit an abstract to a conference or article for publication to an appropriate journal.

**Is there any way being in this study could be bad for you?**

We do not think there is anything in this study that could harm you or be bad for you. Some of the questions we ask might upset you. Please let one of the study staff know if you have any concerns.

**What are the benefits of participating?**

No direct benefits are anticipated from this research. However, you may find that the interview helps you to clarify what you have found helpful with you or your loved one’s treatment. In the future, others may benefit from what we learn in this study.

**How will your privacy be maintained?**

The dialogue of the interview will be audio taped and transcribed. I will work to protect your privacy throughout this study. All information I collect will be maintained in confidence with hard copies (e.g., consent forms) stored in a locked filing cabinet in my work office.

Electronic data (such as transcripts or audio files) will be stored on a password-protected storage device on my work computer. Information will be recorded in hand-written format, transcribed and, where appropriate, summarized, in anonymous format, in the body of the final report. At no time will any specific comments be attributed to any individual unless specific agreement has been obtained beforehand. All documentation will be kept strictly confidential. Data will be stored for 5 years; audio recordings will be deleted following transcription.

Your confidentiality will be respected. Information that discloses your identity will not be released without your consent. All documents will be identified only by code number and kept in a locked filing cabinet. Participants will not be identified by name in any reports of the completed study.

**Will you be paid for taking part in this study?**
We will not pay you for the time you take to be in this study. However, you will be given a $10 Starbucks gift card as an honorarium.

**Who can you contact if you have questions about the study?**

Please feel free to contact me at any time should you have questions or concerns regarding the project and its outcomes [email address] or [telephone number].

If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, you may contact the Research Subject Information Line in the UBC Office of Research Services at [telephone number] or if long distance e-mail [email address] or call toll free [telephone number].
PARTICIPANT CONSENT AND SIGNATURES

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on your treatment from Providence Health Care. Should you decide to withdraw; all information provided by you will be destroyed and will not be used in this study.

Your signature below indicates that you consent to participate in this study and indicates that you have received a copy of this consent form for your own records.

__________________________  ____________________________
Signature of Participant      Name (please print)

Date: ______________________

Contact Information
Phone number:
Email address:
Or
Inpatient Unit:

Thank you for your willingness to participate in this study.