Promoting Nurse-Patient Therapeutic Relationship in the Patient Assessment and Transition to Home Unit at Peace Arch Hospital

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Abstract

Nurse–patient therapeutic relationships (NPTR) have the potential to contribute to optimal health conditions for patients and facilitate quality and effective nursing care; however, there is not always a commitment and focus on NPTR practice. This action-oriented inquiry engaged nursing staff at the Patient Assessment and Transition to Home (PATH) unit at Peace Arch Hospital (PAH) to explore through an appreciative orientation the overarching research question: How might the nursing staff enhance the nurse–patient therapeutic relationship in the PATH unit? Engaging nursing staff through a series of stringed Liberating Structures revealed that the nursing staff are practicing NPTR through diverse and complementary ways, such as building rapport, honest communication, being empathetic, and going above and beyond the assigned responsibility. In addition, situational and systemic factors help nurture NPTR in practice, including staff education and collaboration, patient willingness, and time availability. However, participants also revealed an enhanced emphasis on NPTR is needed to improve patient care, staff well-being and reduce operational costs. The research concludes offering action-oriented recommendations to support an ongoing commitment to NPTR and enhanced NPTR practice.

Keywords: nurse-patient therapeutic relationship, therapeutic relationship, appreciative inquiry.

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Dedication

This work is dedicated to the Almighty God, who is the origin of wisdom, power and strength, the source of knowledge, and the giver of life. To the memory of my late father, Pa Adeniyi Popoola, who wished I become a nurse on his sick bed in 1984 because of the therapeutic relationship the nurses who took care of him demonstrated. I also dedicate it to my beloved husband and pastor, Dr. James Fabiyi, and beloved daughter, Dorcas Promise Fabiyi, for always motivating me to go for gold.

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List of Abbreviations

BC	British Columbia
CNE	Clinical Nurse Educator
FHA	Fraser Health Authority
HCA	Health Care Aides
LPN	Licenced Practical Nurse
MAL-H	Master of Art in Leadership–Health Specialization
NPTR	Nurse–Patient Therapeutic Relationship
PATH	Patient Assessment and Transition to Home
PAH	Peace Arch Hospital
RN	Registered Nurse

Chapter One: Focus and Framing

At the end of the third year of my undergraduate program in nursing, I had the privilege of working as a live-in caregiver for Angelina (pseudonym), an 83-year-old Caucasian woman in the United States of America. She was diagnosed with end-stage chronic obstructive pulmonary disease, depression, and other comorbidities. She struggled with breathing and was on four liters of home oxygen. She quickly got irritated, and it was often difficult for previous caregivers to offer satisfactory care, regardless of how much they tried. When I first moved in, I spent my first three weeks trying to understand her interactions, actions, and reactions. I tried to understand how it might be for her to breathe, and I used my hand to close my nose for a few seconds to help me begin to understand what she might be going through. This helped me to relate to her and to be empathetic and caring. As we developed a nurse–patient relationship, she became easy to care for, cheerful, accepting, and loving. In the final months of her life, she also showed little to no signs of depression.

As she neared her end-of-life, we discussed her wishes. She shared that she did not want to experience the sensation of suffocating to death. As she was dying, I worked with the hospice staff to help ensure her wish was honoured, and she had a painless and peaceful death. Although the hospice staff slighted me, I was steadfast in my conviction to support her wishes and was able to politely and calmly advocate for care that supported her wish to not experience the sensation of suffocating to death. When she passed away calmly, her children expressed deep appreciation for the way I cared for their mother. This experience continues to stay with me, and it sparked a light in my heart to explore how we can promote the nurse–patient therapeutic relationship (NPTR) in nursing practice.

The NPTR with the patient can promote optimal health conditions (Benbenishty & Hannink, 2017) and facilitate quality and effective nursing care (Soklaridis et al., 2016). According to Molina-Mula and Gallo-Estrada (2020), focusing on the NPTR also has the potential to enhance patient recovery, reduce the length of stay in the hospital, and in some cases, prevent hospitalizations. Furthermore, a focus on the NPTR can help nurses and patients experience potentially satisfying and rewarding benefits of providing and receiving care (Molina-Mula & Gallo-Estrada, 2020). Therefore, the purpose of my thesis was to explore and enhance NPTR in the Patient Assessment and Transition to Home Unit (PATH) at Peace Arch Hospital (PAH).

The specific objectives of this research were:

- To engage PATH unit nursing staff in a research process to share their thoughts, perspectives, and insights;
- To define conditions that favour the promotion of a therapeutic relationship between nursing staff and patients from the perspective of PATH unit nursing staff; and
- To identify implementable strategies for promoting and maintaining a therapeutic relationship by the nursing staff.

Exploring change possibilities in any organization can be supported by Stroh's (2015) four-stage change process. Stroh's four-stage change involves (a) establishing a reason for a change, (b) identifying the current reality, (c) choosing a consensus-desired goal, and (d) focusing on high-leverage interventions. I adopted a "how might we" phrase coined by Berger (2012, para. 1) to frame my project inquiry questions and subquestions to provide answers that address the four-stage change process. “How might we” is an inclusion phrase to motivate people to contribute their ideas without fear of being judged or rejected (Berger, 2012, para. 1).

The principal research question guiding my inquiry was: How might the nursing staff enhance the nurse–patient therapeutic relationship in the Patient Assessment and Transition to Home (PATH) Unit at Peace Arch Hospital (PAH)? In this study, registered nurses (RNs), licenced practical nurses (LPNs), and health care assistants (HCAs) are referred to as nursing staff. In using this term, I acknowledge that health care assistants are not nurses, yet are valuable stakeholders in promoting the nurse–patient therapeutic relationship.

The subquestions were:

- Why is a nurse–patient therapeutic relationship important?
- How is the nurse–patient therapeutic relationship currently nurtured?
- What might be possible if we prioritized the nurse patient-therapeutic relationship?
- What strategies and supports nurture the nurse–patient therapeutic relationship?

Recognizing this project’s context, nurses and patients are the primary stakeholders; however, nurses were the only participants engaged in this study. Patients were intentionally excluded given the time limitations of this project; however, it is important to recognize that they are an important player in the nurse–patient therapeutic relationship and need to be engaged to fully understand how to best nurture the nurse-patient therapeutic relationship.

I conducted this research with nursing staff working within the newly reorganized PATH unit at PAH (see Organizational Context below for more information). Currently, I have a permanent position in this unit as a RN. My unit manager was my official partner. Her role was to help me identify and articulate the opportunity to be explored during the project and promote my organization's interests. She also supported the implementation of any recommended strategies that emerge from this study.

Significance of the Inquiry

This project is significant for my partnering organization because it can enhance therapeutic relationships with patients, which will ideally lead to increased patient and staff satisfaction and patient health outcomes. Specifically, this research intended to help the nursing staff in the PATH unit have their voices heard, reach a community agreement to enhance their work and eventually feel a greater sense of fulfillment. Furthermore, it is hoped that this research will support NPTR, which may bring about a sense of satisfaction among staff that leads to nursing staff retention (Zamanzadeh et al., 2015).

Being a RN, I have a connection with this project because it focuses on promoting NPTR, which I believe is critical to improving patient outcomes and enhancing job satisfaction. Learning from the project will help me better engage in a therapeutic relationship with patients, resulting in job satisfaction. I believe the project will help me promote change in my organization by enabling multiple perspectives to contribute towards change.

Organizational Context and Systems Analysis

As noted above, this inquiry was conducted in the newly reorganized PATH unit at PAH under the Fraser Health Authority (FHA). FHA is one of the five regional health authorities in British Columbia (BC) working together under the BC Ministry of Health. The BC Ministry of Health (2015) has broad goals of:

> improving the health of populations; improving the patient experience of care (including quality and satisfaction), to which B.C. has recognized the additional requirement of improving the experience of delivering care for providers and support staff as critical to patient-centred care, build on efforts of those who deliver and support health services; and reducing the per capita cost of health by focusing on quality and efficiency of health care delivery. (p. 3)

To move towards these goals, FHA is committed to improving the health of the population and the quality of life of the people they serve while being guided by the values of respect, caring, and trust (FHA, n.d.). Within the PATH unit, relationships also imbibe respect, trust, and caring (Patient Assessment and Transition to Home, 2016), which are values at the heart of NPTR.

The PATH unit is categorized as a subacute unit, where medically stable patients are supported to be more independent, especially regarding their mobility before their discharge home or to the community. The sustainable transition of patients to their homes is the vision of the PATH unit.

When this inquiry was conceptualized, there were two PATH units located at PAH. The first PATH unit—6-South PATH unit—was located in the main hospital building and admitted only patients from the PAH, and the second PATH unit—Regional PATH unit—was located in another building at PAH away from the main building and admitted patients from all over the FHA region. In June 2020, the 6-South PATH unit was relocated to the site of the Regional PATH unit to create space for COVID-19 patients in the hospital's main building, and the two PATH units merged. The merged PATH unit at PAH, herein referred to as the PATH unit, has two floors. The main, ground-level floor is called Weatherby-1 and the upper floor is called

Weatherby-2. Patients in both Weatherby-1 and Weatherby-2 are admitted from PAH and the FHA region. Weatherby-1 provides care to patients who have a destination to return to, such as home, long-term care, rehabilitation, or convalescent care; and Weatherby-2 provides care to patients who have no fixed address or are experiencing housing problems. PATH unit was reorganized into Weatherby-1 and Weatherby-2 based on an assessment of patient care needs. The estimated length of stay for a patient in Weatherby-1 is five days, whereas the length of a stay for a patient in Weatherby-2 is longer as it often includes plans for placement, a safe discharge and reintegration back into the community. Many patients in Weatherby-2 have more complex behavioural and care needs often resulting from addiction, depression, and self-neglect.

The total number of patient beds in the PATH unit at PAH (Weatherby-1 and Weatherby-2) is 62. Weatherby-1 has 42 patient beds (28 beds are allocated for patients from PAH and the remaining 14 beds are allocated for patients from the regional FHA) and Weatherby-2 has 20 beds. During weekdays, Weatherby-1 is staffed by one unit manager, one unit clerk, one patient care coordinator who is a RN, two RNs, one LPN, four HCAs, and six health care allies (one occupational therapist, one physiotherapist, one rehab assistant, one social worker, one home health liaison, one dietician). During the day, two RNs and an LPN each care for 14 patients each, and at night Weatherby-1 is staffed with two RNs and three HCAs who are responsible for all 42 patient beds on Weatherby-1. During weekdays, Weatherby-2 is staffed by one unit manager, one patient care coordinator who is an RN, one RN, one LPN, three HCAs and health care allies. At night one RN, one LPN and two HCAs are responsible for all 20 patient beds on Weatherby-2. In total, 49 regular nursing staff (RN, LPN, and HCA) and other causal nursing staff work on the Weatherby-1 while Weatherby-2 has a total of 22 regular nursing staff (RN, LPN, and HCA) and other causal nursing staff. The total nursing staff in both Weatherby-1 and Weatherby-2 are 71. The RNs and LPNs work 12-hour shifts while HCAs work eight-hour shifts.

This inquiry engaged nursing staff from this newly reconfigured and combined PATH unit from both floors. It is important to acknowledge this reorganization as it has affected the operations and functioning of the PATH unit, and it has also coincided with the global COVID-19 pandemic which further affected the PATH unit and nursing staff in this inquiry. In particular, nursing staff within the new PATH unit are experiencing more complex working conditions, and the resources available are not sufficient to meet the current and emerging realities. Further, staff turnover has increased, and nursing staff are trying to prioritize many tasks, often at the expense of the patient. COVID-19 restrictions that did not permit family presence (Healthcare Excellence Canada, 2022) have likely contributed to the challenges nursing staff are currently facing. Pre-COVID-19, family presence was permitted and often helped complete daily tasks such as feeding and bathing, and the restriction of family presence has increased the workload for the nursing staff. The lack of family members' presence has also increased patient isolation and loneliness (Simard & Volicer, 2020), as a result, it is often difficult to respond to patient and family calls. Furthermore, according to West et al. (2018), with the increased workload, staff may be experiencing emotional exhaustion and burnout. At times, to offer some relief to the increased expectations, extra staff are provided, and gift cards are given to nursing staff who go above and beyond (e.g., working longer hours and covering sick days). Senge (2006) referred to these as quick fixes that result in temporary relief known as "low-leverage changes" (p. 113). However, these quick fixes do not necessarily support a focus on NPTR. Recognizing the shifting and competing demands in the PATH unit's nursing staff, how can nursing staff in the PATH unit prioritize and uphold their values of respect, caring, and trust in relationships to nurture NPTR? This research sought to work with nursing staff to acknowledge their strengths and develop strategies that would always promote NPTR on the unit.

Overview of the Thesis

The building of quality health care systems with well-established nursing care is essential to support patients and society in navigating health challenges and their debilitating effects. According to Benbenishty and Hannink (2017), the formation of NPTR is foundational to quality nursing care, and several nurse education programs have focused on the importance of NPTR for the past several decades. Nevertheless, less attention is given to NPTR because many nurses spend their time focusing more on documentation and medical interventions than providing care for the patients (Kieft et al., 2014; Watson, 2009). The primary focus of documentation is to help information flow which in theory enhances the continuity of patient care (Keenan et al., 2008). However, documentation has many cross-purposes including minimizing litigation and lawsuits, passing accreditation, and holding nurses accountable for the care they provide which can include medical errors (Keenan et al., 2008). In contrast, medical interventions are the processes by which nurses focus on medical treatment and care plans, and may not involve building an NPTR.

My thesis focused on building NPTR in the PATH unit. In this thesis, I organized my write-up into five chapters based on the Royal Roads University, School of Leadership Studies' (2022) *Thesis Handbook*.

Chapter 2 contains a review of the relevant literature. The topics explored in this chapter include key elements and stages of NPTR, and I explore how professional boundaries can influence NPTR.

Chapter 3 provides an overview of the research methodology, in which I discuss how I approached my project through an appreciative inquiry orientation and describe the methods I used for data collection and analysis. I also explore the ethical principles that guided and enhanced the implementation of this project.

Chapter 4 presents the key study findings that emerged from this study related to NPTR in the PATH unit. The findings are thematically analysed and verified with the research participants. The findings explore four key themes: (a) diverse ways NPTR is practiced/nurtured in the PATH unit, (b) situational/systemic factors supporting NPTR in practice, (c) potential benefits and outcomes of NPTR, and (d) opportunities to strengthen NPTR in the PATH unit. In addition, the scope and limitations of the inquiry are explained.

Chapter 5 focuses on conclusions, recommendations, and inquiry implications. The overarching conclusion helps with the design of a conceptual framework of NPTR in the PATH unit. In this concluding chapter, I synthesize the work done to date and present specific discussions related to recommendations for my organization, organizational implications, and implications for future inquiry.

Chapter Summary

In this chapter, I offered both a rationale and context to frame this research project focused on NPTR. In Chapter 2, I explore relevant publications related to NPTR practice.

Chapter Two: Literature Review

Nursing staff are one of the closest health care providers, aside from family and friends, who support patients in their recovery (Dinç & Gastmans, 2013). Nursing staff provide medication and can provide care, safety, comfort, and a smooth recovery journey (Dinç & Gastmans, 2013). Nursing staff can engage in and support relationship-centred care with patients, and when they fail to do so, the patients' treatment outcomes can become negatively affected (Zugai et al., 2015). In this literature review, I explore relationship-centred care-the umbrella term that encompasses the nurse–patient therapeutic relationship (NPTR). I also explore key elements and stages of NPTR, including the importance of fostering a nurturing environment for NPTR, and I explore how professional boundaries can influence NPTR. Last, I emphasize strategic, evidence-informed approaches to design and assess the NPTR in practice.

Relationship-Centred Care

Relationship-centred care was coined by a task force jointly sponsored by the Pew and Fetzer Foundations in 1994 (Wyer et al., 2014). By definition, relationship-centred care is care in which health care participants acknowledge and embrace the significance of their relationships with one another (Beach et al., 2006). Relationship-centred care is formed based on four basic principles: (a) dealing with the patient as a person, (b) the importance of emotion, (c) relationships do not occur in isolation, and (d) the necessity of maintaining an authentic relationship is morally valuable (Beach et al., 2006). Additionally, relationship-centred care has four domains: (a) clinician-patient, (b) clinician-colleague, (c) clinician-community, and (d) clinician to self (Soklaridis et al., 2016). A clinician-patient relationship is the focus of my research project. However, in the context of this project, nursing staff represent the clinicians.

Relationship-centred care is important for health care professionals because a focus on relationships can improve patients' health-related outcomes (Kornhaber et al., 2016). Soklaridis et al. (2016) described relationship-centred care as a therapeutic relationship. The therapeutic relationship involves the highly esteemed care, compassion, and communication that focus on the patient's biological, psychological, social, cultural, and spiritual needs (Palos, 2014). Therefore, educating new staff and recurrently educating nursing staff to gain knowledge, skills, and values will help develop relationship-centred care (Amoah et al., 2018). Additionally, successful implementation of relationship-centred care is possible by providing a conducive environment for the practice of relationship-centred care and rewarding the staff who adhere to the relationship-centred care implementation strategy (Amoah et al., 2018). Henceforth, I will focus on the therapeutic nature of relationship-centred care, with a specific emphasis on the nurse–patient therapeutic relationship.

Understanding the Nurse–Patient Therapeutic Relationship

In the literature, the therapeutic relationship between nursing staff and patients was described interchangeably as a NPTR, helping relationships, purposeful relationships, nurse-client relationships, and therapeutic alliances (Kornhaber et al., 2016). Both nursing staff and patients described a NPTR as being comfortable with each other, accepting vibes, and having mutual respect (Bylund et al., 2012). According to Molina-Mula and Gallo-Estrada (2020), a NPTR helps the patient express personal feelings comfortably without fear of rejection or being ignored. Pullen and Mathias (2010) affirmed that a therapeutic relationship is based on shared trust and respect and the development of faith and hope between the nursing staff and patient. In a therapeutic relationship, incorporation of Watson's (2009) theory of human caring is important.

Watson's theory stated that nursing care is a professional covenant, where health care providers have committed to developing a caring relationship and a healing environment together with nursing staff to intentionally provide nursing care that promotes healing, irrespective of the circumstance at hand (Watson, 2006, as cited in Watson, 2009). Molina-Mula and Gallo-Estrada (2020) emphasized that nursing staff must intentionally know and connect to the patient to enhance harmony, healing, and health improvement. Furthermore, a therapeutic relationship tends to be strength-based which is often in contrast to the medical model that often exists in health care (Gottlieb & Gottlieb, 2012; Xie, 2013). Gottlieb and Gottlieb (2012) asserted that the medical model tends to focus on pathology, looking for what is wrong and needed to be fixed in the bodily systems of a patient; whereas a strength-based approach focuses on patient's strengths that can be used to deal with and navigate a patient's health concerns.

Despite the importance of NPTR, there is no one universal definition or perception of NPTR, and the perceptions of nursing staff regarding NPTR with patients vary from country to country (Moreno-Poyato et al., 2016). In Canada, NPTR constitutes respect for patients, never personalizing patients' action, providing patients' security, upholding the patient's health, developing an authentic relationship with the patients, and interactive education with patients (Chiovitti, 2008). In Ireland, nursing staff perceive NPTR as a combination of intuition, knowledge and clinical experience, values (i.e., authenticity, respect, and empathy), self-knowledge, active listening, being nonjudgmental, and displaying a sense of humor (Scanlon, 2006). Australian nursing staff perceive NPTR to be self-knowledge, authenticity, provision of personalized care, respect, and understanding while providing comfort and support (Moreno-Poyato et al., 2016). However, the United Arab Emirates' nursing staff view NPTR as the provision of physical care by attending to the daily needs of the patients; assurance of security and protection through trust, genuine relationships, and accessibility; and companionship through friendship, respect, and patience (Moreno-Poyato et al., 2016). Regardless of NPTR's different definitions, at the core of NPTR between patients and nursing staff, the provision of care is relational and founded on respect. NPTR is essential to providing holistic care to the patient by the nursing staff.

In summary, a therapeutic relationship is a relationship that exists between the Nursing staff and the patient but is not based on social relationships. Despite the different perceptions of NPTR from country to country, its goal remains the same: engaging in therapeutic care of the patient. Situational and systemic factors can impact the practice of therapeutic relationships.

Elements of NPTR

NPTR cannot be achieved through one action or step; instead, it is an ongoing process that requires building key competencies, skills, or elements. Furthermore, the nursing staff's relationship initiation does not guarantee that the patient will embrace and/or engage in an NPTR (Rudebeck, 2019); rather, NPTR requires the patient's active engagement. To build an NPTR, Halldorsdottir (2008) advocated that the nursing staff's authenticity and commitment to care for patients as a person is essential. Morck (2016) argued that empathy, connection, commitment and involvement, and transference, nurturance, and maintaining professional boundaries are the key components of NPTR. Notwithstanding, the College of Nurses of Ontario (2006) described the five key elements of NPTR as "professional intimacy, power, empathy, respect, and trust" (p. 3). Additionally, Sheldon (2013) referred to the skills of communication, respect, genuineness, empathy, active listening, trust, and confidentiality. In this section, I explore the elements of communication, respect, trust, confidentiality, and compassion in further detail.

Communication

Effective and skilful communication is an essential component in building a therapeutic relationship between nursing staff and patients with positive treatment outcomes (Sheldon, 2013; Weller et al., 2014). Effective communication must be characterized by clear, courteous, compassionate, and candid talk to nurture NPTR practice (Moreno-Poyato et al., 2016). Communication involves expressing a patient's feeling and nursing staff's acknowledging the patient's feeling (Jiménez-Herrera et al., 2020). According to the College of Nurses of Ontario (2006), "Nursing staff use a wide range of effective communication strategies and interpersonal skills to appropriately establish, maintain, re-establish and terminate the nurse-client relationship" (p. 5). The use of effective therapeutic communication is an excellent instrument to determine patients' needs to enhance appropriate physical care and emotional support, resulting in health promotion and patient satisfaction (Amoah et al., 2018; Faisol et al., 2021).

Communication could be verbal and nonverbal. However, it is essential that "there is an agreement between verbal and nonverbal communication" (Kourkouta & Papathanasiou, 2014, p. 66). The components of verbal and nonverbal communication are demonstration of interest in what the speaker is saying, active listening through being silent, appropriate body and facial gesture, maintenance of eye contact, minimum interruption, and summarizing the speaker's words (Jahromi et al., 2016). In addition, Foley and Gentile (2010) asserted that body movement, facial gesture, and physical distancing from the speaker are nonverbal communication that affects therapeutic relationship development between nursing staff and patient. However, inconsistency between verbal and nonverbal communication can easily be discovered by the patient and hinders the therapeutic relationship. When a nursing staff engages in effective communication toward a patient, such communication is mostly favourably understood and accepted with little or noncontentious behaviour by the patient (Street et al., 2007).

Another aspect of communication is listening. Any nursing staff who wants to engage in a therapeutic relationship with the patient must be an active listener. The practice of therapeutic relations requires the full attention and mobilization of all the nursing staff's senses for the apprehension of verbal and nonverbal information that the patient is trying to pass across (Kourkouta & Papathanasiou, 2014). According to Jahromi et al. (2016), an active listener will avoid or minimize any form of interruption, maintain interest, avoid being judgmental or delay judgment, organize information, and show interest in what the patient is saying.

Effective communication not only promotes therapeutic relationships but also improves the quality of care provided to the patient (Kourkouta & Papathanasiou, 2014). It also helps the performance of correct and consistent nursing assignments with ease, which enables patient satisfaction and nursing staff protection (Kourkouta & Papathanasiou, 2014). Lown et al. (2011) summarized the benefits of effective communication by stating that it improves clinical outcomes such as pain control, physical and mental quality of life, and patients' primary care.

Unfortunately, ineffective communication could result in misinterpretation, misdiagnosis, frustration, and patient dissatisfaction (Amoah et al., 2018). In addition, nursing staff's work overload and patients' anxiety, pain, and physical discomfort, as well as misunderstanding between the nursing staff and patients leads to ineffective therapeutic communication (Amoah et al., 2018).

Respect

The College of Nurses of Ontario (2006) defined respect as nursing staff appreciating the patient as an individual and regards their worth and uniqueness irrespective of their social status and health condition. Respect for patients includes respect for their dignity, embracing the confidentiality and autonomy of patients and their families to decide about their health (Sedig, 2016). The focus is to ensure that the patient is comfortable and that their feelings are recognized (Sheldon, 2013). Sheldon (2013) outlined methods to show respect as self-introduction to patient and wearing an identification badge and calling the patient by their formal name at the first time of meeting the patient and finding out the preferred name he/she would like to be called. These methods help nursing staff build rapport with patients. Respect also involves planning for patient privacy, comfort, and decorum; explaining a procedure to the patient before carrying it out; and demonstrating an interest in listening to and understanding the patient (Sheldon, 2013).

Furthermore, Bhanji (2013) outlined four categories of interventions necessary to accomplish respect by the nursing staff: (a) admit the patient’s suffering, (b) do not judge patient, (c) do not control the patient, and (d) consider the patient as a knowledgeable person regarding his or her illness and medication, given the availability of information on the internet. Therefore, respect is interrelated with establishing trust.

Trust

Trust is a critical component for establishing and nurturing NPTR (Arnold & Boggs, 2016). The disclosure of the patient’s relevant medical history to the nursing staff and submission to nursing care is possible when trust is developed (Kwame & Petrucka, 2021). Dinç and Gastmans (2013) described trust as a time- and space-bound attitude, in which a person confidently relies on someone and is ready to be involved in a relationship based on the acknowledgement that presumes vulnerability may arise. The nursing staff's ability to meet the patient's needs based on the patient's personal assessment and the patient's assessment of the nursing staff's competence and skill precede the trusting relationship between the patient and nursing staff (Kieft et al., 2014). According to Dinç and Gastmans (2013), trust must be viewed as a dynamic process that includes relational, fragile, and ambiguous phenomenon. Sheldon (2013) explained facilitating trust as making an effort to actively listen to patients to make them feel heard and loved and respectfully treat the patient to make them feel valued as human beings: "Patients need to believe that nursing staff are honest, knowledgeable, dependable, and accepting of who they are as people" (p. 65). However, trust can be lost when a patient senses that there is no assurance of privacy and, therefore, might not want to provide full disclosure of personal health information (Nass et al., 2009).

Therefore, certain conditions are critical to trust development. These included the nursing staff's availability and accessibility by the patient, both the nursing staff and the patient having the feeling of being emotionally and physically safe, being valued as an individual, and feeling well informed by the patient (Dinç & Gastmans, 2013). Furthermore, a patient develops trust when a nursing staff delivers care in a nonjudgmental way (Kornhaber et al., 2016). Arnold and Boggs (2016) described key techniques to enhance trust, which include considering the client's unique context, expressing a warm and caring attitude, using the patient's proper name, engaging in active listening, engaging in an honest and open conversation, giving need-to-know information, allowing adequate time to answer questions, using appropriate body language, and maintaining confidentiality and commitments. The College of Nurses of Ontario (2006) also stated that nursing staff should acknowledge patients' vulnerability and sensitivity of trust and aim to maintain a trusting relationship by keeping promises to their patient and trying to be available for them.

Confidentiality

Confidentiality helps to establish a sense of trust and respect. This entails protecting patient information and privacy to promote the therapeutic relationship (Sheldon, 2013). Respect for confidentiality is an instrumental objective of improving health care quality and a key element of care excellence (Tegegne et al., 2022). The practice of confidentiality assures patients that their personal health information will be respected, which will encourage them to engage in open conversation and give important information about their medical history to nursing staff (Canadian Medical Association, 2017; Demirsoy & Kirimlioglu, 2016). In British Columbia, Canada, nursing staff and other health care providers have a responsibility to keep their patients' personal health information secure and private (Health Information Privacy in British Columbia, 2011). The health care providers are only allowed to use the patient's information for the purpose of care and treatment and any related administrative purposes. Generally, giving patient information to other health care providers should be on a need-to-know basis; any disclosure that is not in the patient's best interests violates the patient's privacy (McGowan, 2012). In addition, nursing staff share patients' electronic information on a need-to-know basis (Kelley et al., 2013). Nursing staff are expected not to discuss with or about their patients in public places where information could be heard (Sheldon, 2013).

Compassion

Arnold and Boggs (2016) asserted that NPTR can be nurtured once a nursing staff listens compassionately to the patient's or family's concerns. Compassion makes a nursing staff more sensitive and understanding of the patient's emotions, and the patient can explore his or her spiritual and existential concerns once they notice that the nursing staff is compassionate (Arnold & Boggs, 2016). Compassion is a proactive approach of engaging in a selfless role by the nursing staff to relieve suffering (Sinclair et al., 2017). Arnold and Boggs claimed that compassionate listening to the patient's or family's concerns by the nursing staff fosters the nurturing of NPTR. The techniques to promote compassion include actively listening to patients' concerns, resisting prejudice, being empathetic, being authentic, and being sensitive to the patient's physical and psychological behaviours (Arnold & Boggs, 2016).

Empathy as a characteristic of compassion is all about trying to feel what another is feeling (Blomberg et al., 2016). This results in doing something to alleviate their concerns and problems. Patient care satisfaction also depends significantly on nursing staff's ability to use empathy with patients and their families (Kerasidou et al., 2020). Samuelson (n.d.) highlighted some strategies for promoting empathy using the acronym nurse, where N stands for **N**ame the emotion, U stands for **U**nderstand the emotion, R stands for **R**espect the patient, S stands for **S**upport the patient using powerful words, and E stands for **E**xplore the emotion further. Therefore, empathy is one of the ways nursing staff build rapport with patients.

Empathy is directly linked with NPTR as it helps build patient's trust (Moreno-Poyato & Rodríguez-Nogueira, 2021). Kerasidou et al. (2020) stated that empathy is beneficial to both patients and nursing staff. For the patient, it promotes the development of trust, compliance with treatment, enhanced emotional health, and care satisfaction (Kerasidou et al., 2020). For nursing staff, empathy promotes effective communication with patients (Kerasidou et al., 2020) and can also help minimize nursing staff's distress and burnout (Terezam et al., 2017). Furthermore, Terezam et al. (2017) affirmed that both the nursing staff and the patient could experience physical and mental well-being when empathy is demonstrated or utilized.

As noted, there are many attributes required to build NPTR. Within this study, it is essential to understand what elements promote NPTR in PATH.

Stages of a Therapeutic Relationship

In addition to understanding the elements of NPTR, there are also key stages that describe NPTR in practice. The earliest therapeutic relationship nursing theory identified by Peplau (1997, as cited in Arnold & Boggs, 2016) described five phases to NPTR: namely, (a) orientation, (b) identification, (c) exploitation, (d) resolution, and (e) termination. According to Peplau, the orientation phase begins the therapeutic relationship as the nursing staff politely sets the tone for the relationship, while the patients respond in their usual patterns. The identification phase involves the collaboration between the nursing staff and patient to identify the patient's abilities and skills that the patient might use to achieve the goal of becoming independent for a sustainable transition to home (Gottlieb, 2014). This approach is considered as a strength-based approach to nursing (Gottlieb & Gottlieb, 2012; Xie, 2013). The exploitation phase consists of using the patient's health services and other resources regarding his or her needs. The resolution phase focuses on setting goals that are more progressive after meeting the patient's initial needs. The termination phase brings the end to the relationship between the nursing staff and the patient, as both evaluate the interventions' progress based on the initial and subsequent goals.

Since Peplau, other models have been established to describe NPTR. Specifically, Halldorsdottir (2008) outlined six stages of a therapeutic relationship between nursing staff and patient. The first stage is the initiation and acceptance through open conversation between nursing staff and patients. It is a stage in which the nursing staff and the patient agree to work together to benefit the patient's health recovery (Sheldon, 2013). The second stage is the recognition of personhood. The therapeutic relationship reveals that the nursing staff and patient are unique individuals with their various experiences, values, and perspectives (Beach et al., 2006). Mutual communication and acceptance of everyone's uniqueness as a person leads to the formation of a bond. The third stage is connection acknowledgement, which is evident by either the nursing staff or the patient's verbal or nonverbal reaction. The fourth stage is openness. In this stage, the patients feel safe engaging in truthful conversation and body relaxation that enhances inner healing. The fifth stage defined the solidarity feeling when the patient sees the nursing staff as an advocate and supporter. The sixth and final stage is the negotiation of genuine care. At this stage, the patient readily cooperates with the nursing staff who provides for their care (Halldorsdottir, 2008). In the context of PATH, it will be important to assert how these stages can be best supported in practice to nurture NPTR.

Situational and Systemic Factors

Many nursing staff spend their time focusing on documentation and medical interventions which can affect the quality of care (Kieft et al., 2014) and NPTR (Moreno-Poyato et al., 2016). In the review conducted by Michel et al. (2021), RNs spend between 20% and 38%

of their total work time on patients' direct care while they spend between 11% and 25% on indirect care like documentation and stocking of supplies. In addition, indirect care is elaborated to include paperwork, learning new technology and procedures, adjusting to management and administration turnover (Krichbaum et al., 2007). In contrast, Krichbaum et al. (2007) estimated that RNs spend up to 40% of their workday on providing indirect care, which can significantly reduce time spent with patients. Furthermore, too much time spent on administrative duties is known to directly limit the time nursing staff have available for nursing care and building NPTR with patients (Felton et al., 2018; Moreno-Poyato et al., 2016) Addressing some situational and systemic factors that impact the work of nursing staff might improve the available time that nursing staff spend with their patients.

Situations can affect workload (Carayon & Gürses, 2008). Some situational factors that may affect nursing staff's performance include the physical work environment, supply stocking, patients' and patients' family needs and actions/reactions, and multidisciplinary team members' communication (Carayon & Gürses, 2008). From the findings of Carayon and Gürses (2008), a favourable physical work environment, adequate stocking of supplies, moderate patient's and patient's family needs, fewer calls from patient in between nursing rounds, and effective communication among the multidisciplinary team members are likely to promote NPTR and reduce workload. By definition, effective communication is the exchange of information between two parties to ensure clarity and understanding of their intent message thereby promoting active engagement (Boykins, 2014). In practice, effective communication could refer to information flow among the multidisciplinary team to avoid duplication of care. For example, an occupational therapist may plan to complete an assessment of daily living for a patient. Prior to the assessment, they could communicate their plans to ensure that the nursing staff does not assist the patient to complete their daily living tasks before their assessment. It is evident that most of the time, the situation dictates how people behave (i.e., act or react), and according to Dalal et al. (2015) nursing staff may not be able to engage in any therapeutic relationship with their patients if the situations at work seem overwhelming.

Workload is a key element contributing to the situational factors affecting NPTR practice, and finding a moderate workload under which nursing staff can effectively perform the needed patient care without overstress and burnout is essential. Recently, British Columbia Nurses’ Union (2021) developed and implemented an interim patient care assessment process tool to help the Health Employers Association of BC and the Nurses' Bargaining Association in the process of evaluating the care needs and the nursing staff requirements. The patient care assessment process (PCAP) form is designed to address three primary questions relating to a) comparison between the baseline and the current nursing staffing on the unit, b) the meeting of the patient direct care needs with the unit’s expectation, and c) the matching of the nursing staff scope and skill mix with the patient direct care needs (British Columbia Nurses’ Union, 2021). PCAP is a generalized approach to address the staffing size and mix requirements; it is not for a specific unit; however, it could offer an opportunity to consider how workload affects NPTR practice.

In addition to workload, patient willingness and prioritization of nursing care activities are other aspects of situational factors that enhance the promotion of NPTR practice. Lake et al. (2009) explained that prioritization of care helped nursing staff to decide what patients’ needs or nurse–patient interactions could be done first among many potentially competing nursing activities to achieve long-term beneficial results. Giving the same attention to major and minor nursing care activities resulted in devoting less time to resolving urgent and major care. Therefore, prioritization of nursing care becomes a necessary and advanced skill of practice for nursing staff to understand, navigate, and prioritize patients' needs amidst other tasks (Lake et al., 2009).

Systemic factors that influence NPTR practice include adequate resources, staff education and collaboration, workload, and time availability. Adequate resources involve staffing, an adequate mixing of staff, and engagement of volunteers' service. Staff mix includes combinations of RNs, LPNs and HCAs working on the care team and this has the potential to enhance NPTR (McGillis Hall, 1997, as cited in Daniel, 2013). For example, HCAs can assist patients with daily living like feeding, bathing and dressing, which gives RNs and LPNs the opportunity to spend time and build rapport with patient and focus on documentation and medical interventions. In addition, volunteers help engage the patients in some extra activities, thereby relieving the nursing staff's workload (Hotchkiss et al., 2008). The volunteers help the hospital to give food, keep company, and sometimes advocate on behalf of the patients (Giles et al., 2006). Teamwork and collaboration within health care providers enable the management and delivery of high-quality care (Rosen et al., 2018).

Collaboration among the health care providers fosters patients' quality care (Wei & Watson, 2019). In a review, Morley and Cashell (2017) stated, "Collaborative teams are reported to demonstrate improved sharing of evidence-based practices between professions, improved decision-making, increased innovation, and reduced length of hospital stay" (p. 208). Embracing a collaborative culture results in staff satisfaction and higher retention (Morley & Cashell, 2017).

According to Morley and Cashell, staff education and education enhance collaboration among health care providers. Wei and Watson (2019) highlighted 10 important attitudes required to engage in a productive collaboration among the health workers. Wei and Watson's 10 attitudes are (a) expression of compassion among the team and toward the patient, (b) encouragement of team members to enhance sense of belonging, (c) exercise trust that accommodate members' uniqueness, (d) engage in building relationship that nurture members' growth, (e) embrace forgiveness without being judgemental, (f) apply all possible approaches to caring, (g) engage in dialogue and connection, (h) co-create a healing environment, (i) treat team members as you would like to be treated, and (j) be open to new possibility.

In summary, situational and systemic factors responsible for the promotion of NPTR practice were discussed. However, practicing NPTR within professional boundaries and ethics is important.

Professional Boundaries in NPTR

Recognizing the importance and value of NPTR, it is also important to reinforce that NPTR differs from a social relationship (Sheldon, 2013) and requires professional boundaries. In developing NPTR, nursing staff need to maintain an appropriate space to protect patients' rights at every stage of the relationship (Olejarczyk & Young, 2021). NPTR is expected to be protective, optimistic, sociable, humanistic, unsuspicious, and be open in nature (Mirhaghi et al., 2017). Halldorsdottir (2008) asserted that maintaining a comfortable distance of respect and compassion by nursing staff is essential to promoting NPTR.

Understanding the nurse–patient therapeutic professional boundaries helps nursing staff practice ethical care aligned with professional practice standards (Sheldon, 2013). The practice of professional boundaries by a nursing staff when caring for a patient is crucial to the provision of safe, skilful, and ethical nursing care (College and Association of Registered Nurses of Alberta, 2020). Professional boundaries are also described as “the spaces between the nursing staff’s position power and the patient’s vulnerability” (National Council of State Boards of Nursing, 2018, p. 4).

According to Arnold and Boggs (2016), professional boundary violations are ethically wrong and include acts such as sexual encounters with patients, excessive personal disclosures, personal or business relationships, requests for or acceptance of special favours or expensive gifts, and/or extensive following of a client after discharge. According to the College of Registered Nurses of Manitoba (2019), when navigating NPTR, nursing staff need to recognize their patients’ potential vulnerability and restrain from exploiting their trust and dependency and must not abuse their relationship. Recognizing the crucial importance of professional boundaries, Sheldon (2013, pp. 71–72) outlined some practical ways for maintaining professional boundaries in NPTR, which include:

- Defining the activities associated with the nurse–patient-patient relationship
- Developing appropriate professional boundaries between the nursing staff and the patient. Care must be taken not to allow cultures and ethnicity to stand on the way.
- Developing self-awareness to support the patients and navigate their personal needs.

Practicing NPTR within the professional boundary and being ethical will help a nursing staff exercise the right attitudes known as elements of NPTR when caring out therapeutic care.

Chapter Summary

The literature review has provided a detailed explanation of the NPTR. NPTR is crucial to patient outcomes. Unfortunately, it is less prioritized because of some competing activities and workload as stated earlier in this chapter. To nurture and respect NPTR in the PATH unit, it is important to adhere to professional boundaries while demonstrating some key elements: professional intimacy, power, empathy, respect, and trust. Therefore, this review showed the link between relationship-centred care and NPTR. The situational and systemic factors that help nurture NPTR while practicing with professional boundaries were explained. The elements of NPTR and stages of building a therapeutic relationship were highlighted and described. In the next chapter, I explore the methodology employed to explore NPTR in the PATH unit.

Chapter Three: Methodology

This engaged, action-oriented research explored the nurse–patient therapeutic relationship. Specifically, it explored the research question: How might the nursing staff enhance the nurse–patient therapeutic relationship in the Patient Assessment and Transition to Home (PATH) Unit at Peace Arch Hospital (PAH)? This research question was supported by four inquiry sub questions:

- Why is a nurse–patient therapeutic relationship important?
- How is the nurse–patient therapeutic relationship currently nurtured?
- What might be possible if we prioritized the nurse patient-therapeutic relationship?
- What strategies and supports nurture the nurse–patient therapeutic relationship?

In this chapter, I describe my research methodology and how this study was conducted to explore how to promote the nurse–patient therapeutic relationship (NPTR) in the PATH unit at PAH. I also explore the ethical considerations underpinning this study and the study's limitations.

Methodology

For the past five decades, many nurses have engaged in action-oriented research projects that deal with the improvement of nursing practice and management for effective health care (Cusack et al., 2018). Action-oriented research is an alternative approach to traditional forms of social or scientific research because it involves a participatory framework that considers the contexts of people's lives instead of researchers considering the people as research subjects (Young, 2006). Specifically, action-oriented research is defined as a methodological approach that generates knowledge through a collaborative effort of university researchers and community partners that can simultaneously contribute to change in a community context (Worthington et al., 2011). Furthermore, action-oriented research refers to a group of research methodologies in which a systematic investigation is conducted on a given social situation to promote community change and stakeholders' collaborative participation—people who will affect or be affected (Burns, 2007).

There are many research methodologies in the action-oriented research family, including arts-based research, appreciative inquiry, collaborative inquiry, community action research, community-based research, community-based participatory research, Indigenous methodologies, and participatory action research (PAR) (MacDonald, 2012). Each of these methodologies has its distinguishing features and critical principles that express its uniqueness. One of the similarities among methodologies in the action-oriented research family is a focus on imparting social change, with the ultimate goal of a defined specific action instead of focusing on knowledge finding (Moch et al., 2016; Reid & Frisby, 2008). Among all action-oriented research methodologies, appreciative inquiry fits the perspective of considering the strength-based approach (Bushe, 2012). For the purposes of my research, I used appreciative inquiry (AI) as my proposed methodology.

AI is a research approach where researchers and participants cultivate a positive relationship and emphasize the members' core motivations, strengths, and values to enhance teamwork and embrace the change around common goals (Ruhe et al., 2011). AI provides an optimistic approach to investigate, discover possibilities, and pursue a shared vision (Cooperrider & Whitney 2001, as cited in Hung et al., 2018); which is in contrast to the deficit-based models often employed in health care contexts (Gottlieb & Gottlieb, 2012; Xie, 2013). Furthermore, Bushe (2012) asserted that appreciative questions can amplify, encourage, and help us get more of whatever we are looking for when conducting social change research. Cooperrider and Srivastva (1987, as cited in Grieten et al., 2018) described AI as a branch of action-oriented research that focuses on forming new theories, ideas, or images to enhance the developmental change of a system. Harris and Agger-Gupta (2015) asserted that orientation to possibility helps people minimize challenges while embracing the opportunity to explore what might be possible. AI was appropriate for this project because it can enhance the use of NPTR and how we achieve the desired goal (Vega & Hayes, 2019).

AI has a significant transformational prospect that shifts organizational focus from problems to be solved to discovering opportunities to make a positive change (Koster & Lemelin, 2009). AI also offers a flexible framework that allows grassroots people to contribute to finding solutions (Trajkovski et al., 2013). The inclusive nature of the AI process breaks the barriers to communication created by health care organizations' bureaucratic bottleneck (Conn et al., 2010).

Cooperrider et al. (2005, as cited in Moore & Charvat, 2007, p. S65) summarized the eight general principles guiding AI:

- in every society, organization, or group, something works;
- what is focused on becomes the reality of the organization;
- the language used creates reality;
- the fact is created at the moment, and there are multiple realities;
- the act of asking questions of an organization or group influences the group in some way;

- people have more confidence and comfort in their journey to the future when they carry forwards parts of the past;
- if we move parts of the past forward, they should be what is best about the past; and
- it is important to value differences.

In addition, the strengths of AI include:

- A focus on strengths instead of weaknesses helps organizations to be empowered for positive change and innovation and motivates employees to improve their adeptness (Bright, 2009; Linley et al., 2010);
- The promotion of a conducive atmosphere of learning through collective inquiry and the provision of skills needed by the people to discover solutions for themselves. It encourages creative thinking (Conklin & Hartman, 2014) and promotes sustainable change (Mishra & Bhatnagar, 2012);
- AI can increase loyalty and commitment to systems (Moore & Charvat, 2007); and
- In nursing practice, AI can identify distinctive strengths and expose and confront damaging dynamics without exploring them through a negative orientation (Watkins et al., 2016, p. 182).

The limitations of AI include:

- AI can take considerable time—it is not a quick fix (Drew & Wallis, 2014);
- The unrealistic involvement of all stakeholders can be challenging and could hinder a democratic consensus (Bright, 2009; Schooley, 2008).
- Participants can initially have a difficult time focusing on the challenge through an appreciative lens (Schooley, 2008).

There are various models for conducting AI, but the model I used for my research is the 5-D model (Cooperrider et al., 2008). The 5-D model represents the five primary AI phases(Cooperrider et al., 2008; Ruhe et al., 2011).

- Phase 1: Define: This phase involves choosing the positive as a focus of inquiry.
- Phase 2: Discovery/Appreciating: “What is the best of what is?” This phase consists of participants interviewing each other and sharing stories about their peak experiences. It also includes inquiry into stories of life-giving forces.
- Phase 3: Dream/Envisioning Results: “What might be?” In this phase, the participants envision themselves and their organization functioning at their best based on the discovery phase’s information. Participants think broadly and holistically about a desirable future through various kinds of visualization and other creative exercises. Participants also locate themes that appear in the stories and select topics for further inquiry.
- Phase 4: Design/Co-constructing the Future: “What should be the ideal?” In this phase, participants propose strategies, processes, and systems based on the information at the dream phase. They make decisions and develop collaborations that will create and support positive change. They develop provocative propositions - concrete, detailed visions based on what was discovered about past successes. They also create shared images for a preferred future.
- Phase 5: Destiny/Delivery/Sustaining the Change: “How to empower, learn and adjust/improvise?” In this phase, participants begin to implement their overall visions of the dream phase and the design phase’s specific provocative propositions. In

essence, this phase finds innovative ways to create the future that participants seek. This phase is ongoing as participants continue to implement changes, monitor their progress, and engage in a new dialogue and appreciative inquiries.

AI is an exceptionally useful methodology considered in this project, as it builds from strengths and is intended to strengthen relationships within PATH as promoting NPTR was explored. Specifically, the promotion of NPTR is a potential resource for improving patient care, and Bushe (2012) noted that this is an ideal content for AI to promote change.

Data Collection Methods

Meaningful engagement with and effective communication (i.e., listening and talking) amongst participants about NPTR and how it could be further strengthened was crucial to this project’s success. Hence, to support nursing staff in expressing their experiences and insights, I used liberating structures as the primary data collection method for this research. Liberating structures are practical and straightforward approaches to engagement that enhance group participation and performance in various organizational settings (Singhal et al., 2020). Liberating structures consist of 33 practical methods, which include appreciative interviews, conversation cafés, 1-2-4-All, TRIZ, improv prototyping, and many others (Lipmanowicz & McCandless, 2013, p. 68). Liberating structures encourage the listening and talking between participants to improve information sharing and encourage independent thinking and reflection (Lipmanowicz & McCandless, 2013). Liberating structures also seek to identify and move towards the desired future (Singhal et al., 2020). The most significant reason for using liberating structures is based on its ability to give every individual a voice, thereby truly producing solutions that are influenced by all participants in some way (Lipmanowicz & McCandless, 2013). Furthermore, the way liberating structures support active engagement and encourage all participants to voice their opinions means that liberating structures can be an enjoyable, effective, and rewarding exercise and can result in trust, active communication, community agreement, and outcome ownership among participants (Lipmanowicz et al., 2015).

Lipmanowicz et al. (2015) described 10 principles that characterize liberating structures:

- The inclusion of every participant with the opportunity to contribute freely,
- Regard the participants and their suggested solutions,
- Develop trust among the participants over time,
- Learn by failing forward (e.g., learning from mistakes),
- The practice of self-discovery among the participants,
- Create a free environment and encourage responsibility,
- Optimism for possibilities,
- Minimize obstacles while maximizing the opportunity to be innovative, and
- Engage in meaningful result-oriented curiosity in a fun-filled environment.

There are many different types of liberating structures; however, for my research, I applied appreciative interviews and conversation cafés. These two methods were facilitated in a consecutive manner, which Lipmanowicz and McCandless (2013) referred to as a string of liberating structures. These two methods are described in this section.

Appreciative Interview

An appreciative interview is a narrative process used to discover what made past successes a reality (Lipmanowicz & McCandless, 2013). It focuses on what is working instead of what is not, thereby discovering and building on the root cause of success. Lipmanowicz and

McCandless (2013) stated that the expression of unrecognized success stories leads to creating incredible ideas for positive change within an organization. The appreciative interview is facilitated in small groups. People are energized to share their personal success stories regarding the interview question at hand, rather than on depressing stories about what they have done wrong (Lipmanowicz & McCandless, 2013). The interview starts with a brief description of an appreciative interview's concept and purpose (American Medical Association, 2016). After that, the interviewees are given the opportunity to share their real success stories, followed by an additional question on what made the success stories possible (American Medical Association, 2016). The interviewers need to give the interviewees adequate time to share their stories, redirect them when majoring on negative experiences, and reframe the question to obtain useful information (American Medical Association, 2016). In short, appreciative interviews activate natural, constructive energy and insights for positive change through often uncovered, unrecognized, or hidden success stories and create the conditions to get everyone engaged in talking about what works and action. In this project, I used the appreciative interview guide design by Cooperrider et al. (2008).

Conversation Café

The second liberating structure (LS) applied in this research was a conversation café. A conversation café is a structured conversation process in a friendly environment where groups of participants gather to discuss a specific topic of consideration (Lipmanowicz & McCandless, 2013). A conversation café enhances an exchange of opinions, feelings, and thoughts among participants (Tamarack Institute, 2017). It is a simple method that can be adapted to any desired topic. At the start of the conversation café, the facilitator usually establishes engagement rules to foster a polite and honest dialogue. Conversation cafés encourage connection by providing space for people to talk, listen, and learn with a spirit of curiosity, respect, and warmness (Lipmanowicz & McCandless, 2013). A conversation café was suitable for this research because it offered an opportunity for nursing staff to explore, through conversation with their peers, how NPTR could be nurtured and prioritized in the PATH unit.

String of Liberating Structures

As noted previously, I strung two LSs together in a sequential approach, which is referred to as a "string" (Lipmanowicz & McCandless, 2013, p. 86). Stringing two or more LSs is considered necessary to navigate complex tasks or questions (Lipmanowicz & McCandless, 2013). In my project, I strung the appreciative interview and the conversation café. Appreciative interviews were used to uncover what made success stories possible, and the conversation café was used to make sense of the identified success stories and start to envision possibilities and strategies for the PATH unit to promote NPTR (Lipmanowicz & McCandless, 2013).

Project Participants

The stakeholders for this project were the nursing and nursing support staff within the PATH unit, of PAH. Nursing staff includes the registered nurses (RNs) and licenced practical nurses (LPNs), while the nursing support staff includes health care assistants (HCAs). In total, 49 regular nursing staff (10 RNs, 4 LPNs, and 25 HCAs) and other causal nursing staff (RNs, LPNs, and HCAs) were invited to participate in this study. In total, 12 nursing staff participated in this study. Three RNs, four LPNs, and four HCAs participated in the Zoom meetings. However, one RN who was unable to attend the Zoom meeting but was interested in participating requested the inquiry questions. They answered the questions via email, and the Clinical Nurse Educator forwarded their responses to me.

I involved RN, LPN, and HCAs because they clearly understand the unit's present situation and its future goal. Collaborating with them enhanced seeing different perspectives of the reality of the current situation. In tapping into their collective intelligence and ideas (Woolley et al., 2015), strategies for promoting NPTR were generated. Stroh (2015) supported that people with a shared aspiration, such as vision, mission, and values, and a shared understanding of their current state can efficiently resolve any discovered creative tension in favour of their aspiration.

Ideally, patients would also be involved in this study; however, they were intentionally excluded given the time limitations of this project. Additionally, the prevention of the coronavirus identified in 2019, known as COVID-19, from spreading resulted in enforcing restrictions on gathering and physical contact, which affected the involvement of patients. Furthermore, studies currently exist to explore patient perspectives of NPTR (Benbenishty & Hannink, 2017; Moreno-Poyato & Rodríguez-Nogueira, 2020). According to Price (2017), patients' perspective on therapeutic relationships centred on effective communication, building rapport with the patients, trust development and commitment to caring for patients. Unfortunately, I could not find any published article on the patients' perspectives of NPTR conducted on the medical subacute units of any hospital.

The circumstances surrounding the conduct of this research required two separate sessions. The two sessions were necessary, as the two subdivisions of PATH, Weatherby-1 and Weatherby-2, focus on two categories of patients who are there to receive nursing care with the goal of improving their ability to manage their care needs independently and be discharged to home or community within a short time. Another reason for not gathering the participants into one session was because of the prevalence of the COVID-19 pandemic that started in March 2020. To control the spreading of the virus from one group of patients to another group, government restrictions did not allow the gathering of participants from Weatherby-1 and Weatherby-2. In addition, the COVID-19 pandemic caused a heavy workload for nursing staff, so it became difficult for nursing staff to leave their unit to attend the inquiry sessions - data collection meeting. Therefore, the research was conducted in two sessions: the first session with Weatherby-2 and the second session with Weatherby-1. The participants from Weatherby-1 who engaged in the research were two RNs, two LPNs, and two HCAs. Additionally, one RN, two LPNs, and two HCAs from Weatherby-2 participated in the research.

Inquiry Team

According to Woolley et al. (2015), brainstorming with professional colleagues enhances productivity and product quality, and so for this research, I sought support from an inquiry team. During the proposal stage of this research, my inquiry team consisted of three members. However, a new member was added due to change in the time of the first Zoom meeting and the availability of the team member assigned to facilitate the Zoom session.

My inquiry team consisted of four members. They included two of my classmates in the Master of Arts in Leadership program, one non-health care professional, and the PATH unit's Clinical Nurse Educator (CNE). The team was selected based on their academic background, professional background, and experience. Two team members were Master of Art in Leadership–Health Specialization (MAL-H) students, in which one was a respiratory therapist by profession and the other was a primary care paramedic. The third member of the inquiry team had a master’s degree in Climate Change Policy Formulation from the University of British Columbia and has a sound understanding of participatory research methods. The CNE has close relationships with project participants. The use of an inquiry team was an integral part of this research to mitigate power over by me as stated on the consent form and reiterated during each research session.

Two of the research inquiry team members, the respiratory therapist and climate change graduate, served as facilitators during data gathering methods via Zoom to comply with COVID-19 restrictions in the hospital. The CNE served as a recruiter and helped with securing the consent forms. All inquiry team members, except the CNE, also helped to review the data analysis and draft findings emerging from the study. All team members were instructed about their roles before data collection as indicated in the consent form (Appendix A).

Study Conduct

Action-oriented research requires the recruitment and selection of stakeholders who can effect changes related to the study findings and recommendations (Stroh, 2015). In this study, I recruited participants by emailing an electronic invitation (Appendix B) and participant consent form/research information form (Appendix C) to all the nursing staff in the PATH unit through the CNE. I engaged the CNE to mitigate power-over possibility related to my position. I wanted staff that I work with to feel free to participate or not participate in this study without my coercion. In addition, a poster was placed at the nursing station in the PATH unit at PAH to remind the nursing staff about the study (Appendix D). The nursing staff who were interested in participating in the research contacted the CNE through email. The signed consent forms were then emailed back to the CNE before any data collection method began. The CNE stored the signed consent forms in a locked filing cabinet and verified that participants gave their full consent to participate in the inquiry.

The RNs, LPNs, and HCAs, irrespective of their culture, language, religion, race, disability, sexual orientation, ethnicity, linguistic proficiency, gender, or age, were invited and allowed to participate in this research. Participants were selected on a first-come, first-served basis. The total representatives of each group of RN, LPN, and HCA participants are presented in Table 1. In addition, when a group was not well represented (i.e., up to four representatives) among the interested participants, an invitation was reopened for the second time to the deficient group. Unfortunately, not all the interested participants finally participated. The nursing staff on or off duty on the day of the data collection were allowed to participate since it was done through Zoom conference call. Participants who could not attend the Zoom conference call were given the opportunity to participate. The questions were sent to them via email from the CNE (Appendix E), and no one offered their responses via email.

Table 1:

Number of Participants by Nursing Staff Type

Number of Participants	Nursing Staff
4	Registered Nurse
4	Licenced Practical Nurse
4	Health Care Aides

RNs, LPNs, HCAs, and others who were not currently working in the PATH unit at PAH were excluded from participating in the research. The other exclusion criteria concerned the patients. Ideally, patients would have been involved in this study; however, they were intentionally excluded given the time limitations of this project.

After the participants' recruitment was completed, the times for inquiry and dialogue sessions were fixed. As noted earlier, two sessions were held to accommodate the different PATH units. Each session was facilitated virtually by a member of my inquiry team. I, the student researcher, was not involved in any of the research data collection activities to give room for the participants to freely share their views, thereby avoiding power over based on my coinvestigator's dual responsibilities.

Participants joined the Zoom conference call. In addition, the Zoom breakout platform or feature was used to assign participants into their respective rooms: RN, LPN, and HCA groups. At the start of the Zoom session, prior to the use of breakout rooms, the facilitators provided an overview of the various activities that would take place. A table showing the timing for conducting the methods was shared with the participants (Appendix F).

At the beginning of each data collection method, the facilitators informed the participants about the nature of the method, participants' anticipated role, the research's objective, and the findings' possible uses. According to Grady (2017), the process of informed consent is an expression of respect for research participants and their autonomy, thereby allowing the prospective participants to make free decisions about participating and continuing in research and respecting whatever choices they make about participation or withdrawal.

The first LS activity was an appreciative interview, which addressed the discovery phase of AI. "During discovery [phase], interviews were conducted, stories were shared, and themes were identified that cut across the many stories and high-point experiences" (Cooperrider et al., 2008, p. 104). The interview session lasted for 25 minutes. The appreciative interview guide designed by Cooperrider et al. (2008) was adopted and modified (Appendix E). The facilitators invited participants to pair up with someone in the same nursing role to mitigate power over, and each had a turn telling a success story while the other person served as an interviewer. The storyteller shared about two questions:

- Why is a nurse–patient therapeutic relationship important?
- How is the nurse–patient therapeutic relationship currently nurtured?

The facilitator informed the interviewers not to give opinions about their experiences but allowed them to tell their stories. While the interviewees told their stories, the interviewers were encouraged to pay attention to the possible successes and write them down. It took a total of approximately 25 minutes, 10 minutes per person.

The second LS activity was a conversation café. This session took approximately 35 min. A guide to the conversation café was followed (see Appendix E). Two pairs from the appreciative interview session formed small groups of four, using Zoom to breakout into various rooms. The conversation café began by inviting participants to elaborate on what truly stood out for them from the appreciative interview. In the first round, each person spoke briefly to the topic (1 minute each) without any listener giving feedback or response. In the second round, participants were invited to further elaborate on the earlier shared story (1 minute each). In the third round, the group then engaged in deep conversation about the subquestion: What might be possible if we prioritized the nurse patient-therapeutic relationship? This activity addressed the dream phase of AI. This lasted for 12 minutes. In the final round, participants came together to focus on the destiny phase. They deliberated on the ideas and strategic actions to promote NPTR in the PATH unit. This session lasted for 20 minutes. This was followed by a debrief of the process and an identification of key themes emerging from the session, which lasted for 15 minutes.

Data Analysis and Validity

Qualitative data analysis primarily consists of content or thematic analyses, which involve searching for patterns and themes (Bradshaw et al., 2017). To gain familiarity with the data collected in this inquiry, a Zoom recorder was used to record the conversation/data. However, during the data collection, the inquiry session facilitators grouped the participants into different Zoom breakrooms of two participants during the appreciative interview session. The group of two later regathered to share the summary of their discussion, which was recorded. The recorded audio was sent to a transcription service by the CNE. The transcript was stored in my personal, password-secured hard drive and in a safe locker that will be in my house for one year following my graduation. Wherever I needed clarification, I worked with the facilitators. I analysed the data using thematic analysis. Thematic analysis focuses on systematic identification, organization, analysis, and reporting patterns (i.e., themes) across a dataset (Braun & Clarke, 2012; Castleberry & Nolen, 2018).

Reading the transcripts repeatedly enabled me to identify the themes and subthemes. Many themes were initially identified, but after further analysis, a smaller number of themes stood out to describe the NPTR practice in the PATH unit. Colorafi and Evans (2016) described this approach as a descriptive summary of the information collected and organized that best represents the data. The various themes and subthemes were captured by identifying similar patterns in the collected data. This method helped me identify commonalities in the answers given to each of the addressed questions. I used an inductive approach to data coding and analysis as described by Braun and Clarke (2012). Thomas (2006) defined inductive analysis as "approaches that primarily use detailed readings of raw data to derive concepts, themes, or a model through interpretations made from the raw data" (p. 238). I involved the inquiry team members in data analysis and verification by identifying the themes from the collected data. The data analysis comprised reading and rereading of transcribed recorded conversations by the research inquiry team to validate the participants' convergent and divergent data (Canning et al., 2007). The entire group of participants came up with recommendations from the strategies outlined during inquiry sessions.

There is a possibility of encountering researcher bias, such as selection bias, confirmation bias during data analysis, and publishing bias during interpretation (Šimundić, 2013). Inductive data coding of themes was derived from the content of the data collected (Braun & Clarke, 2012; Šimundić, 2013). Additionally, publishing bias, which results from the perception of less interesting findings, was avoided by including the outcome, whether exciting or less exciting, of the collected data (Šimundić, 2013).

The credibility of the data collected was tested by requesting the facilitators review the raw data and compare the data with the identified themes and subthemes for accuracy. This process is referred to as member checking, which is an integral part of establishing trustworthiness in research findings to ensure that the raw data collected from the participants were representative of their input and perspectives (Candela, 2019).

Ethical Implications

Applying ethical principles to protect human rights and prevent harm is essential when conducting any research that involves participants and stakeholders (Grady, 2017). The Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council, and Social Sciences and Humanities Research Council (Tri-Council, 2018) are the three federal research agencies that jointly published a policy statement on how to ethically conduct research involving humans, known as the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*. The policy mandates that researchers respect human dignity by protecting and honouring them as human beings. The three core principles enunciated regarding ethical conduct are “Respect for Persons, Concern for Welfare, and Justice” (Tri-Council, 2018, p. 6). “Respect for the rights, welfare, dignity, and freedom of choice of individual humans is indispensable [when conducting research]” (Grady, 2017, p. 20). Therefore, respect for participants, concern for their welfare, and justice were considered in this project as described in the next section.

Respect for Persons

I recognized participants’ rights, which include the right to be well informed about the research, to voluntarily accept or refuse to participate, and to withdraw at any stage without penalty from the research (Grady, 2017; refer also to Appendix C). I also acknowledged there could be power dynamics with myself and the participants and also amongst participants. To address these concerns, I did not participate in the study recruitment or data collection processes, and ensured that the research methods offered RNs, LPNs, and HCAs to engage in dialogues with people in the same type of position to help mitigate power-over.

Concern for Welfare

I believed my thesis project had minimal risk for the participants because it was conducted as a group conversation. Additionally, this project did not focus on a topic area that could retraumatize the participants. However, when working in a group there could be a risk related to confidentiality. Nevertheless, I informed the participants that every discussion should end within the group, not to be discussed outside the group. Participants' privacy was protected by ensuring that information that could identify the participants was removed from the data collected or by coding the data that the participants shared. Detailed information about the research, who attended, and how information shared by participants was protected and disseminated were provided.

Justice

Regarding justice and fairness in this project, I extended an invitation to all the RNs, LPNs, and HCAs in the PATH unit. In addition, avoidance of participants' feeling of being coerced to participate was vital to overcome information withholding by the participants(Barrow et al., 2022). Therefore, the CNE in my unit, a neutral party, conducted recruitment so that my position as an RN did not influence the participant's decision. This was important to ensure that research participants were given autonomy to make their voice heard without bias or coercion (Roffee & Waling, 2017).

Study Limitations

The research sought to understand and learn more about how NPTR in the PATH Unit at PAH is currently nurtured and how it can be promoted. Like all research studies, this study had some limitations worth mentioning. First, while this study focused on NPTR and engaged nursing staff, it did not engage patients; therefore, it excluded one of the key players in NPTR. Second, this research was conducted during the COVID-19 pandemic, so the inquiry was conducted on Zoom instead of an in-person activity, which may have limited participant engagement. Third, the number of participants engaged in this research was small, making it difficult to generalize the findings beyond the participants in this study. For the purposes of this research, the sample size of 12 participants was appropriate for the data collection methods used; yet further exploration through surveys, in-depth interviews, or additional focus groups, could further enhance the findings and support greater rigor and generalizability.

Chapter Summary

This chapter offered an orientation to action-oriented research and appreciative inquiry as the qualitative research methodology guiding this research study. I explained how the 5-D model of appreciative inquiry was applied to explore the inquiry questions through the methods of appreciative interviews and a conversation café. In this chapter, I also described my research process or study conduct and discussed the ethical considerations and implications for this study. The findings and conclusions of this research are presented in the next chapter.

Chapter Four: Findings

This action-oriented research project engaged nurses (RN and LPN) and health care aides (HCAs) to explore the principal research question: How might the nursing staff enhance the nurse–patient therapeutic relationship in the Patient Assessment and Transition to Home (PATH) Unit at Peace Arch Hospital (PAH)? The subquestions considered were as follows:

- Why is a nurse–patient therapeutic relationship important?
- How is the nurse–patient therapeutic relationship currently nurtured?
- What might be possible if we prioritized the nurse patient-therapeutic relationship?
- What strategies and supports nurture the nurse–patient therapeutic relationship?

In this chapter, I share the key study findings that emerged from data gathered in relation to the nurse–patient therapeutic relationship (NPTR) in the PATH unit. I will end the chapter with a discussion of the scope and limitations related to this inquiry.

Study Findings

The findings were thematically analysed and verified with the inquiry team. The findings explore four key themes: (a) diverse ways NPTR is practiced/nurtured in PATH, (b) situational/ systemic factors supporting NPTR in practice, (c) potential benefits and outcomes of NPTR, and (d) opportunities to strengthen NPTR in PATH. Each finding is detailed in this section.

Finding 1: NPTR is Practiced/Nurtured in PATH in Diverse and Complementary Ways

During the appreciative interviews about successful NPTR interactions and engagements, many participants shared personal stories and experiences about how NPTR is nurtured in PATH. Participants shared how NPTR is practiced through diverse and complementary ways, including building rapport; offering clear, kind, and honest communication; being patient and empathetic; spending time with patients; offering touch; and going above and beyond. These are discussed as part of this finding.

Building Rapport. Participants in this study shared many examples about ways the nursing staff can build NPTR with patients through verbal connection and communication. Participants described how they work to initially build rapport by introducing themselves at the first contact with a patient in a polite, warm, and welcoming way (Participants 1, 5, & 10). For example, one participant commented that they were able to build a strong NPTR because "of simple politeness, . . . and introducing myself as another human being, [who is] there to support them in the patient's recovery journey, . . . it truly works for me" (Participant 10). Furthermore, another participant commented on how the initial interaction sets the tone for the nurse–patient relationship moving forward and goes a long way to create the conditions for the patient's openness to effective, open communication and acceptance of care (Participant 5). In short, building rapport was identified as an important and welcoming way to nurture NPTR.

Offering Clear, Compassionate, and Honest Communication. In addition to building rapport with patients, participants in this study shared the importance of offering clear, compassionate, and honest communication between nursing staff and patients. According to study participants, clear communication is about providing patients with simple and understandable information about plans and expectations related to their care. One participant shared about how being honest and clear about one's illness and treatment plan could help to alleviate a patient's fear and agitation related to not knowing what to expect while also supporting patient cooperation and compliance (Participant 5). The same participant shared a story about how when they explained to a patient, "Here you get stronger, you have a physio in the morning, we're going to help you do exercise," it helped with the patient's cooperation and compliance with the care plan and "the patient completed the goals" (Participant 5). Another participant described how some patients arrived on the PATH unit crying, not eating, and refused care. They noted that this is often because patients find themselves in an unfamiliar environment with unfamiliar people and are unsure what will happen to them. The participant shared that offering clear communication with patients about the purpose of their admission and care expectations can help to alleviate the fear for patients (Participant 1).

While clear, compassionate, and honest communication is helpful for all patients, participants shared that it can be particularly useful when working with patients with social issues and behavioural problems related to alcohol, drug, and substance use (Participants 1 & 2). Specifically, participants working with this patient demographic suggested that clear, honest, and compassionate communication can help to de-escalate behaviours, calm down patients, and support compliance with the continuation of care (Participants 1 & 2). In summary, however, participants noted that verbal communication with all patients plays an integral role in nurturing NPTR.

Being Patient and Empathetic. When talking about the importance of communication, participants also unanimously spoke about the importance of empathy and patience to build NPTR. One participant shared that she was able to practice NPTR because of her demonstration of empathy to patients, which led to a trusting relationship and the patients' openness to express their needs and concerns (Participant 1). The participant shared a heart-breaking story that reinforced what I deduced as being patient and empathetic, which cannot be overlooked in nurturing NPTR:

> We have a patient a couple of days ago. She was very sick; she was diagnosed with lung cancer and is without her family. . . . After a while, she wanted to go back to bed, but we are very short-staffed that day. Despite our inability to meet up with providing care for all the patients, she truly wanted to go back to bed because she had generalized pain. We explained to her to sit for some time and that she can go back to bed after lunch. However, she didn't seem to understand; she truly wanted to go back to bed. She started crying and saying, "I don't like this place" and that she wanted to go home. She refused to eat. She didn't want even to take her pills. Therefore, I held her hands, sat down with her, and I explained to her the reason for our inability to do her wish now. She understood after patiently explaining the situation to her. The conversation began to flow; then, we started talking about different topics of interest for approximately half an hour to 45 minutes. As we were talking, I started helping her with feeding, and then she became comfortable and happy with the provided care. . . . Every time we see each other, we exchange jokes, so I think I developed a rapport." (Participant 1)

Spending Time With Patients. As illustrated in the previous story, spending time with patients is another important way nursing staff cultivate NPTR (Participant 4). As one participant shared:

> I think it is just (about) taking your time with patients, and I think it is just what they want; they just want you to listen. Honestly, giving them five minutes of your time means a lot to these people. In addition, I think as nurses, and like care staff, sometimes we're always in a rush, we're always short, and if you took an extra two minutes to do the

> smaller things for them, they appreciate it. I know that's truly what goes a long way with the patients. (Participant 7)

Another participant offered that spending time can help patients feel more comfortable and shared a story about how spending time with the patient "made her [the patient] feel that she is not alone . . . and she feels like there's somebody there to care for her. She believes that somebody is listening to what she is saying, and somebody is there for her to make a difference" (Participant 9). Through conversations with participants, it was evident that spending time with patients was important to NPTR, and this is intimately linked with nursing staff's availability to do so (see Finding 2).

Offering Touch. In addition to communicating with patients in verbal ways, some participants in this study also spoke about the importance of offering physical touch to nurture NPTR. For example, one participant stated that she held the hands of a paralyzed patient who did not want to eat her food. While still holding her hands, the nursing staff started talking with her, and both the patient and the nursing staff immediately engaged in conversations about family life (Participant 1). Another participant expressed that "patient needs human touch" to nurture NPTR in practice (Participant 4). While offering touch was identified as an important way to nurture NPTR, participants also advised that touch needed to align with ethical guidelines and respective scopes of practice.

Going Above and Beyond. To help build NPTR, participants also spoke about going above and beyond the required nursing care responsibilities by performing extra tasks for the patient. For example, some participants shared specific acts of going beyond the nursing care activities to support the patient, which enhanced the therapeutic relationship between nursing staff and patient (Participants 3 & 11). One participant shared that “getting a warm blanket and a drink and snack can go a long way” and “work for her” to engage patients in a therapeutic relationship (Participant 11). Participant 3 explained that she saw messed stockings in a patient’s washroom and then washed and put them in the right place. The patient was so impressed with what she did. This action explained the flexibility and care support that promoted NPTR. It is important to note that many of the ways in which NPTR is nurtured go beyond the official job descriptions of nursing staff.

Finding 1 Summary. In summary, NPTR is nurtured in many ways by care staff in NPTR. However, it is important to note that how NPTR is nurtured does not happen through only one of these methods or ways. Instead, NPTR occurs through a combination of interrelated and intersecting ways. In addition to ensuring that NPTR is nurtured in a multitude of ways, the situational and systemic factors at play also support or inhibit NPTR in practice.

Finding 2: Situational/Systemic Factors Supporting NPTR in Practice

Throughout this research process, participants talked about the support required to promote and enhance NPTR in PATH. Specifically, participants spoke about the situational and systemic factors that support NPTR in practice, including provision of staff education and collaboration; patient’s willingness; and workload, assignment prioritization, and time availability. These are discussed further in this finding.

Staff Education and Collaboration. To help support NPTR practice, participants spoke about the importance of ongoing staff education and collaboration among the health care providers and the health care team. Specifically, one participant described how staff education helped the team in Weatherby-2, a PATH subunit, pivot to the provision of NPTR: “What made the experience possible for the therapeutic relationship is our education" (Participant 1). Participants also reinforced the importance of collaboration amongst the health care team, whereby each interaction with the patient by a team member lays a foundation for NPTR. One participant shared a story about how the social worker for their PATH unit (WP2) played an integral role in nurturing NPTR when they engaged a scared and agitated patient who was unsure where he would be discharged to. Through the conversation between the social worker and the patient, they created a care plan to support the patient to stay in the PATH unit until he could be discharged to the appropriate place, and this made all the difference (Participant 4). Another participant reinforced the importance of working together, sharing:

> We de-escalate patients' behaviour with our therapeutic relationship, good communication skills, and working with other health authority members. . . . Good communication between the staff members and between nursing staff and patients enhances better and mutual understanding, which encourages us to put 100 percent of our attention to their care, which makes them [patients] feel better day by day. (Participant 1)

Investment and commitment to education and collaboration to support NPTR cannot be overstated.

Patient's Willingness. Another subtle yet strong factor identified by participants to support NPTR was what I refer to as patient willingness. This is evidenced by a story by one participant who stated, "The situation [patient willingness] itself made it possible" (Participant 10). Likewise, one participant mentioned, "[The] patient's willingness and cooperation made the practice of NPTR possible" (Participant 5). The patient and their willingness to engage in NPTR play an integral role in NPTR and cannot be overlooked.

Workload, Prioritization of Care Responsibilities, and Time Availability. In addition to the aforementioned factors, participants in this study noted that systemic factors such as a light workload, assignment prioritization, and time availability also contributed to successful NPTR. For example, as one participant shared, “So what made it possible was the limited [light] workload we have on the unit” (Participant 3). That same participant admitted that assignment prioritization is another contributing factor that supports NPTR practice in PATH, stating, “What made it possible was . . . because I was providing my care to the patient based on my priority, which is mostly patient care” (Participant 3). Building from Participant 3’s statements, many other participants in this study shared the importance of having time to commit to supporting NPTR practice. For example, Participant 8 shared that “the availability of time” made the practice of NPTR possible. For all participants in this study, having the time to engage with patients because of a balanced workload distribution and prioritization of care responsibilities played a vital role in supporting NPTR in practice.

Finding 2 Summary. In summary, the participants in this study noted that situational and systemic factors play an important role in supporting NPTR in practice. Similar to Finding 1, these factors cannot be considered in isolation. The interrelationships among these factors and the factors presented thus far in this chapter must be considered in collaborative and interrelated ways.

Finding 3: Potential Benefits and Outcomes of NPTR

During the appreciative interviews, many participants shared personal stories and experiences about the importance of NPTR to patients and their nursing practice and the associated benefits and outcomes of NPTR. Specifically, participants spoke about how NPTR has the potential to promote patient independence and healing, increase patient satisfaction, increase staff satisfaction, and perhaps even reduce health costs. These potential benefits and outcomes of NPTR are discussed under this finding.

Promote Patient Independence and Healing. According to the participants in this study, promoting NPTR can foster healing and encourage patients to be more independent. In fact, participants shared that one of the goals of the PATH unit is to support the health and well-being of the patients in anticipation of their eventual discharge. As one participant stated, "Patients have their routines, and they want to maintain them in our unit for their quality of life. If we support them in keeping those routines, it will make them more independent" (Participant 1). Another participant emphatically said that NPTR "helps them [patients] emotionally and physically" and can support "patients [to] heal quickly" (Participant 3). In response, another participant offered, "The effective care provided led to patients' physical, mental, spiritual, and emotional well-being" (Participant 1). Clearly, participants feel strongly that NPTR can enhance the health and well-being of patients, facilitate healing, and support their discharge and return home.

Increased Patient Satisfaction. In addition to supporting the health and well-being of patients, all participants in this study suggested that a focus on building NPTR with a patient often results in greater patient satisfaction and appreciation of the patient care experience. For example, as one participant noted, "I tried to engage my patient and, you know, just build a sort of a rapport, and I find that truly helps so like, you know, patient saying, 'Thank you for coming by, thank you for saying hello'" (Participant 2). Participants also reinforced that patient satisfaction is not only verbal; they also noted that patients also offer nonverbal expressions of appreciation and satisfaction, such as smiling and being happy during and after care provision (Participants 1, 2, 3, 4). Participant 3 stated that the patient was so impressed and happy with their action after having washed a patient's stockings.

The participants in this study clearly stated that appreciation is expressed not only by patients but also by family members. Participants offered examples of how they build relationships with patients; family members appreciated the nursing staff through words and kind gestures. For instance, Participant 1 stated, "Then they completed their [treatment] goals, they go home. In addition, family appreciated it, they appreciated [the services provided to their family member who receives medical care]. Therefore, they give us gifts, thank you cards." It was evident through this study that a focus on NPTR may contribute to greater patient appreciation and satisfaction. However, the benefits of NPTR are not only for the patient; therefore, next, I explore the benefits for staff who invest in building NPTR.

Encouragement from Patients and Increased Staff Satisfaction. When talking about the benefits of NPTR, participants spoke about nursing staff having a sense of satisfaction when patients share gratitude and appreciation for the care provided and a sense of accomplishment when they see their patients heal or become discharged. One specific example of patients sharing gratitude and appreciation that results in job satisfaction is through what one participant expressed as: "At the end of the of the day, then you see a smile on their face, then you feel like, you know, you did something, like you know when someone's happy that makes you happy" (Participant 1). Participant 3 affirmed that the outcomes of prioritizing NPTR make them "wanting to do more or like doing more next time. Therefore, when you feel good about the job you are doing, it also helps the patient." As the health care system navigates the realities of COVID-19, this benefit cannot be overstated.

Reduce Health Costs. A final subtheme related to the benefits of NPTR was the suggestion that NPTR prioritization may help to reduce health costs. Participant 3 offered a statement suggesting that a focus on NPTR could reduce nursing staff's "stress, use fewer resources, [and] save energy, time, and money for Fraser Health." Although this subtheme was only identified in passing, it does raise questions about the potential for NPTR to save money for health systems more broadly.

Finding 3 Summary. In summary, participants in this study identified that promotion of patient independence and healing, increased patient satisfaction, increased staff satisfaction, and reduced health costs are the benefits and outcomes of the NPTR practice. Similar to Finding 1, these benefits and outcomes cannot be considered in isolation because they are interconnected. The interdependence of these benefits and outcomes presented thus far in this chapter must be considered in interrelated ways. The outcomes that have positive effects on the patients, nursing staff, and the organization are driving forces to seek strategies and opportunities to strengthen NPTR practice.

Finding 4: Opportunities to Strengthen NPTR

Although participants throughout this study talked about how NPTR is currently practiced, participants also expressed possibilities to strengthen NPTR in practice. Specifically, participants talked about the importance of providing adequate staffing, embracing ongoing education and support, providing patient resources and programs, supporting volunteer engagement, and supporting interdisciplinary collaboration and care.

Providing Adequate Staffing. To strengthen NPTR in PATH, the importance of adequate staffing was reinforced by all participants. For example, a participant stated,

> Patients are very frustrated as a result of the restrictions that are in place due to COVID-19; they need staff to spend time with them. The patients are going through a hard time, staying away from their families. The care staff, nurses, and doctors all experience considerable stress at the same time. . . . We are short-staffed and it's like a lot, like we are going mentally and physically affected. (Participant 6)

Specifically, participants in this study shared that adequate staffing would allow the nursing staff to spend more time with individual patients and ultimately support patients' wishes and needs. As one participant shared, "You know spending more time with them makes a huge difference" (Participant 8), and another reinforced, "More staff, more activities" (Participant 9). In short, adequate staffing was considered important for patients to nurture NPTR.

Embracing Ongoing Education and Support. In addition to offering additional staffing, participants suggested that an investment in staff education and support would help to enhance NPTR. As Participant 1 offered:

> Management is the one who can organize workshops for us and who can make us strong. If the foundation is strong, the building will automatically be strong. If the workers are emotionally, mentally, and physically strong, if they don't have so much stress, so much pressure, so that we can give our 100 percent output to our patients so things will be smooth.

When reflecting on specific educations that could support NPTR, participants mentioned two specifics education examples, including a focus on professional and ethical boundaries and another on cultural sensitivity and awareness. Culturally sensitive nursing care is described as services provided by the nursing staff to meet the needs and expectations of the patients by respecting their cultural heritage and belief systems which influences their attitudes, feelings and values (Tucker et al., 2011). Tucker et al. (2007) asserted that culturally sensitive care aimed at promoting patients' health and reducing health differences among culturally diverse patients. Specifically, Participant 3 reinforced the importance of compliance with professional and ethical boundaries, and other participants suggested that they need to have education on cultural sensitivity and awareness to best support the patient population.

Providing Patient Resources and Programs. Participants in this study also reinforced the importance of resources and programs to support patients' holistic well-being. Specifically, it was suggested that reading materials, cards, playing cards, videos, and TVs be available to support patients and keep them engaged. As noted by one participant:

> Family who are nice do promise they'll bring their loved one TV, video, whatever. However, some patients don't have anyone providing things like that for them; so, they become envious. However, I think the hospital should provide something for them. . . . I know it's not their home, but at least they can feel like a home for whatever time they're staying here because not everybody can afford the TV here. I think it's all Frasier Health responsibility. I think they pay for it, that could be why we have one TV here, which is in the hallway. This is not adequate; everybody wants to come out and watch something, what's going on in the news and the movies industries. I think it's all about their need to provide more. (Participant 9)

An additional recommendation to support patients was to offer activities for patients can connect with other patients, and this was particularly considered important during the pandemic. As one participant shared,

> Many naturally nice patients can be agitated, aggressive, and anxious about everything when bored. It is like they cannot go anywhere outside. All they're seeing is like the sun coming from the window, and they don't know how it looks. I was thinking like they will go outside today in the morning, like how the weather will be good. Unlike prior to the COVID-19 pandemic, they used to have outings to go to different events, but now they cannot, so lots of them are very frustrated. (Participant 8)

It was suggested that an interactive forum or way of communicating via a physical board could support patients in connecting with one and the other. For example, one participant shared that a patient interactive forum could encourage patients to come together to play cards (Participant 3).

Supporting Volunteer Engagement. Participants also reinforced the importance of volunteer engagement to best support NPTR. As noted on countless occasions in this study, sometimes nursing staff can have many patients to care for, and it can be difficult to care for and entertain patients. Participants suggested that volunteers could support patient engagement in PATH and could engage patients in recreational activities. For example, a participant shared an experience of a volunteer coming in every day to spend time playing puzzles with her daughter when she was admitted to the hospital (Participant 7). Therefore, using the service of the volunteers could reduce the workload of the nursing staff and help engage patients and potentially reduce boredom.

Supporting Interdisciplinary Collaboration and Care. Finally, some of the participants in this study pointed out that embracing collaboration and shared learning is an essential strategy for promoting NPTR in the PATH unit. Participants noted that there should be collaboration among interdisciplinary team members to support patients. For example, if a patient is "supposed to be getting this care, all the staff should be on one page and continue with the care, even when the person will be discharged, it should be the same thing" (Participant 5). Furthermore, participants suggested that staff need to feel supported by management to carry out their responsibilities effectively and efficiently and feel encouraged. For example, Participant 4 said,

> For us also to be able to manage the therapeutic relationship, it's not only the nursing, but management also must come in and support the staff as well. For example, if the staff are burning out and they have a shortage of staff, that's when the management can come in and help the staff be able to relieve them because if you cannot take care of yourself, you cannot take care of others. Therefore, the management must support their staff as well.

To support interdisciplinary collaboration, one participant suggested that nursing staff could share success stories with other staff members and at Fraser Health meetings, as it could encourage the heart, educate others, build relationships, and promote continuity of care (Participant 5).

Finding 4 Summary. In summary, participants in this study identified that opportunities to strengthen NPTR practice in PATH include providing adequate staffing, embracing ongoing education and support, providing patient resources and programs, supporting volunteer engagement, and supporting interdisciplinary collaboration and care. These opportunities are interrelated and mutually inclusive.

Scope and Limitations of the Inquiry

The research sought to understand and learn more about how NPTR in the PATH–PAH unit is currently nurtured and how it can be promoted. I specifically engaged nursing staff to explore stories about NPTR and consider ideas and strategies to promote NPTR with patients. This study offered value by engaging nursing staff to share their unique perspectives and identify opportunities and recommendations for quality improvement.

Like all research studies, this study had some limitations worth mentioning. First, while this study focused on NPTR and engaged nursing staff, it did not engage patients; therefore, it excluded one of the key players in NPTR. Further research is required to engage patients and understand their experiences and perspectives about NPTR practice. Second, this research was conducted during the fourth and fifth waves of the COVID-19 pandemic at a time when many staff felt overextended, stressed, and burned out. It is likely that this limitation impacted participant engagement and the perspectives and insights offered. Last, this study was specific to the nursing staff in the PATH unit, and therefore, it is difficult to generalize these findings to other hospitals, hospital units, and contexts. As such, further studies are needed to explore beyond nursing staff in the PATH unit.

Chapter Summary

This chapter explored the findings that emerged from this study exploring how NPTR is currently practiced amongst nursing staff and how NPTR could be strengthened. Four key findings were introduced focused on the ways NPTR is practiced, the situational and systemic factors that promote NPTR, the associated benefits of NPTR for patients and nursing staff, and the ways NPTR could be strengthened or enhanced. It is important to recognize that each of these findings is interrelated and complementary to support NPTR in practice. In the chapter that follows, I explore the study conclusions, recommendations, and implications related to NPTR in practice within the PATH unit.

Chapter Five: Study Conclusions, Recommendations, and Inquiry Implications

This engaged and action-oriented inquiry engaged nursing staff to explore the overarching research question: How might the nursing staff enhance the nurse–patient therapeutic relationship in the Patient Assessment and Transition to Home (PATH) Unit at Peace Arch Hospital (PAH)? This question was supported by four subquestions:

- Why is a nurse–patient therapeutic relationship important?
- How is the nurse–patient therapeutic relationship currently nurtured?
- What might be possible if we prioritized the nurse patient-therapeutic relationship?
- What strategies and supports nurture the nurse–patient therapeutic relationship?

In this chapter, I share the study conclusions and recommendations emerging from this research and the associated implications for nursing staff, patients, and the PATH unit.

Study Conclusions

Rather than presenting each conclusion as it pertains to each research subquestion, I have decided to present four overarching research conclusions, as they are interrelated, interconnected, and complementary to support and strengthen nurse–patient therapeutic relationship (NPTR) practice. Specifically, four conclusions emerged from this study:

1. NPTR must be built, cultivated, and maintained in diverse, complementary, and ongoing ways.
2. Workload, education, and an environment of collaboration are essential systemic factors to enable effective NPTR.
3. NPTR offers benefits for patients and families, staff, and organizations.
4. Ongoing commitment and resources are needed to improve NPTR in practice.

5. Patients play an integral role in supporting and promoting NPTR in practice.

In the first section of this chapter, I present these four main conclusions by comparing, contrasting, and integrating evidence from the research data emerging from this study and relevant literature as presented previously in Chapter 2.

Conclusion 1: NPTR Must be Built, Cultivated, and Maintained in Diverse, Complementary, and Ongoing Ways

Participants in this study talked about the diverse ways NPTR is both built and nurtured in PATH. Aligned with existing research, nursing staff identified building rapport through introductions and initial conversations (Peplau, 1997, as cited in Arnold & Boggs, 2016) as essential to set the tone for effective NPTR and to begin building trust (Wright, 2021) with the patient. Ongoing communication was also identified as essential to NPTR (Sheldon, 2013; Weller et al., 2014). Specifically, nursing staff in this study spoke to the importance of being honest and empathetic (Bloomberg et al., 2016; Flickinger et al., 2016; Moreno-Poyato et al., 2016), communicating verbally and nonverbally (Kourkouta & Papathanasiou, 2014), spending time with patients (Feo et al., 2017), and going above and beyond their normal nursing care responsibilities (Davies, 2014; McCormack & McCance, 2010; Wyder et al., 2015).

Throughout this study, it was reinforced that NPTR must be built, cultivated, and maintained (College of Nurses of Ontario, 2006)—NPTR, it is not a one-off event. Nor can NPTR be built and/or maintained by only focussing on one of the ways or attributes identified in this research. It is clear from this study that NPTR is a way of working and requires ongoing commitment from frontline staff as well as management to effectively support NPTR in practice.

Conclusion 2: Workload, Education, and an Environment of Collaboration Are Essential Systemic Factors to Enable Effective NPTR

As noted in Conclusion 1, spending time with patients was identified by participants as being integral to effective NPTR. To support spending time with patients, participants specifically spoke about "light" workloads, multidisciplinary team members' communication (Carayon & Gürses, 2005 as cited in Carayon & Gürses, 2008), and their ability to prioritize patient engagement over other tasks(Lake et al., 2009). In essence, they were referring to a more ideal situation-level workload (Carayon & Gürses, 2008) that could support and nurture NPTR. According to Aiken et al. (2014), a decreased or lighter workload significantly increases the level of care provided to the patient and increases motivation to engage in therapeutic relationships.

Participants in this study also noted that education plays an integral role in supporting nursing staff in practicing NPTR. Specifically, ongoing education and skills were noted as essential to sustain and enhance the competence of nursing staff (Chaghari et al., 2017; Patelarou et al., 2009). While a focus on education and learning is considered essential to support NPTR, research also suggested that education can improve nursing staff's job satisfaction (Aminoroaia et al., 2014), and this is particularly important as the health care system navigates the COVID-19 pandemic and staff are feeling more overstretched and burned out (Maunder et al., 2021).

Education helps nursing staff refresh their memory about certain nursing practices and update their skills for better practices (Patelarou et al., 2009). Organizing continuous education programs for nursing staff will enhance the increase in their knowledge, attitude toward the patients and staff, and practice of nurses to promote patients' health as well as nursing staff's job satisfaction (Aminoroaia et al., 2014).

Finally, care coordination among health care providers was identified as another important systemic factor to nurture and support NPTR. According to Rosen et al. (2018), the management and delivery of high-quality care enabled through NPTR requires dependable and honest teamwork and collaboration amongst health care providers and the patient and patient's family. The management and delivery of high-quality care enabled through NPTR requires dependable and honest teamwork and collaboration within health care providers (Rosen et al., 2018). Participants in this study reinforced that leadership plays an essential role in modelling collaboration in action, where according to Bowers et al. (2011), "leadership impacts on teamwork, teamwork impacts on the structure, structure influences burnout, and burnout influences attitudes towards difficult patients" (p. 147).

In summary, two factors responsible for creating enabling conditions for nurturing NPTR were discussed. Situational factors include patient willingness and prioritization of care responsibilities, while systemic factors include staff education and collaboration, workload, and time availability. This is evidence that these factors cannot be considered in isolation. For example, staff education and collaboration will foster patient willingness and assignment prioritization, which will eventually result in time availability. Therefore, they must be considered in collaborative and interrelated ways. Therefore, the ultimate goal of NPTR practice, which is to benefit the patient, nursing staff, and organization, will only be achievable when diverse and complementary ways to cultivate NPTR are practiced and situational and systemic factors to nurture NPTR are put in place.

Conclusion 3: NPTR Offers Benefits for Patients and Families, Staff, and Organizations

The participants in this study shared that a focus on NPTR can offer benefits to patients and families. Specifically, NPTR was identified as a way to help enable patient satisfaction (Kourkouta & Papathanasiou, 2014; Merkouris et al., 2013; Wright, 2021); improve clinical outcomes, such as pain control and physical and mental quality of life (Kourkouta & Papathanasiou, 2014); support more holistic healing (Molina-Mula & Gallo-Estrada, 2020); enhance the quality of the patient’s primary care (Lown et al., 2011; Street et al., 2007); improve patient cooperation and compliance; and support patient independence and discharge (Sheldon, 2013). Collaboration was identified as crucial to promoting therapeutic relationships among teams given that it can reduce workload, support continuity of care, enhance learning with and from one another, and support sharing of information and quick patient discharge (Morley & Cashell, 2017).

The nursing staff in this study also spoke to value NPTR for the nursing staff themselves. Participants spoke about how a focus on NPTR may contribute to increased empathy from patients towards nursing staff and greater job satisfaction amongst nursing staff (Mrayyan, 2006). These findings were supported by the view of Castaneda and Scanlan (2014) that positive patient outcomes result in nursing staff’s job satisfaction. In addition, nursing staff who engaged in a therapeutic relationship with the patients expressed great job satisfaction (Moreno-Poyato et al., 2018).

In addition to benefiting patients and families and nursing staff, one of the participants in this study suggested that NPTR prioritization could support cost savings for the Fraser Health Authority. Specifically, it was suggested that a focus on NPTR could support patient independence and holistic healing and may result in a shorter hospital stay. This suggestion is aligned with the literature that suggested health care costs may be reduced or decreased when NPTR is competently practiced (Shay et al., 2012). Recognizing the value of NPTR to patients, nursing staff, and the organization, the importance of nurturing and cultivating NPTR cannot be overstated.

Conclusion 4: Ongoing Commitment and Resources are Needed to Improve NPTR in Practice

Participants in this study emphasized the importance of adequate staffing to support and improve NPTR in practice. Specifically, participants spoke of the importance of both paid staff (Kief et al., 2014; Rivaz et al., 2017) and volunteer roles and opportunities (Giles et al., 2006; Hotchkiss et al., 2008; Saunders et al., 2019) to ensure that more time is spent with patients and that there are more opportunities for patient engagement. It should also be noted that physical resources were also identified by participants and the literature as important contributors to improve NPTR (Kief et al., 2014; Rivaz et al., 2017).

This research also revealed that NPTR practice could be improved by embracing a spirit of collaboration (Kieft et al., 2014; Morley & Cashell, 2017) and shared learning (Barclay & NHS Kidney Care, 2012) within the organization. Collaboration was identified as crucial to promote therapeutic relationships among teams given that it can reduce workload, support continuity of care, enhance learning with and from one another, support sharing of information (Morley & Cashell, 2017), and support staff satisfaction and retention (Morley & Cashell, 2017). Participants also noted that NPTR could be further strengthened with an additional support system from the management. Kief et al. (2014) emphasized that nursing staff believe improved patient therapeutic care would increase when there is managerial support.

Therefore, the research participants agreed that establishing a working culture and environment that enabled collaboration and shared learning among the health care providers is one of the strategic plans to promote NPTR in PATH.

According to the participants, the commitment of nursing staff to maintaining professional and ethical boundaries is required to improve NPTR in practice. This is in agreement with the College of Nurses of Ontario (2006) on the importance of keeping professional boundaries as one of the parameters to promote the therapeutic relationship for meeting the patient's needs. The attempt to encourage therapeutic relationships by nursing staff with patients through empathy and compassion, effective communication, especially nonverbal-like touch, and so forth can bring tests to violate professional and ethical boundaries(Aravind et al., 2012). It is professional misconduct and abuse of power to build personal or social connections with patients by nursing staff (Griffith, 2013). The nursing staff must be committed to knowing and detecting the thin line between professional and social relationships between a nursing staff and a patient. The British Columbia College of Nurses and Midwives (BCCN&M; 2020) code states that "a nursing staff may violate a boundary in terms of behaviour related to favouritism, physical contact, friendship, socializing, gifts, dating, intimacy, disclosure, chastising and coercion" (p. 1). Every nursing staff is required to only disclose personal information that enhances therapeutic connections to meet the patient's health care needs (BCCN&M, 2020). Therefore, for the effective development and promotion of NPTR, the professional boundaries documented in BCCN&M code need to be followed during care provision by the nursing staff.

Respect is one of the ethical issues in the nursing profession. Therefore, it is the responsibility of every nursing staff to be sensitive to the culture of the patient. Embracing cultural sensitivity helps nurses respect the patient’s culture. The role of culture in developing and promoting therapeutic relationships by the nursing staff toward the patient cannot be overemphasized due to globalization resulting in an increasingly diverse society. A diverse population is associated with diverse cultures. A nursing staff must understand that some patients are at arm’s length to the caregiver because of their culture. A positive therapeutic relationship may easily develop when health care providers embrace the cultural background of their patients (Hynes, 2019). Therefore, cultural competence in nursing care is described as the ability to provide unbiased care based on the patient’s culture (i.e., beliefs, race, and values).

In summary, conclusion four revealed that supporting the ongoing commitment and allocation of resources have great potential to enhance NPTR practice in the PATH unit. This position cannot be overlooked when thinking about NPTR, and any attempt to think that NPTR can be improved and promoted without addressing these issues would potentially be dangerous to staff and patients. Therefore, a focus on supporting the ongoing resources and commitment of nursing staff to collaboration and operating within the professional boundary and ethics must be developed.

Conclusion 5: Patients Play an Integral Role in Supporting and Promoting NPTR in Practice

Although patients were excluded from this study, it is of utmost importance to honour and recognize the important role patients play in establishing, supporting, promoting, and sustaining NPTR. Two of the participants shared how the acts of patients made them feel good about their job, which eventually encouraged them to continue with the practice of NPTR; one patient was asking about the health condition of her son, while another patient was telling other nursing staff about how a nursing staff washed his stocking. This outcome of NPTR practice aligns with the findings of researchers who have investigated patients' satisfaction with the level of care (Merkouris et al., 2013; Wright, 2021). Patient satisfaction, an opinion of the patient based on the nursing staff's therapeutic relationship and care provided, has become a performance indicator of the holistic care provided (Merkouris et al., 2013). Mrayyan (2006) expatiated a patient satisfaction definition as "the degree to which nursing care meets patients' expectations in terms of the art of care, technical quality, physical environment, availability and continuity of care, and the outcomes of care" (p. 226).

Overarching Conclusion: Understanding the Conceptual Framework of Nurse-Patient Therapeutic Relationship May be a Motivation for Engaging and Promoting Its Practice

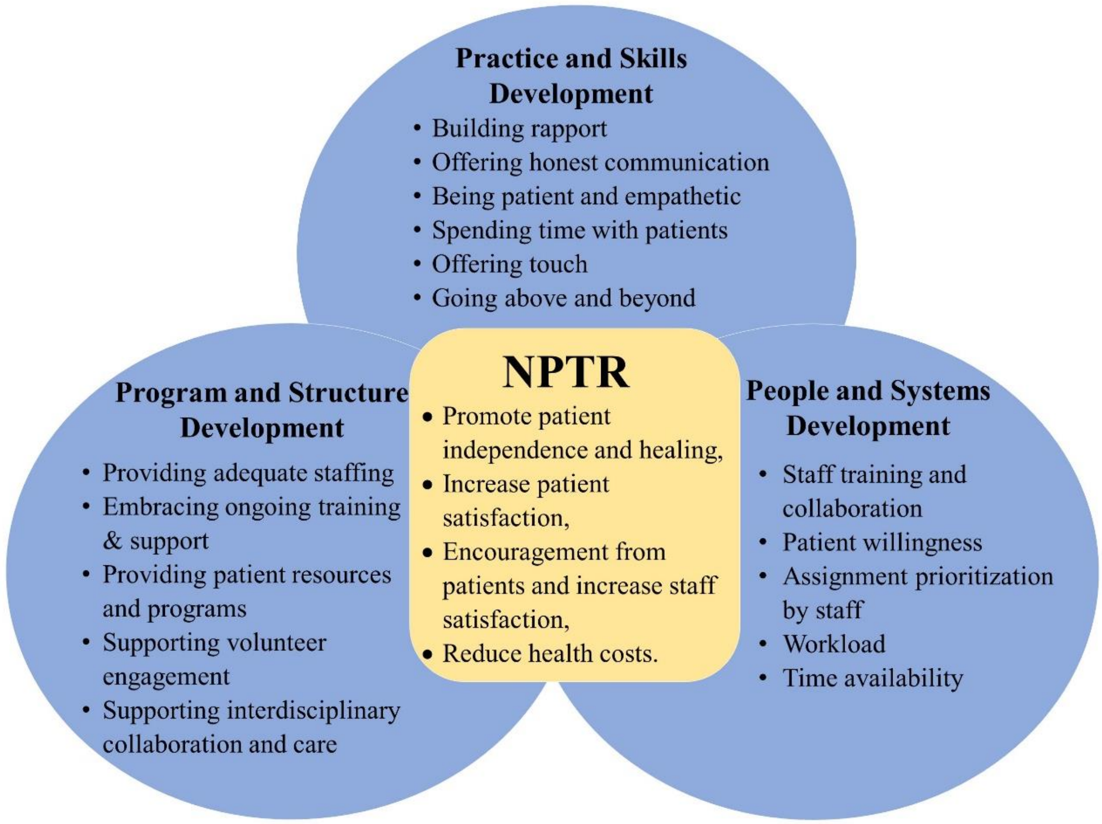
This research aimed to address how might the nursing staff enhance the nurse–patient therapeutic relationship (NPTR) in the Patient Assessment and Transition to Home (PATH) Unit at Peace Arch Hospital (PAH)? Based on the action-oriented research and through employing appreciative inquiry, it can be concluded that four outcomes emerged: (a) promote patient independence and healing, (b) increase patient satisfaction, (c) encouragement from patients can increase staff satisfaction, and (d) reduce health costs. These outcomes could not have been achieved without the two types of development that were in place: (a) the practice and skills developed and (b) people and systems development. Practice and skills development incorporate the diverse and complementary ways that NPTR is nurtured in PATH. There are six aspects of practice and skills developed in PATH unit to nurture NPTR: (a) build rapport, (b) be patient and empathetic, (c) offer honest communication, (d) spend time with patients, (e) offer touch, and

(f) go above and beyond the assigned nursing responsibility. People and systems development consists of the situational or systemic factors that helped the nurses in PATH practice NPTR. These comprise five components: (a) patient willingness, (b) prioritization of care responsibilities by nursing staff, (c) workload, (d) time availability, and (e) staff education and collaboration.

However, program and structure development aim at promoting NPTR in practice at PATH unit. Program and structure development involve strategies that the organization can embrace to promote and strengthen NPTR. Four strategies were identified: (a) provide adequate staffing, (b) embrace ongoing education and support, (c) provide patient resources and programs, (d) support volunteer engagement, and (e) support interdisciplinary collaboration and care. Therefore, a conceptual framework of NPTR has been designed from this inquiry's overarching conclusions (see Figure 1).

Figure 1:

The Conceptual Framework for the Nurse-Patient Therapeutic Relationship



In Figure 1, the practice and skills development, people and systems development, as well as program and structure development convergence point consists of the benefits and outcomes of NPTR. Therefore, the designed conceptual framework helps to visualize, understand, and remember how NPTR is practiced and how it can be promoted in the PATH unit.

Study Recommendations

Grounded in the findings and conclusions emerging from this study are five core recommendations: (a) continue to value and support nursing staff to practice NPTR, (b) recognise and support NPTR as an ongoing, integrated practice, (c) invest in education and resources to support NPTR, and (d) explore how NPTR could be enhanced and reinforced. These recommendations are discussed in this section.

Recommendation 1: Continue to Value and Support Nurses to Practice NPTR

Participants in this study noted that PATH has been doing quite well to support the practice of NPTR. It is recommended that management continue to support and value the practice of NPTR and optimise some key factors that could maximize benefits and outcomes of NPTR for patients, nursing staff, and the organisation. Key factors include maintain and support light workloads through adequate staffing and support volunteer engagement, increase collaboration and care coordination amongst interdisciplinary teams, and encourage continuity of care with nursing staff and patients.

Maintain and Support Light Workloads Through Adequate Staffing. Study participants shared that light workloads were integral to support their practice of NPTR. As noted in the findings and conclusions, greater time availability for nursing staff to nurture and sustain NPTR has the potential to promote patients' quick recovery, reduce patient length of stay, increase nursing staff job satisfaction and retention (Rivaz et al., 2017), and reduce health care costs (McHugh et al., 2021). Although many of the nursing staff in this study suggested they currently spend time with patients, they also expressed a desire to spend more time with patients. To do so would require adequate staffing. Adequate staffing can provide nursing staff enough time to build NPTR and support nurse–patient agreement on nursing care (Roviralta-Vilella et al., 2019). According to Driscoll et al. (2018), adequate staffing requires an interrelated understanding of patient care needs, ward needs, and nursing responsibilities and capacities, and these needs have changed throughout the COVID-19 pandemic. The PCAP form for evaluating the care needs and the nursing staff requirements ensures the baseline for British Columbia nurses irrespective of the uniqueness of their units (British Columbia Nurses' Union, 2021). Therefore, PATH unit needs a localized evaluation tool because of its uniqueness and goal. As such, I suggest that management review the current PCAP and modify it to reflect the PATH unit's needs to fully nurture and support NPTR. To support this review, I suggest that a review be done to evaluate the care needs of patients on the PATH unit and the nursing tasks and requirements to assess a new staffing size and mix.

Support Volunteer Engagement. Relatedly, research participants advocated that volunteer engagement could reduce the workload on the nursing staff and support a greater focus on NPTR. Volunteering offers a particularly great opportunity to both directly and indirectly influence NPTR on PATH. Volunteer engagement could help to engage patients in activities (Hotchkiss et al., 2008), offer company and companionship to patients (Giles et al., 2006), and also relieve nursing staff workload (Hotchkiss et al., 2008). Volunteer engagement has the potential to also increase patient satisfaction and reduce hospital costs. Furthermore, volunteer services are already employed in many other areas across the hospital, and the PATH unit appears to be a welcome place to engage volunteers. Historically, the PATH unit did not use the service of volunteers because the management team thought that the patients in the unit are medically stable and the nursing staff should be able to care for them.

Increase Collaboration and Care Coordination Amongst Interdisciplinary Teams. To further support NPTR on the PATH unit, it was recommended through this study that there be a greater emphasis on collaboration and coordination amongst health care teams. Collaboration and care coordination amongst nurses and the rest of the care team (e.g., occupational therapy, physiotherapy) has the potential to promote communication and information sharing, support continuity of patient care, reduce repetition or redundancy, reduce workload, and enhance learning amongst staff (Morley & Cashell, 2017). Furthermore, a focus on increasing care coordination and communication offers an opportunity to continue to strengthen NPTR practice. In PATH, patient rounds involve an interdisciplinary team; however, nurses are mostly exempt from this process to give them time to complete their assigned nursing care. Therefore, an example of a starting point to enhance collaboration will be to involve nurses in every patient round since they provide direct care to patients.

Encourage continuity of Care with Nursing Staff and Patients. Nursing staff in this study talked about how continuity of care could increase and enhance NPTR. Specifically, nursing staff talked about continuing to work with the same patients from shift to shift. According to Van Walraven et al. (2010, p. 947) continuity of care is essential for high-quality patient care and is best achieved through “provider continuity” or nursing staff continuity through a relationship between a patient and provider over time. This type of continuity of care is also referred to as “continuous caring relationship” (Gulliford et al., 2006, p. 249) and supports more focused and personalized support for the patient during their hospital stay (Van Walraven et al., 2010). I therefore suggest that PATH unit consider how a continuity of care could be supported to further enhance NPTR in practice. I suggest that the team consider employing a team-based mapping approach to look at respective roles and tasks of each member of the team and explore enhanced communication (Price et al., 2020). A team-based mapping approach helps the nursing staff to identify care needs and share responsibilities based on the scope of practice of each staff member.

Summarily, NPTR can be promoted through a continued effort of the management to support nursing staff in several ways, like reducing the workload by providing adequate staffing and supporting volunteer engagement, increasing collaboration and care coordination amongst interdisciplinary health care teams, and encouraging continuity of care with nursing staff and patients. However, it is important to note that supporting the nursing staff does not happen through only one of these ways. Instead, the promotion of NPTR occurs through a combination of diverse ways of supporting the nursing staff.

Recommendation 2: Recognise and Support NPTR as an Ongoing, Integrated Practice

Study participants spoke about the diversity of ways that NPTR can be cultivated through building rapport, offering effective communication, spending time with patients, and going above and beyond the call of duty. Nearly all the success stories shared by study participants revealed that integrating more than one of these ways was essential for building and sustaining effective NPTR practice. Supporting NPTR requires multiple skills, such as collaboration, communication, compassion, mutual understanding, and respect (Molina-Mula & Gallo-Estrada, 2020), and involves the combination of interrelated and complementary ways of cultivating and nurturing NPTR practice (Morck, 2016). Therefore, I suggest that NPTR be seen as ongoing, integrated practice that requires a diverse set of skillsets, rather than a goal to be achieved and then forgotten about. As such, ongoing education and capacity building are required to nurture, grow, and sustain NPTR practice.

Recommendation 3: Invest in Education and Resources to Support NPTR

Linked to the previous recommendation, nursing staff education and education is essential to nurture NPTR practice. In addition, participants also spoke about offering activities and programs for patients to help nurture NPTR.

Support Ongoing Education and Education. Participants explained that nursing staff education and education is integral to nurture, sustain, and grow NPTR practice. Specific, ongoing education and education in NPTR will likely contribute to the competence of nursing staff (Chaghari et al., 2017), update and enhance skills and knowledge (Aminoroaia et al., 2014; Patelarou et al., 2009), and support nursing staff to better equipped to provide therapeutic care. Furthermore, investing in education and education may result in nursing staff job satisfaction (Aminoroaia et al., 2014). Through this study, workshops and seminars were identified as possibilities to strengthen and enhance practice, as well planned occasional guest speakers/ educators to teach topics that promote NPTR and explore the possibility of designing and mandating professional development courses on NPTR were suggested. Participants also suggested that specialized education around culturally safety and cultural competence would be helpful to build the therapeutic relationships with people of diverse cultural backgrounds different from their own.

Offer Activities and Programs for Patients to Help Nurture NPTR. Participants in this study also suggested that resources be allocated to support activities and programs for patients. Suggested possibilities for activities included cards, puzzles, arts and crafts, and fitness activities. It is suggested that conversations are held with patients to determine what would be most valuable to support them and, in turn, support NPTR.

Recommendation 4: Explore How NPTR Could be Enhanced and Reinforced

NPTR could be improved and strengthened by engaging the nursing staff and patients to share their perspective to embrace shared learning that promote shared vision.

Engage Nursing Staff in Strategic Dialogues about NPTR. Through this research, it was evident that nursing staff are passionate and want to talk about NPTR; however, there are few opportunities to do so. I suggest that opportunities be identified to meaningfully engage staff in PATH to brainstorm and share on how NPTR can be cultivated and promoted. Furthermore, the act of brainstorming and sharing could build collective ownership of NPTR practice (Kieft et al., 2014; Morley & Cashell, 2017) and support shared learning (Barclay & NHS Kidney Care, 2012) in the PATH unit. To begin, I suggest that the PATH unit, both management and staff, has a strategic conversation on NPTR once a quarter. Additionally, it was suggested by my thesis partner that nurse practitioners be involved in future research, as their ideas and perspectives will likely complement and enhance some of the findings presented in this study.

Engage Patients to Understand Their Experiences of NPTR. This study did not engage patients to understand their perspectives about NPTR and how it could be strengthened, reinforced, or enhanced. However, patients' perspective as a stakeholder or recipient of care is crucial to NPTR practice. Therefore, I suggest that PATH explore how they might regularly engage patients and families in conversations and activities to gather their input and perspectives about NPTR practice. This information could then be integrated into the strategic dialogues with nursing staff and other practitioners to consider how they can improve or strengthen NPTR.

Engage Additional Nurses to Enhance Generalizability of Research Findings. This research engaged 12 nursing staff within the PATH unit at PAH. This is a good starting point, and there is an opportunity to send out a survey to all nursing staff within PATH to further verify and/or generalize the research findings. Furthermore, as noted above, more dialogues can be held with nursing staff and patient care teams to explore NPTR in deeper and contextual ways.

Inquiry Implications

The findings and conclusions of the study suggest that a focus on NPTR has the potential to support a PATH unit to provide better care for patients, enhance capacities of staff, contribute to staff well-being, and ultimately has the potential to decrease health care costs for PATH units. Implementing the recommendations offers tangible steps or actions to support nursing staff and management within PATH to enhance and value NPTR in practice. The recommendations are not intended to be a checklist of actions or approaches, rather they require an ongoing commitment, monitoring, and evaluation to explore how NPTR is improved and the implications this has in practice for patients, families, nursing staff, the health care team, and the organization.

In conversations with my thesis partner about this research, it was evident that this research was of value and that there is commitment to beginning to implement some of the recommendations immediately. However, it also noted that some of the recommendations would take time and would not happen overnight. Specifically, my thesis partner identified three areas where she is willing to act upon the recommendations identified in this study: (a) focus on education, (b) commit to engaging volunteers, and (c) nurture collaboration. These are discussed next.

Focus on Education

My thesis partner affirmed a commitment to focus on education with specific emphasis on the practice of NPTR. For example, how might NPTR be practiced when dealing with a depressed patient or someone who is feeling confused or may have dementia? She also noted a desire to offer educational opportunities that support staff wellness and resilience to enable staff to be more equipped to practice NPTR. It was suggested that perhaps I could offer some education on NPTR focused on research and praxis.

Commit to Engaging Volunteers

Once COVID-19 ramps down, there is a commitment to explore how volunteers can offer support to patients. It was suggested that volunteers could walk and talk with patients, provide nutrition and hydration, and other tasks, as identified by the nursing team, that are within the scope of practice of volunteers. Volunteers can also provide patients an opportunity to interact with members of the community which would enhance patient transitions back to home as they gain greater autonomy and confidence. The presence of volunteers in a hospital setting also decreases patient boredom as other individuals, who are not part of the health care team engage in activities and conversation. The mobilization of patients as well as their socialization and relationships with others in the long run promote normalization, overall health and well-being.

Nurture Collaboration

To support greater collaboration amongst the health care team, it was suggested that regular huddles could serve as a means to engage in conversations about how NPTR is being implemented and how it could be enhanced and reinforced. Further, it was suggested that greater emphasis be placed on working in collaboration with Allied Health and the interdisciplinary team to support more cohesive care and that scheduling be modified to support continuity with patients and amongst health care teams.

To support an ongoing commitment to NPTR and these areas of commitment, my thesis partner suggested that she would like to share these findings, conclusions, and recommendations with the Director in Charge of PATH and would also like to have ongoing meetings to assess progress and problem-solve any challenges that may arise.

Chapter Summary

Explored in this chapter were the conclusions, recommendations, and implications that emerged from this study exploring how NPTR is currently practiced amongst nursing staff and how NPTR could be strengthened. Five conclusions emerged from the findings:

1. NPTR must be built, cultivated, and maintained in diverse, complementary, and ongoing ways.
2. Workload, education, and an environment of collaboration are essential systemic factors to enable effective NPTR.
3. NPTR offers benefits for patients and families, staff, and organizations.
4. Ongoing commitment and resources are needed to improve NPTR in practice.
5. Patients play an integral role in supporting and promoting NPTR in practice.

In addition to the five conclusions, an overarching conclusion focused on understanding the conceptual framework of NPTR to encourage engaging and promoting its practice. Four recommendations were developed:

1. Continue to value and support nursing staff to practice NPTR.
2. Recognise and support NPTR as an ongoing, integrated practice.
3. Invest in education and resources to support NPTR.
4. Explore how NPTR could be enhanced and reinforced.

Finally, the implications of this inquiry on the patients, nursing staff, and the organization were discussed.

Thesis Summary

This project was designed to explore NPTR practice in PATH and consider how it could be enhanced. Through the engagement of nursing staff (RNs, LPNs, and HCAs) through a series of stringed liberating structures, this inquiry found that participants value and practice NPTR through diverse and complementary ways, including building rapport; offering clear, kind, and honest communication; being patient and empathetic; spending time with patients; offering touch; and going above and beyond. Participants also spoke about how situational and systemic factors support NPTR in practice, including providing staff education and collaboration, patient willingness, workload, assignment prioritization, and time availability. Participants also expressed possibilities to strengthen NPTR in practice through provisions of adequate staffing, embracing ongoing education and support, providing patient resources and programs, supporting volunteer engagement, and supporting interdisciplinary collaboration and care. To support these findings, four key recommendations emerged from this study:

- continue to value and support nursing staff to practice NPTR,
- recognise and support NPTR as an ongoing, integrated practice,
- invest in education and resources to support NPTR, and
- explore how NPTR could be enhanced and reinforced.

In support, my thesis partner has expressed a strong desire to implement and further explore the recommendations emerging within PATH, demonstrating both ongoing commitment and tangible action towards the enhancement of NPTR in practice.

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Appendix A: Inquiry Team Letter of Agreement of Confidentiality

In partial fulfillment of the requirement for a Master of Arts in Leadership Degree at Royal Roads University, *Rebecca Fabiyi*, will be conducting an inquiry study at *Peace Arch Hospital, Patient Assessment Transition to Home unit* to *promote nurse-patient therapeutic relationship*. The Student's credentials with Royal Roads University can be established by calling Dr. Catherine Etmanski, Director, School of Leadership, at [phone #] 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 or focus group, taking notes, transcribing, reviewing analysis of data, and/or reviewing associated knowledge products to assist the Student and the *Peace Arch Hospital, Patient Assessment Transition to Home unit* 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 advisor 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.

Bridging Student's Potential or Actual Ethical Conflict

In situations where potential participants in a work setting report directly to the student, you, as a neutral third party with no supervisory relationship with either the Student or potential participants, may be asked to work closely with the Student to bridge this potential or actual conflict of interest in this study. Such requests may include asking the Inquiry Team Advisor to: send out the letter of invitation to potential participants, receive letters/emails of interest in participation from potential participants, independently make a selection of received participant requests based on criteria you and the Student will have worked out previously, formalize the logistics for the data-gathering method, including contacting the participants about the time and location of the interview or focus group, conduct the interviews (usually 3-5 maximum) or focus group (usually no more than one) with the selected participants (without the Student's presence or knowledge of which participants were chosen) using the protocol and questions worked out previously with the Student, and producing written transcripts of the interviews or focus groups with all personal identifiers removed before the transcripts are brought back to the Student for the data analysis phase of the study.

This strategy means that potential participants with a direct reporting relationship will be assured they can confidentially turn down the participation request from their supervisor (the Student), as this process conceals from the Student which potential participants chose not to participate or simply were not selected by you, the third party, because they were out of the selection criteria range (they might have been a participant request coming after the number of participants sought, for example, interview request number 6 when only 5 participants are sought, or focus group request number 10 when up to 9 participants would be selected for a focus group). Inquiry Team members asked to take on such 3rd party duties in this study will be under the direction of the Student and will be fully briefed by the Student as to how this process will work, including specific expectations, and the methods to be employed in conducting the elements of the inquiry with the Student's direct reports, and will be given every support possible by the Student, except where such support would reveal the identities of the actual participants.

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 Rebecca Fabiyi, the Student.

Statement of Informed Consent:

I have read and understand this agreement.

__[Name on File____	_[Signature on file]__	_[DD/MM/YYYY]_
Name (Please Print)	Signature	Date

Appendix B: E-mail Invitation

Dear Prospective Participant,

I am contacting you on behalf of Rebecca Fabiyi. Please see the invitation from Rebecca below:

My name is Rebecca Fabiyi, and I would like to invite you to be part of a research project titled "Promoting nurse–patient therapeutic relationship (NPTR) in Patient Assessment and Transition to Home (PATH) unit at Peace Arch Hospital (PAH)" that I am conducting. Dr. Cheryl Heykoop is my supervisor and the principal investigator. This project is part of the requirement for my Master of Art in Leadership-Health Specialization at Royal Roads University. This project was approved by Faye Jennifer, PATH unit Manager, and I have been given permission to contact potential participants for this purpose.

The purpose of my research is to unveil strategies that enhance the promotion of nurse–patient therapeutic relationships in the PATH unit at Peace Arch Hospital. Your name was chosen as a prospective participant because of your position as a member of the nursing staff in the PATH unit who provides direct care of the patients. This project will involve RNs, LPs, and HCAs. The first four individuals or team members who indicate a willingness to participate from each category will be selected.

My research engagement methods will consist of an appreciative interview and conversation café. The total time for the session was 1.5 hours.

The attached document contains further information about the study conduct and will enable you to make a fully informed decision on whether to participate. Please review this information before responding.

I realize that due to our collegial relationship, you may feel compelled to participate in this research project. Please be aware that you are not required to participate and, should you choose to participate, your participation would be entirely voluntary. If you choose to participate, you are free to withdraw at any time before and during the research project until immediately after data analysis 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. Your choice will not affect your relationship with Rebecca Fabiyi or your employment status in any way.

Please feel free to contact me at any time should you have additional questions regarding the project and its outcomes.

If you would like to participate in this research project, please contact the CNE at:

Name: Navjot Cheema

Email: [email address]

Telephone: [phone #]

Sincerely,

Navjot Cheema (sent on behalf of Rebecca Fabiyi)

Appendix C: Participant Consent Form/Research Information

Title of Study: Promoting Nurse-Patient Therapeutic Relationship in the Patient Assessment and Transition to Home Unit at Peace Arch Hospital (PATH - PAH)

Principal Investigator: Cheryl Heykoop, PhD.

Royal Roads University

[phone #]

Co-Investigator(s): Rebecca Bosede Fabiyi, BScN.

Royal Roads University

&

Fraser Health Authority (Peace Arch Hospital)

[phone #]

Funder: None

INTRODUCTION AND STUDY PURPOSE

The purpose of my capstone project is to explore and enhance the nurse–patient therapeutic relationship (NPTR) in the Patient Assessment and Transition to Home (PATH) Unit at Peace Arch Hospital (PAH).

The objectives of this research are

- To define conditions that favour the promotion of a therapeutic relationship between nurses and patients
- To identify implementable strategies for promoting an initiation and maintaining a therapeutic relationship by the nurses towards the patients

The principal research question is as follows: how might the nursing staff enhance the nurse–patient therapeutic relationship in the PATH unit?

The subquestions are as follows:

- Why is a nurse–patient therapeutic relationship important?
- How is the nurse–patient therapeutic relationship currently nurtured?
- What might be possible if we prioritized the nurse patient-therapeutic relationship?
- What strategies could be taken to nurture the nurse–patient therapeutic relationship?

Registered nurses (RN), licenced practical nurses (LPN), and health care aides (HCA) who are currently working at PAH in the PATH Unit will be invited to participate irrespective of their culture, language, religion, race, disability, sexual orientation, ethnicity, linguistic proficiency, gender, or age. Participants will be selected on a first-come, first-served basis until 12 participants are reached. Ideally, four representatives of each group of RNs, LPNs, and HCAs will be involved. RNs, LPNs and HCAs on or off duty will be given the opportunity to participate since it will be done through a Zoom conference call. If someone is interested in participating but cannot attend, they will be sent the questions via email from the Clinical Nurse Educator (CNE) and can offer their responses via email.

This research project is part of a Master of Arts in Leadership – Health Specialization requirement at Royal Roads University.

YOUR PARTICIPATION IS VOLUNTARY

Your participation is completely voluntary; this means that you are not obligated to participate in this study. If you decide to participate, you will be required to sign this form. Note that you are still free to withdraw at any time without giving any reasons for your decision.

In addition, no explanation is required for your decision not to participate in this study. It is also important to establish that your decision to participate or not will not affect your employment and other benefits to which you are entitled.

WHAT DOES THE STUDY INVOLVE?

I will collect opinions, perspectives, ideas, and recommendations from the participants. This will be done in the form of hand-written notes, flip chart notes, and audio recordings. This project, as an action-oriented research, aims to effect a social change – promotion of nurse–patient therapeutic relationship (NPTR) in the Patient Assessment and Transition Home unit at Peace Arch Hospital (PATH).

Appreciative Inquiry: I plan to use one of the action-oriented research (AR) methodologies called appreciative inquiry (AI) because it focuses on strengths instead of weaknesses (Bright, 2009). AI explores what works, why it works, and how it can be enhanced (Vega & Hayes, 2019). AI has a significant transformational prospect that shifts organizational focus from problems to be solved to discovering opportunities to make a positive change (Koster & Lemelin, 2009). AI is an exceptionally useful methodology to consider in this project, as it builds from strengths and is intended to strengthen relationships within PATH as we explore promoting the NPTR. There are various models for conducting AI, but the model I plan to use for my research is the 5-D model (Cooperrider & Whitney, 2005). The 5-D model includes five primary AI phases: Phase 1: Define – This phase involves choosing the positive as a focus of inquiry. Phase 2: Discovery/Appreciating – "What is the best of what is?" This phase consists of participants interviewing each other and sharing stories about their peak experiences. It also includes inquiry into stories of life-giving forces. Phase 3: Dream/Envisioning Results – "What might be?" In this phase, the participants envision themselves and their organization functioning at their best based on the discovery phase's information. Participants think broadly and holistically about a desirable future through various kinds of visualization and other creative exercises. Participants also locate themes that appear in the stories and select topics for further inquiry. Phase 4: Design/Co-constructing the future – "What should be the ideal?" In this phase, participants propose strategies, processes, and systems based on the information at the dream phase. They make decisions and develop collaborations that will create and support positive change. They develop provocative propositions - concrete, detailed visions based on what was discovered about past successes. They also create shared images for a preferred future. Phase 5: Destiny/Delivery/Sustaining the change – "How to empower, learn and adjust/improvise?" In this phase, participants begin to implement their overall visions of the dream phase and the design phase's specific provocative propositions. In essence, this phase finds innovative ways to create the future that participants seek. This phase is ongoing as participants continue to implement changes, monitor their progress, and engage in a new dialogue and appreciative inquiries.

Methods of Data Collection: The 5-D model phases will be examined using three data collection methods - appreciative interviews and conversation cafés, which are examples of liberating structures (LSs). LS are practical and straightforward approaches to engagement that enhance group participation and performance in various organizational settings (Singhal et al. 2020). LS encourage the listening and talking of participants to improve information sharing and encourage independent thinking and reflection (Lipmanowicz & McCandles, 2013) and seek to identify and move towards the desired future (Singhal et al., 2020). Appreciative interviews and conversation cafés will be facilitated in a consecutive manner. Sessions will be facilitated virtually by one of my inquiry team members with my support. Participants will join via Zoom, and breakout rooms will be utilized to assign participants into their respective rooms – RNs, LPNs, and HCA groups. Prior to breakout into groups' rooms, PowerPoint slides will be shared with all the participants (using zoom screen share) at the start of the first meeting to give an overview and guidelines of the methods that will be used. At the beginning of each data collection method, I will inform the participants about the nature of the method, participants' anticipated role, the research's objective, and the findings' possible uses. According to Grady (2017), the process of informed consent is an expression of respect for research participants and their autonomy, thereby allowing the prospective participants to make free decisions about participating and continuing in research and respecting whatever choices they make about participation or withdrawal.

Appreciative Interview: An appreciative interview is a narrative process used to discover what made past successes a reality (Lipmanowicz & McCandless, 2013). It discovers and builds on the root cause of success. It starts with a brief description of an appreciative interview's concept and purpose (American Medical Association, 2016). After that, the interviewees are given the opportunity to share their real success stories, followed by an additional question on what made the success stories possible (American Medical Association, 2016). The appreciative interview, which is the first LS activity, will address the discovery phase of AI. I will invite participants to pair up with someone in the same nursing role to navigate power over, and each will have a turn telling a success story while the other person serves as an interviewer. The storyteller shares two questions: Why is a nurse–patient therapeutic relationship important? How is the nurse–patient therapeutic relationship currently nurtured?" While the interviewees tell their stories, the interviewers will be encouraged to pay attention to what made the success possible and write them down. It will take approximately 25 min, 10 min. per person.

Conversation Café: To generate new ideas on how we might prioritize the NPTR in the PATH unit, consultation with the nursing staff using a conversation café (CC) format is essential. A conversation café is a structured conversation process in which groups of participants gather to discuss a specific topic of consideration (Lipmanowicz & McCandless, 2013). CC encourages connection by providing space for people to talk, listen and learn with a spirit of curiosity, respect, and warmness (Lipmanowicz & McCandless, 2013). At the start of CC, the facilitator will establish engagement rules to foster a polite and honest dialogue. In the first round, two pairs from the appreciative interview session will form small groups of four using zoom break out into various rooms. The data collection will begin by inviting participants to elaborate more on the two questions discussed during the appreciative interview. Each person will speak briefly to the topic (1 minute each) without feedback or response from the listeners. In the second round, participants will be invited to further elaborate on the earlier shared story (1 minute each). In the third round, which is the dialogue session, all groups will come together to address a follow-up question based on the information gathered during the first and second rounds. The group will engage in a deep conversation about the subquestion - What might be possible if we prioritized the nurse patient-therapeutic relationship? This is to address the dream phase of AI. This will last for 12 min. In the final round, every participant will come together to address the destiny phase. They will deliberate on the ideas and strategic actions to promote nurse–patient therapeutic relationships in the PATH unit. This session will last for 20 min. Then, debriefing will last for 15 min. The guide designed by Cooperrider et al. (2008) will be adopted and modified for appreciative interviews and conversation cafés (Appendix A). A table showing the timing for the methods will be shared with the participants (Appendix B).

Data analysis: I will personally transcribe the audio recordings from the participants last shared in the conversation café. Wherever I need clarification, I will contact the groups' facilitators. My inquiry team and I will analyse my data using thematic analysis (TA). This method will help us to identify commonalities in the answers given to each of the questions addressed. I will use an inductive approach to data coding and thematic analysis described by Braun and Clarke (2012).

I plan to conduct my research virtually with staff from the Patient Assessment and Transition to home unit at Peace Arch Hospital, White Rock, BC.

WHAT ARE THE POSSIBLE RISKS AND INCONVENIENCES OF PARTICIPATING?

I believe my capstone project has a minimal risk to the participants because it will be conducted as a group conversation. Additionally, this project is not focused on a topic area that can retraumatize the participants. However, working in a group could be a risk related to confidentiality. Nevertheless, I will inform the participants that every discussion should end within the group, not to be discussed outside the group meeting.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

Participants' voices will be heard; they will contribute to a social change by providing solutions to the problem related to NPTR on the PATH unit. This will lead to the participants' satisfaction and sense of fulfillment. For my organization and society, this project can help increase patients' and staff's satisfaction as well as patients' health outcomes. This study will help me to better engage in a therapeutic relationship with patients and enhance my job satisfaction. In addition, the research outcomes will help me to promote change in my organization by engaging multiple perspectives that contribute to change. It will also contribute to the successful completion of my Master of Arts in Leadership – Health Specialization degree.

WHAT HAPPENS IF I DECIDE TO WITHDRAW MY CONSENT TO PARTICIPATE?

- Participants will be informed of their right to withdraw in the information letter at the start of each engagement section.

- Participants can also withdraw at any stage of the project by contacting the CNE.

- Participants can leave at any time during the study; however, due to the collective nature of the research, it is difficult and likely unfeasible to withdraw their contributions without compromising the data set. That being said, all information will be deidentified to support anonymity and confidentiality.

AFTER THE STUDY IS FINISHED (if applicable)

In the research session, research participants will have an opportunity to prioritize key themes and recommendations. Following the data analysis, a draft of the research findings and recommendations will be sent to participants for verification and review. Participants will have the opportunity to propose changes. The final report will be shared with management, and a conversation will ensue about how the changes can be incorporated into practice and implemented.

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?

At the beginning of the Zoom call, the facilitator will ask each participant to use a pseudonym as their Zoom to protect their identity. If participants do not feel comfortable sharing their video, they will have the option of turning their video off. Participants will also be reminded that they can share their thoughts via audio or in the chat room. Participants will also be reminded to keep the conversation confidential to maintain a safe space for people to share their perspectives and views.

Photography, Audio/Video Taping

The CNE will have access to the audio recordings. The Zoom meeting will be recorded by the CNE using the Zoom record feature. According to Zoom, all meetings are encrypted (Zoom, n.d., Encryption for meetings, para. 1-4). The audio recording will then be sent by the CNE to a transcription service using the secure file transfer portal, Cerberus, and the transcript will be stored on the secure Fraser Health M drive. A copy of the data will also be shared with the PI via Cerberus and securely stored on their RRU Desktop for five years.

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY DURING MY PARTICIPATION?

If you have any questions or desire further information about this part of the study before or during participation, you can contact Rebecca Fabiyi at [phone #].

WHO DO I CONTACT IF I HAVE ANY QUESTIONS OR CONCERNS ABOUT MY RIGHTS AS A PARTICIPANT DURING THE STUDY?

By signing this consent form, you are not giving up any of your legal rights. If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the PATH unit's CNE.

CONSENT TO PARTICIPATE

Title of Study: Promoting the Nurse–Patient Therapeutic Relationship in the Patient Assessment and Transition to Home Unit at Peace Arch Hospital (PATH - PAH)

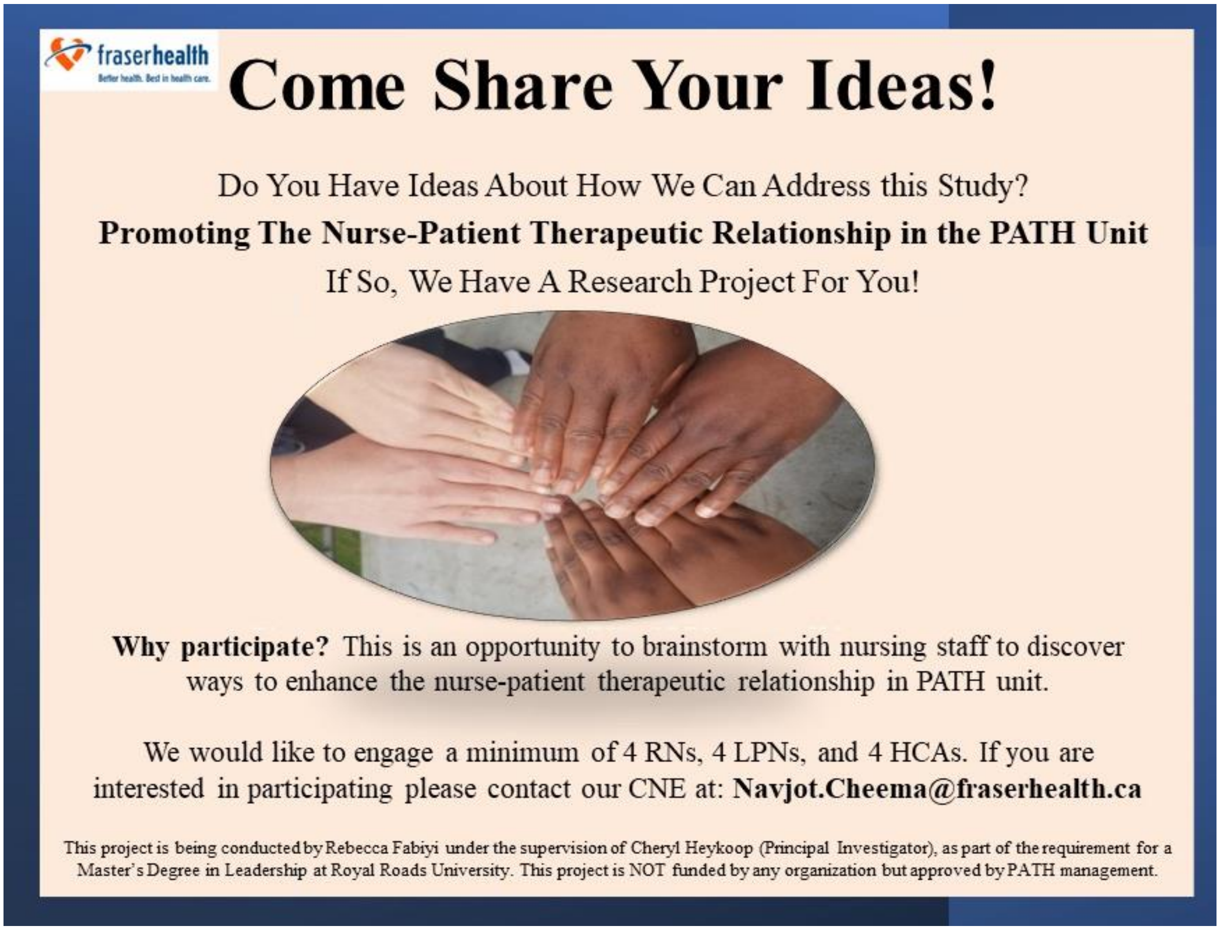
You understand that this consent form is not a contract; therefore, you are not giving up any of your legal rights by signing it. By signing this form, you agree that you have read, understood, and appreciated the information concerning the study.

- I have had the opportunity to ask questions about the information provided in this consent form and have had satisfactory responses to my questions.
- I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time.
- I understand that I am not waiving any of my legal rights as a result of signing this form.
- I have read this form and freely consent to participate in this study.
- I have been told that I will receive a dated and signed copy of this form.
- I consent to the audio recording of the appreciative interview and conversation café.
- I commit to respecting the confidential nature of the data collection methods by not sharing identifying information about the other participants.

SIGNATURES

______________________________	______________________________	_____________
Participant signature	Printed name of participant	Date
______________________________	______________________________	_____________
Signature of person administering consent	Printed name/title of person administering consent	Date

Appendix D: Participant Recruitment Protocol



Appendix E: Guides for Appreciative Interviews and Conversation Café

Appreciative interview guide

- Can you describe an exciting experience when a nurse–patient therapeutic relationship was demonstrated between you and your patient? (Answer to this question should contain when, where and how it happened?)
- What made it possible?
- Questions focusing on the discovery phase
  - Why is a nurse–patient therapeutic relationship important?
  - How is the nurse–patient therapeutic relationship currently nurtured?

Conversation café guide

The Conversation café will focus on the concluding questions that address the dream and destiny phases.

- What might be possible if we prioritized the nurse patient-therapeutic relationship? Where do you envision the PATH unit three to five years from now if we prioritized the nurse patient-therapeutic relationship? What are your three wishes for the future effectiveness of the nurse patient-therapeutic relationship in PATH?
- What strategies and supports nurture the nurse–patient therapeutic relationship?

Appendix F: Timing for the Methods

Method	**Duration (mins)**	**Activity**	**Description**
Appreciative interview and Conversation café	2	Introduction	Brief introduction of the facilitator, the other inquiry team members, and participants
	8	Overview	Walkthrough of the purpose, agenda & ground rules for the afternoon
Appreciative interview	25	Discovery phase	Why is a nurse–patient therapeutic relationship important? How is the nurse–patient therapeutic relationship currently nurtured?
Conversation café	20	Dream phase	Elaborate on what truly standout for them from the appreciative interview What might be possible if we prioritized the nurse patient-therapeutic relationship?
	20	Destiny phase	The vital answer related to prioritizing therapeutic relationships will be shared and discussed to answer the question of what strategies could be applied to nurture the nurse–patient therapeutic relationship? Elaborate on ideas and strategic actions to promote nurse–patient therapeutic relationship in the PATH unit
	15	Debrief	All the participants will come together Discuss and prioritize three to five identified key ideas