1-1-2015

Advancing Recovery in Adult Mental health Inpatient Services in Ireland

Jennie Synnott

Royal College of Surgeons in Ireland

Citation
Creative Commons Licence:

This work is licensed under a Creative Commons Attribution-Noncommercial-Share Alike 4.0 License.

This thesis is available at e-publications@RCSI: http://epubs.rcsi.ie/mscttheses/73
MSc in Leadership

Student ID: 12139084
Date: 9th of May 2015
Word Count: 15,163
Advancing Recovery in Adult Mental Health Inpatient Services in Ireland

Jennie Synnott (JS) BSc, BSc (Hons), HDip (Hons), RPN.

A dissertation submitted in part fulfilment of the degree of MSc in Leadership, institute of leadership, Royal College of Surgeons, Ireland.

(2015)

Supervisor: Mr Liam Duffy
Declaration Form

Declaration:

“I hereby certify that this material, which I now submit for assessment for the Final Dissertation of the MSc in Leadership is entirely my own work and has not been submitted as an exercise for assessment at this or any other University.”

Student’s Signature(s):

Date: 9th of May 2015

Student’s Number (s): 12139084
# Table of Contents

## Contents

1. **Introduction** ................................................................................................................................. 9  
   1.1 Background .................................................................................................................................... 10  
      1.1.1 Title of Organisational Development .................................................................................... 11  
      1.1.2 Aim of the organisational development project. .................................................................... 11  
      1.1.3 Objectives: .............................................................................................................................. 12  
   1.2 Organisational context .................................................................................................................... 13  
   1.3 Outcomes and significance ............................................................................................................. 15  
   1.4 Summary ........................................................................................................................................ 15  

2. **Chapter 2: Literature Review.** ...................................................................................................... 16  
   Introduction .......................................................................................................................................... 16  
   2.1 Search strategy ............................................................................................................................... 16  
   2.2 Recovery in mental health settings ................................................................................................. 18  
   2.3 Training in recovery ....................................................................................................................... 21  
   2.4 Maintaining recovery on discharge ............................................................................................... 25  
   2.5 Summary ........................................................................................................................................ 29  
   2.6 Conclusion ...................................................................................................................................... 29  

3. **Chapter 3: Methodology** ................................................................................................................ 31  
   3.1 Change ............................................................................................................................................ 31  
   3.2 Models of change and organisational development. .................................................................... 31  
   3.3 Initiation........................................................................................................................................... 33  
      3.3.1 Political Drivers .......................................................................................................................... 33  
      3.3.2 Economic drivers ....................................................................................................................... 34  
      3.3.3 Social Drivers ............................................................................................................................ 35  
      3.3.4 Technological drivers ................................................................................................................. 35  
      3.3.5 Leverage points and opportunities for change .......................................................................... 36  
      3.3.6 Internal strengths ....................................................................................................................... 36  
      3.3.7 Internal weaknesses ................................................................................................................... 37  
      3.3.8 External opportunities and threats ............................................................................................. 37
3.3.9 Securing mandate ..............................................................38
3.3.10 Key Influencers and stakeholders ...........................................39
3.4 Planning .................................................................................42
  3.4.1 Building Commitment ........................................................42
  3.4.2 Determining the detail of the change ......................................45
  3.4.3 Developing an implementation plan .......................................45
  3.4.4 Implementation plan ..........................................................46
3.5 Implementation ......................................................................47
3.6 Mainstreaming .......................................................................50
  3.6.1 Summary ............................................................................51
4 Chapter 4: Evaluation .................................................................52
  4.1 Focus groups evaluation ........................................................52
  4.2 Discharge planning metrics .....................................................55
  4.3 The PoRSAT evaluation ........................................................56
  4.4 Summary ..............................................................................58
5 Chapter 5: Discussion and Conclusion ........................................60
  5.1 Leading and managing a change ..............................................60
  5.2 Focus groups: linking evidence to practice ..............................61
  5.3 Education sessions: linking evidence to practice ......................62
  5.4 Recovery discharge package ................................................64
  5.5 PoRSAT (MHC, 2008) .............................................................65
  5.6 Future for the organisation ....................................................65
  5.7 Conclusion ...........................................................................67
6 References ...............................................................................68
7 Appendix ....................................................................................75
  7.1 Appendix 1: PEST ................................................................75
  7.2 Appendix 2: SWOT ...............................................................76
  7.3 Appendix 3: PoRSAT 1 ..........................................................77
  7.4 Appendix 4: PoRSAT 2 ..........................................................89
List of tables:

Table 1: Search strategy ............................................................................................................. 18
Table 2: Stake holder analysis .................................................................................................... 39
Table 3: Implementation plan .................................................................................................... 46
Acknowledgements

No change in the status quo is completed in isolation by a single actor therefore I would like to first acknowledge all my work colleagues who have supported me on my professional journey. They have shown great compassion and dedication towards this project and I will be ever grateful as it is they that made this experience a success.

I would like to thank the faculty for all their input over the last two years, you have changed and how I am as a manger and as a person. I hope that many more will be given the opportunity to experience this MSc. To my fellow students I am honoured to call you my Peers, you have shared this experience, particularly in the last year of completing this thesis. And thank you also to Mr Liam Duffy whose dedication to our projects could not be matched.

Finally I would like to thank my husband and children who have tolerated this journey with unending patience and constant support.
Abstract

HSE Change Model (2008) was used to improve the delivery of recovery-orientated care in an adult mental health inpatient service. The areas of education on recovery and maintaining recovery on discharge were selected for improvement. A literature review was conducted and found that recovery had common themes and that with training these themes could be translated into practice. Regarding discharge the evidence suggests that when certain interventions are used they can have a dramatic effect on supporting a service-users recovery.

During initiation stage, a PEST and SWOT were used to explore the drivers for the change and then a stakeholder analysis was conducted. Mandate was sought from stakeholders who provided buy-in and credibility for the change.

During the planning stage focus groups were used to engage staff and put forward a case for change. A working group was recruited and a recovery discharge package was created. The package has been implemented but ongoing communication and engagement remains a priority. A staff member and a service user were recruited and trained to deliver the training to all staff.

During mainstreaming the re-admission rate of the people who have been involved in developing their package was measured to demonstrating a reduction in re-admission rates. The PoRSAT was re-measured to demonstrate a 35% increase in the recovery orientation of the service. The education packages are ready to go however funding for service-user input has been a barrier to implantation. The HSE Change model served as a template to introduce a successful change and an improvement in the recovery orientation of a mental health service.
1 Introduction

Modern mental health services are expected to be built on a recovery philosophy, a philosophy that encourages staff to develop attitudes, beliefs and approaches that assist those they care for to recover from mental health problems (Mental Health Commission (MHC), 2008; Cleary et al, 2013). Within the Irish context, following extensive consultation, A Vision for Change (AVFC) (Department of Health (DoH), 2006) has been adopted as the blueprint for mental health services in Ireland. AVFC (DoH, 2006) maintains that recovery should ‘inform every level of service provision’. In fact with the rise of the consumer movement recovery has become ‘de rigueur’ for a modern mental health organisation with most services seeking to deliver care that is grounded in this ethos. In addition, organisationally, the most recent mental health division operational plan published by the Health Service Executive (HSE) (2014) states that the very ‘essence of a high quality mental health service is one which is recovery focussed’ (pg 4).

This organisational development (OD) project seeks to develop and advance the recovery philosophy of an adult mental health inpatient service in Ireland. The following thesis will first explore the evidence base surrounding the development of recovery by conducting a stringent literature search. This will examine the most current peer reviewed literature and research to demonstrate the evidence that supports the actions of this organisational project. The thesis will then demonstrate a baseline of where the writers organisation situation prior to the implementation of the project and describe what interventions were used to progress the project. Furthermore, in the methodology section organisational development models will be explored with one selected which will
outline the processes used to manage the change put forward. Finally a discussion will be presented that will draw together conclusions from the project, including a review of the change and an analysis of the impact of the project on the recovery orientation of adult inpatient mental health services.

1.1 Background

In a review of strategies to improve inpatient mental health care Baker et al (2014) suggest that despite many initiatives little improvement has been made in the delivery of services. Mental Health Reform (2013) agree, the congregate of stakeholders informing the delivery of mental health services in Ireland, assert that recovery values should be translated across organisations, however a poor understanding of recovery by professionals has lead to a slow progression of organisational change.

Recovery in mental health emerged from the writing and perceptions of people who had experienced and recovered from mental health problems (Anthony, 2000) and has led to a increasing movement towards the insistence that care be recovery focussed. The MHC (2008:7) state that recovery is difficult to define as it ‘is a multidefinitional concept’ and as it is ‘unique and individualised’ to each person. However common themes of recovery throughout the literature are hope, personal empowerment, individualised person centred care, how the persons engages with the organisation and others, and dignity and humanity being central to the services delivered for those experiencing mental ill-health (Baker et al., 2014; Cleary et al., 2013; Health, 2013; McKenna et al., 2014; MHC, 2008; Mental Health Reform, 2013; Slade et al, 2014; Williams et al., 2012).
Despite the clarity of the principals mentioned above, inpatient services have been criticised for not having these at the forefront of care delivery (Leese, 2014). It is therefore vital that the people who access adult inpatient mental health services meet staff who clearly understand and deliver recovery focussed care. Despite this ideal it remains challenging to be able to actively demonstrate Mental Health Recovery principals organisationally (Cleary et al, 2013).

The Pillars of Recovery Audit Tool (PoRSAT) (MHC, 2008) was created to enable services to measure how recovery focussed they are. The tool proposes six pillars, or areas, of service development to identify ‘priority areas for organisational change’ and in the reapplication of the tool an ability to assess the impact of those changes (MHC, 2008: 25). The PoRSAT was used in this project to establish a baseline and then identify if the organisational change had indeed improved the organisations ability to deliver recovery orientated care. The aims and objectives set out below exhibit how recovery in adult mental health inpatient services can be improved and credibly shown.

1.1.1 **Title of Organisational Development**
Advancing Recovery within acute adult inpatient mental health services in Ireland.

1.1.2 **Aim of the organisational development project.**
To increase and enhance organisational compliance with the PoRSAT audit (MHC, 2008) within the next seven months.
1.1.3 **Objectives:**

1. By 3\textsuperscript{rd} of November 2014 the writer will use the PoRSAT to establish the current levels of recovery orientated care delivered in the inpatient service (MHC, 2008).

2. By the 10\textsuperscript{th} of November 2014 the writer will identify key stakeholders and prioritise them in relation to power and influence.

3. By the 31\textsuperscript{st} of November 2014 the writer will conduct 5 focus groups with inpatient staff on discharge and recovery focussed care. This will ascertain collective thematic views on recovery and discharge and will be used as a training needs analysis on recovery and to develop a new recovery discharge package.

4. By the 1\textsuperscript{st} of December 2014 the writer will have recruited a working group to develop a discharge package that will be approved for use by the Multidisciplinary Team (MDT).

5. By the 31\textsuperscript{st} of January 2015, the writer will present the results of the focus groups to the local management team.

6. By the 6\textsuperscript{th} of February a staff member and a service-user will be identified to attend a train the trainer workshop in Dublin. To enable 3 hourly training packages on recovery to be provided for the adult inpatient staff.

7. By the 31\textsuperscript{st} of March 2015 the discharge package will be finalised and begin to be used by in-patient staff for 80\% of all service-users being discharged.

8. By the 30\textsuperscript{th} of April 2015 funding will be secured to pay the service-user to co-present the training to 30\% of inpatient staff.

9. By the 30\textsuperscript{th} of April 2015 the PoRSAT (MHC, 2008) will be reapplied to evaluate the impact of the interventions stated in the OD project.
1.2 **Organisational context**

The writer’s area of work is an acute mental health inpatient service within the grounds of a rural hospital in Ireland. This hospital provides healthcare to a population of people spread out over a large geographical area (Higgins, 2009). The inpatient unit is registered as an approved centre by the MHC. The local population is approximately 55,000 which is split into 3 sectors and is required by the MHC to deliver best practice of recovery orientated care and the area plans to advance a recovery ethos of care (MHC, 2011).

Organisationally, the writer’s area has been chosen as a key pilot site for Advancing Recovery in mental health services in Ireland (ARI). ARI is an initiative that aims to deliver key service concepts from AVFC (DoH, 2006) and to ‘maximise personal recovery opportunities and outcomes for service-users’ (ARI, 2013: 3) therefore an opportunity arose for the writer to become involved with this project and to assist in its implementation in the adult inpatient service.

The writer’s current role is as a Clinical Nurse Manager 2 (CNM2) managing an 18 bedded registered MHC approved centre that provides a 24 hours 7 day week inpatient service. In addition the unit provides telephone support to anyone in the community regarding mental health issues over a 24/7 basis. The unit cares for people with various mental health difficulties ranging from acute anxiety difficulties to serious enduring
mental health issues and psychosis. As a nurse manager the writer is expected to have responsibility for maintaining, developing and leading the improvement of the quality of the inpatient services. A senior member of staff had been identified as the area lead for the implementation of ARI and this lead asked if the writer would like to join the ARI group to consider improving the recovery ethos in the inpatient service.

The nominated lead embraces a shared ownership of ARI and encourages staff to share the responsibility of developing all aspects of the service. The leadership construct that fits best within this development is distributed leadership. Distributed leadership is described by (Avolio et al, 2009) as a team based style of leadership where the leadership role is not limited to the formal leader, alternatively it is dispersed amongst the team members. Indeed this style is often described as team based leadership (Avolio et al., 2009; Bolden et al., 2003).

Consequently, through the writer becoming involved with the ARI project, it was noted that whilst there had been marked improvements in the recovery focus of the outpatient services there had been limited development of the inpatient services. This presented an opportunity to consider advancing a recovery ethos in the acute adult inpatient area. Furthermore, as the Mental Health Services Operational Plan for 2014, mentioned above, states that ARI will be developed in all mental health areas in the fourth quarter of 2014 (HSE, 2014a) this demonstrated that ARI indeed was being translated across the organisational division.
1.3 Outcomes and significance

The above project intends to enhance and develop the recovery orientation of adult mental health inpatient services. There is significant and increasing momentum to meet the needs of people who use mental health service to engender hope and compassion in all aspects of service delivery (Mental Health Reform, 2013). Ultimately it is the objective of the writer to place recovery at the heart of service delivery to meet the needs of the people who use the services.

1.4 Summary

To summarise the above, recovery should be the accepted norm and hope for anyone who experiences mental health problems. In fact most modern mental health services are aspiring to deliver on that norm (Lakeman, 2010). The aims and objectives of this project identify a clear path to lead and advance recovery based care for adult inpatient services. The objectives listed ensure that the service will assist in the recovery of people who use the service. This next chapter will explore the current research and literature concerning recovery in adult mental health services.
Chapter 2: Literature Review.

Introduction

This organisational development project seeks to improve the recovery orientation of a mental health service in Ireland by focussing on two selected areas. The areas selected for development are maintaining recovery on discharge and improving the understanding of recovery by staff by initiating a training project. The review below will describe a search strategy used to select articles relevant to these subjects, then consider this literature in guiding the interventions adopted by this project.

The topic of recovery provides much opportunity for discourse and examination within research literature (Cleary et al, 2013; Cleary, A. and Dowling, 2009; Kartalova-O'Doherty and Doherty, 2010; McKenna et al., 2014). Parahoo (2006) asserts that nurses and professional staff should be able to evaluate and consider the literature available on a topic to enable translation of evidence into practice. This literature review will enable the best available evidence to be used to guide interventions for this organisational development (OD) project. The search strategy used the variables recovery, training/education and inpatient/acute to disseminate the literature available.

2.1 Search strategy

To ensure that the most contemporary evidence was reviewed the search was limited to the last 5 years, between 2009 and 2014. However two articles were extended outside the parameters as they were highly relevant to the variables. Research into recovery in
mental health care has escalated within recent years, therefore a plethora of relevant articles were available (McKenna et al., 2014). See below for a table 1 listing search engines used (figure 1). In the first search, using Medline, the terms recovery, mental health/illness or psychiatry/psychiatric in all fields yielded eight hundred and eighty eight thousand articles consequently exclusion and inclusion criteria was set for all subsequent searches.

Inclusion criteria were articles were published between 2009 and 2015; published in English and published in academic peer reviewed journals. Furthermore, the terms adult and staff were applied with acute or inpatient added. Finally to ensure that the relevant setting was selected the terms mental health/illness or psychiatric/psychiatry were applied. Research conducted in drug and alcohol settings was excluded, as were those in older persons and child and adolescent mental health settings. Once these limiters were used the same search within Medline yielded two thousand nine hundred and thirteen articles. This led to the search being limited to Europe, Australasia and the United States of America and to items that were solely research based. This yielded thirty-two articles on Medline. There was no differentiation between Cinahl and Medline search engines. The two areas of interest in this literature review were then included, see chart below for full results of search strategy (see table below).

From this search eleven research articles were finally chosen due to their appropriateness for this OD project. A manual search of the references from these papers yielded eight more articles, therefore a final total of twenty-one articles were
included in this literature review. It was during this manual search that the two articles that were outside the time frame were included as they were so frequently referenced.

Table 1

<table>
<thead>
<tr>
<th>Search Engine</th>
<th>Term: recovery</th>
<th>Term: discharge</th>
<th>Term: training or education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cinahl/ Medline</td>
<td>32</td>
<td>35</td>
<td>206</td>
</tr>
<tr>
<td>Embase</td>
<td>13</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Emerald</td>
<td>161</td>
<td>33</td>
<td>7</td>
</tr>
</tbody>
</table>

Of the literature reviewed, there was a variety of research methods used to study the topics described above. Two literature reviews were also selected to provide a comparison to the findings of this review and one randomised control trail (RCT) was selected due to the rigor of this particular approach to research. So of the remaining literature four papers used mixed methods, two papers used a quantitative approach and by far the most common method used was a qualitative approach (eight papers).

2.2 Recovery in mental health settings

Qualitative measures are often used to grasp the unique experience of individuals and the language a person uses to describe and understand their view of the world (Parahoo, 2006a). Certainly, as noted in the introduction, that whilst there are different definitions of recovery similar themes are noted in the language used to describe the subject in mental health (Cleary et al, 2013). Kartlova-O’Doherty and Tedstone-Doherty
(2010) concur and in their qualitative analysis conducted in Ireland found that the themes described by staff and service users were similar to research conducted in America, Australasia and Europe. Therefore international research on how staff articulate recovery is transferable to Irish settings.

The language of recovery tends to be positive and uses common terms such as hope, empowerment, responsibility and partnership (Beckett et al., 2013; Gilburt et al, 2013; Salgao et al, 2010; Williams et al., 2012). The provision of these themes is the organisational objective of modern mental health services (Kartalova-O’Doherty and Tedstone-Doherty, 2010). In Ireland Mental Health Reform (MHR) (2013) suggests five building blocks to providing recovery orientated services. First and foremost, services and staff must express hope that a person can recover, they must respect the service-users unique experience and they must act as a partner in sharing responsibility for recovery. The last two blocks put forward are that the service should provide choice in treatment and finally the services engage with the local communities to ensure that people with mental health issues connect with available community services.

Hope is essential to recovery, consequently, it was a salient theme in many of the studies reviewed (Aston and Coffey, 2012; Cleary and Dowling, 2009; Jonikas et al., 2013; Kartalova-O’Doherty and Doherty, 2010; McKenna et al, 2014; Salgado et al, 2010). Both Salgado et al (2010) and McKenna et al (2014) asserted that without conveying hope to service-users recovery orientated care is unlikely to be engendered by staff or organisations. Cleary and Dowling (2009) concur and assert that the absence of hope being conveyed to service-users leads to slow down in recovery occurring. In
fact, the more hope that exists within a service the more likely a service-user is to recover (Salgado et al, 2010). The study by Salgado et al (2013) demonstrated that staff could be taught to be hopeful for recovery and that staff who felt hopeful increased hope for service-users.

McKenna et al (2014) are of the same opinion as the suggestions put forward by MHR (2013) in that services should be hopeful and expect recovery as the norm. McKenna et al (2014) examined recovery-orientated care in Australia and found that the adoption of hope and the fundamental principals set out by MHR led to the transformation of services into delivering recovery orientated care. Moreover, although the research in Ireland by Cleary and Dowling (2009) predates the building blocks recommended by MHR (2013) the staff expressed similar requirements of a service agreeing that services should be hopeful, holistic, collaborative and empowering (Cleary and Dowling, 2009). In both studies though staff agreed with the essential aspects of recovery oriented care they had also reported finding the entire concept ambiguous.

The theme of ambiguity is omnipresent within the research on recovery (Aston, and Coffey, 2012; Cleary et al., 2013; Cleary and Dowling, 2009; Le Boutellier et al, 2014; Turton et al, 2011). Gilburt et al (2013) set out to explore how recovery is actually shown in mental health services and found that whilst staff feel recovery is something they ‘do’, confusion around what recovery skills they use impacted on the actual delivery of recovery orientated care. Without understanding recovery Gilburt et al (2013) purport that staff have difficulty in actually demonstrating the required skills to bring about recovery. Furthermore, if it is difficult to observe tangible recovery orientated skills,
Gilburt et al (2013) proceed to state it is difficult to witness and measure recovery in action.

To summarise, the language of recovery has common themes but staff have both difficulty understanding and demonstrating how they go about delivering recovery orientated care. The importance of hope and that all staff are aware of what recovery actually is, is highly important in this OD project. The project seeks to enlarge the services understanding of recovery is and how to put recovery orientated skills into action. Many of the studies suggest that training on recovery should be provided by organisations for all staff as a way of mitigating the confusion described above (Gilburt et al., 2013; Leamy et al., 2014). The next section will consider the evidence to support staff receiving training in recovery.

### 2.3 Training in recovery

Six of the papers included in this review considered training or educational interventions on recovery with staff, two in particular studied the effectiveness of training to improve the recovery orientation of staff. Gilburt et al (2013) and Salgado et al (2010) found educational interventions that improved the way staff worked lead to greater levels of recovery orientated care. Both Cleary and Dowling (2009) and Salgado et al (2010) identify that the knowledge staff have of recovery principles is a key factor in being able to provide recovery orientated care, with staff frequently requesting training in recovery.

Staff in other included studies also believed that training was vital due to the individualistic understanding of recovery (Aston and Coffey, 2012; Cleary et al., 2013;
Cleary and Dowling, 2009). These studies found that training in recovery orientated practice increased the staff’s knowledge about how to deliver this type of care, indeed other papers considered this and agree that improvements in practice can be made (Cleary et al., 2013; Gale and Marshall-Lucette, 2012; McKenna et al., 2014).

Staff attitudes to recovery-orientated care were mentioned as a factor in some of the papers reviewed (Cleary et al., 2013; Gale and Marshall-Lucette, 2012; McKenna et al., 2014). Attitudes can be defined as ‘a settled way of thinking or feeling about something’ (Oxford English Dictionary Online, 2012). Staff that were included in the studies believed that promoting recovery was a desirable way of working in mental health (Cleary et al., 2013). In fact, staff attitudes to recovery orientated care were specifically considered by Cleary and Dowling (2009). Their research in Ireland examined the attitudes of staff to recovery and found with training that attitudes do indeed change and improve. The staff that returned their questionnaires viewed this ‘philosophy of care overwhelmingly as positive’ (pg 543) and requested further training on the recovery model (Cleary and Dowling, 2009).

Furthermore, Gale and Marshall-Lucette (2012) considered the training needs mental health nurses and revealed that although they reported high levels of confidence in their ability to provide recovery-orientated care that they would also welcome further training. The study proceeded to say that nurses were indeed keen to improve their knowledge of recovery to be able to further embed recovery in their practice (Gale and Marshall-Lucette, 2012). Two studies stated that it would be relatively easy to translate recovery
principals into training due to the common themes associated with the concept (Cleary et al., 2013; Gilburt et al., 2013).

Recovery training needs analysis drawn from the writers review suggests common criteria for training staff. Staff should be trained to understand and how to cultivate hope in a person, they should promote choice for the service-user and through collaborative practice support the person to take control of their own healthcare (Gale and Marshall-Lucette, 2012; Gilburt et al., 2013; Salgado et al, 2010).

One of the major issues described by the writers review is that despite staff requesting training most staff don’t actually receive any formal training (Cleary et al, 2013) The research by Cleary et al (2013) found that only 19% of their sample had any formal training on recovery. What is more, training programmes, may state that they provide recovery training but in fact may only deliver didactic training and then fall short of providing the practical skills staff need to assist in a service-users recovery (Gilburt et al, 2013; Leamy et al., 2014). Gale and Marshall-Lucette (2012) analysed the contents of twenty eight mental health professional development courses and found that whilst these courses frequently cited recovery as a taught concept there was some difficulty in understanding what exactly was to be taught. The key concepts of recovery orientated care were stated as provided by the descriptors, however under scrutiny crucial items such as hope, as mentioned above, were only mentioned ‘in two modules’ (pg 351). Indeed the concepts of personal responsibility or self-advocacy were completely absent from the course descriptors examined. This led to the authors suggesting that whilst recovery training is needed for and requested by staff that the more practical aspects of
the training seem to be absent (Gale and Marshall-Lucette, 2012). Certainly Gale and Marshall-Lucette (2012) suggest that to get the most from education the practical skills of recovery should be taught, not only by professionals but often most invaluably from those people who were already on the path to recovery.

The theme of co-produced service development and staff training is ubiquitous in the earlier and more current literature regarding recovery. The Irish strategic document A Vision for Change (DoH, 2006) stated at the time of development there was no official requirement for the involvement of service-users and carers in the development of training packages (pg 192) however the most recent service plan for mental health (HSE, 2014) states that service-users should be involved at all levels in education initiatives (pg 15). Indeed the studies by both Gilburt et al (2013) and Aston and Coffey (2012) state that any recovery training delivered in services should be co-produced by both staff and service-users. In fact the research conducted by Gilburt et al (2013) advances that co-produced training programmes fundamentally impacts on the attitudes of staff to recovery.

To conclude this section of the review, recovery remains a vague and difficult concept to grasp however staff do want training. Training has been found to impact on the ability of staff to deliver recovery orientated services however training perhaps needs to focus on the more practical skills required to work in this way. Finally the involvement of service-users significantly assists staff in developing these skills and is crucial to success of raining packages. Therefore this organisational development project will be cognisant of being able to provide practical recovery orientated skills for staff that includes service
user input. Service-user involvement is also seen as crucial in the next section of this review.

2.4 **Maintaining recovery on discharge**

The final variable of discharge appears to have the widest gap in this literature review. One systematic review of transitional interventions to reduce early readmission was retrieved by this search Vigod *et al* (2013). Vigod *et al* (2013) state that the first ninety days after discharge from hospital are the most significant for a service-user to maintain recovery, actually Vigod *et al* (2013) suggests that readmission rates are now being used as Key Performance Indicators for mental health services with ‘international governments now setting benchmarks for reducing readmission’ (pg 187). In Ireland, the most recent statistics from the Health Research Board (HRB)(2013) state that admissions to psychiatric services are increasing, consequently as readmissions make up sixty-six to seventy percent of all admissions then they too are increasing (HRB, 2013). Therefore the interventions described by this organisational development project are decidedly timely and relevant in this particular component.

Nine papers included in this review considered the discharge and transition of service-users from inpatient services to community or home settings. Some of the studies considered all three variables in their studies, notably Cleary *et al* (2013), Gilburt *et al* (2013) Lawn *et al* (2008) and McKenna *et al* (2014). Common themes emerged.
One of the most frequent themes was support following discharge with McKenna et al (2014) and Turton et al (2011) both citing this is a crucial to maintaining recovery at home. Good coordination of transition from hospital to the community was seen by the literature as significant in maintaining recovery (Alghzawi, 2012; Lawn et al, 2008). During this movement through the services the staff need to view their input as sharing responsibility with the service-user. Inpatient services may play no part or only a small part of care delivery (National Health Service: Quality Improvement Scotland, 2007) but this review was undertaken to consider maintaining recovery goals met during movement from inpatient to being discharged to outpatient services.

Good support prior to and following discharge was considered vital by service users to maintaining recovery (Alghzawi, 2012; Cleary et al, 2003; Lawn et al, 2008). Lawn et al (2008) offered peer support packages to forty-nine service-users on transition from inpatient services to community settings in Australia and found that three hundred bed days were saved following their interventions to reduce readmission. This intervention provided weekly education and support groups for staff and service-users in both inpatient and outpatient settings. The intervention was reported as having produced a net saving of ninety-three thousand Australian dollars (Lawn et al, pg 503). The studies by Cleary et al (2013), Cleary et al (2003), Turton et al (2011) and Vigod et al (2013) all support the findings on the importance and significance of support. However support is only one intervention put forward as a way to assist service-users in recovery on discharge from inpatient services. In fact relapse prevention and reducing re-admission are factors that are seen as vital to recovery (A. Higgins et al., 2010), however both
Turton *et al* (2009) and Williams *et al* (2012) caution that re-admission can only be considered a marker of clinical recovery.

The systematic review included by Vigod *et al* (2013) considered what interventions were significant pre-discharge, bridging the gap between inpatient and outpatient care and post discharge to reduce hospital readmissions and suggests a number of interventions reduced the chance of readmission.

In agreement, both Cleary *et al* (2003) and Gerson and Rose (2012) concur with Vigod *et al* (2013) in that that information on medications should be given to the service-user pre-discharge with Cleary *et al* (2003) adding that this should be provided in a written format. Both Alghzawi (2012) and Cleary *et al* (2003) purported that information on a person’s diagnosis should be included in education sessions prior to discharge with ways of coping with symptoms also included in pre-discharge care delivery. Stress management and the development of activity plans with the person should also be included in discharge planning (Alghzawi, 2012; Cleary *et al*, 2003; Gerson and Rose, 2012; Turton *et al*, 2011). And finally and perhaps most significantly, education around relapse prevention and crisis management were agreed to be vital by many of the studies (Cleary *et al*, 2003; Gerson and Rose, 2012; Lawn *et al*, 2008; Turton *et al*, 2011; Vigod *et al*, 2013). In fact Vigod *et al* (2013) found that this intervention was highly significant in preventing relapse.

As noted above reduced readmission rates can only be considered an objective measure of a service-users recovery journey (Williams *et al*., 2012). Only one paper
included linked relapse to recovery, Turton et al (2011) suggested that relapse and readmission should be seen as markers that signify success, or not, of a service-user to continue to recover. However, due to the paucity of literature connecting these variables, there is at best a tenuous proven link that discharge planning improves recovery. This seems a significant gap, as noted above.

Critically, when considering successful discharge despite Vigod et al (2013) suggesting that readmissions can be reduced organisations continue to focus on inpatient or outpatient services without consideration for the transition between the two. Indeed this review was the first to statistically indicate that interventions can reduce the rate of readmission (Vigod et al, 2013). However the literature considered here demonstrates a continued lack of importance being placed on bridging this transition.

The research revealed by this review suggests that discharge planning is more often than not poorly implemented, poorly planned and frequently doesn’t include the service-user as an integral part of that process (Alghzawi, 2012; Cleary et al, 2013; Gerson and Rose, 2012; Lawn et al, 2008). In addition discharge planning is often not integrated into the inpatient treatment process (Gerson and Rose, 2012) and where it has been identified as being included there is a strong bias towards medication education (Gerson et al, 2013; Cleary et al, 2003; McKenna et al, 2014) with only generic information being provided (Cleary et al, 2003). Gerson and Rose (2012) also found that often there is little information on symptoms and symptom management something described as significant by Vigod et al (2013). Also Gerson et al (2013), Lawn et al (2008) and Milbourne et al
(2014) state that there is often little meaningful activities for service-users after discharge, with service-users being expected to fit in with what is provided rather than what they want. This is more marked in service-users with severe enduring mental health issues (Gerson and Rose, 2013). Finally, Cleary et al (2003), Cleary et al (2013) and Turton et al (2011) state that despite the importance of support there is often poor follow up of service-users once discharged.

2.5 Summary

To summarise this section, the systematic review by Vigod et al (2013) put forward clear interventions that aid transitions from inpatient services. The other authors referenced agreed with these and recommended common interventions that their research found assisted service-users on discharge from inpatient services, these which were listed above. Conversely the evidence this review identified suggest that the topic of maintaining recovery on discharge has not been fully explored. However there is limited evidence to support that reduced admissions in fact aid a person’s recovery. This organisational project seeks to demonstrate that the introduction of a recovery package that includes the interventions described above does indeed advance recovery orientated care in considering discharge from inpatient services.

2.6 Conclusion

In the review above three areas were considered, firstly recovery alone in mental health services, secondly the role of education in recovery and lastly the role of interventions on discharge to promote recovery. Drawing on the literature in the first section recovery has common themes but requires the organisation, the staff and the service-user to
hope for recovery as realty. This requires everyone to be singing off the same hymn sheet and certainly the evidence would suggest that training for both staff and service-users would improve agreement on what recovery is. Additionally training, if skills based, would equip service providers to actually work in a recovery orientated way. Furthermore evidence exists to support that certain interventions delivered pre and post discharge will assist the service-user on discharge from hospital.

This review set out to consider empirical evidence to advance recovery in mental health inpatient service in Ireland. It provides clear evidence that recovery orientated care can be delivered by inpatient services however interventions need to take place to deliver on this ideal. The above literature will be reflected and referenced throughout the remaining aspects of this organisational development project. The next chapter on methodology will remain cognisant of the data set out above and demonstrate a clear link between the evidence and the interventions set out in the next chapter.
3  Chapter 3: Methodology

3.1  Change

A Vision for a Recovery Model in Irish Mental Health Services sets out that services have to change to provide recovery orientated care (MHC, 2006: 11). Change can be simply defined as ‘a move from one state to another’(Anders and Cassidy, 2014: 132). Chapter 3 will consider models of change leading to a particular change model being selected and then use this model to illustrate the change process. The chapter will use strategic analysis tools to consider the driving and resisting forces affecting this change and finally conclude, using a business case, to summarise the project.

3.2  Models of change and organisational development.

There are many different change models and theories and an understanding of these is considered essential (Shanley, 2007). Change can be defined simply, as listed above, however this suggests that change is predictable. Two paradigms exist in the literature regarding change, ‘planned change’ and ‘emergent change’.

Planned change is ‘consciously conceived and implemented by knowledgeable actors or agents’ (HSE, 2006: 3) One of the most frequently cited planned change model is Kurt Lewin’s force field model (Hardiman, 2010; HSE, 2006; Sullivan and Garland, 2010). Lewin (1951) saw change as a process in which an imbalance unfreezes the status quo, a change occurs, which then refreeze as a new state. Factors that cause this imbalance are seen as driving and restraining forces. Other models of planned change are Lippitt’s
Model, Cummings Model and Huse’s model, all using steps to plan change (HSE, 2006). These models have been critiqued as subsequent authors argued that change is a developing process and not linear (Hewison, 2012; Shanley, 2007; Kerridge, 2012). This has led to the emergent theory of change.

Emergent theory maintains that change is unpredictable and it is the norm to have unexpected events that cannot be planned for (Kerridge, 2012b; Van der Voet et al, 2013). This model sees change as something that is driven from the bottom up as it begins on the frontline (HSE, 2006). Shanley (2007) contends that both emergent and planned change have their place in change management strategies, especially within a complex organisation. The author as a change lead may be able to plan a process but through effective consideration may be able to consider where emerging issues could occur (Shanley, 2007; Hewison, 2012).

Organisational development (OD) was borne out of the expectation that change can both be planned and emergent (Oswick, 2013). Traditionally OD was described as a top-down prescribed effort to improve an organisation (HSE, 2006). However, Oswick (2013) argues that a contemporary view is that OD can be top-down or bottom-up. Whether change is planned, emergent or a combination the writer is bound to select a model to guide this OD therefore rationale for the model chosen is set out below.

Models, including those listed above, assist the agent to prepare for a change process. Lundy and Morin (2013) suggest three criteria when choosing a change model firstly that it is easy to understand, secondly that it allows the collection of data and finally that the
model should fit the organisation in which it is to be used. The writer, who works in the HSE, was familiar with the HSE’s own model as it had been used in a previous assignment. Hewitt-Taylor (2013) asserts that familiarity with a framework assists the change agent to develop an empirical strategy to change management. And whilst change is complex and unpredictable the writer, being pragmatic, also found the model to have high utility in developing a strategy for change. Taking all this into consideration the HSE change model was used to guide this OD process. The first step of the model is initiation where the writer plans the OD change.

3.3 **Initiation**

Healthcare systems have both internal and external forces persuading the organisation to change (Kerridge, 2012b; Mitchell, 2013). Consequently, careful analysis of these forces permits the writer to manage a change process (National Health Service Improvement (NHSI), 2012; Anders and Cassidy, 2014). A PEST is an acronym for political, environmental, social and technological environmental forces that are exerted on an organisation (HSE, 2006) (See appendix 1) The writer will first consider the political organisational environment.

3.3.1 **Political Drivers**

Shanley (2007) and the HSE (2008) both agree that there is a need to attend to local politics during change. The local area has been an ARI site for the last two years and has had significant developments in the community with regards recovery. A local consumer panel has been set up which links with the area management team.
Consumer panels are ‘where users of services, their family members and significant others meet up to discuss their experience of services and then meet with the local management team to raise their concerns’ (MHR, 2013: 18). This group is involved in community initiatives that reduce stigma and improve recovery orientation of the service but has been critical of the inpatient services. Consequently, there is a political drive to improve the recovery orientation of inpatient services, however, with the cost of healthcare rising the economic drivers should also be considered (HRB, 2013).

3.3.2 **Economic drivers**

Mental health issues have significant costs and accounts for 13% of the overall global burden of health care (World Health Organisation (WHO), 2012). Spending in Ireland has reduced from 13% in 1994 to its lowest of 5.2% in 2011/12 (Faedo, 2013). More recently there has been a slight increase with the most recent service plan allocating 6.5% of the health budget to mental health (HSE, 2015). However this remains significantly below the 13% stated by the WHO (2012).

The writer's local mental health area is poorly funded having had the lowest per capita allocation of the entire country in 2011 of €115.50 per person. This is 33% less than the average spend (€173.13 per person) (Faedo, 2013). This has led to services being creative and engaging with the local community to help develop and improve services. Service-users, their families and carers are often involved in the delivery of care which economically saves money. Community services have improved, however the writer is
considering the inpatient services which have seen significant cuts, staffing is currently 75% of what is recommended by AVFC (DoH, 2006). To summarise, fiscal support for the change will be difficult to gain and the change will have to be as cost neutral as possible. Both the social drivers and the technological drivers will be considered next.

### 3.3.3 Social Drivers

AVFC (DoH, 2006) aims to remove stigma for citizens with mental health issues. McGabhan et al (2010) state that stigma is difficult to define but the substantive fact is that stigma affects a person’s social status. Stigma is considered by the WHO one of the largest barriers to overcome for people to recover from mental health issues (WHO, 2001). In Ireland stigma is a significant issue, ‘70% of people state that they conceal their mental health problems from others’ (Mac Gabhan et al., 2010: 4).

Easy access to information through technology has had a significant part to play in service-users recovery (Musiat and Tarrier, 2014). The internet has enabled service-users to connect with others in recovery and provides both support and information (Musiat and Tarrier, 2014). Locally the consumer panel has recruited service-users which not only empowers service-users to use their collective voice to improve services but has also led to a social outlet for the group. The group is currently considering how to use social media to promote their group.

### 3.3.4 Technological drivers

Technology such as ehealth has become increasingly relevant for healthcare organisations (DoH, 2012; HSE, 2013). The WHO defines ehealth as ‘the use of
information and communication technologies (ICT) for health’ (WHO, 2005: 1). In their systematic review of the use of ehealth interventions in mental health Musiat and Tarrier (2014) found that the use of ehealth interventions was promising. Certainly people have access to information on diagnosis, treatment and recovery and are using this information to guide treatment preferences (The European Comission, 2012). In the writers area more and more inpatients have access to the internet and inform themselves of treatment options. Understanding and being involved in treatment options has been found to improve a service-users health outcome. Jonikas et al (2013) in their RCT found that service-users, who were well informed, made decisions with healthcare providers were more likely to engage with treatment.

To conclude the intention of the PEST was to examine influences that are exerted on an organisation to change (HSE, 2006). Identified were significant factors to support this project. The HSE change model (HSE, 2008) recommends that a PEST provides only one perspective and often a SWOT is completed to provide additional information (HSE, 2006).

3.3.5 Leverage points and opportunities for change

A SWOT is a strategic tool described as ‘an acronym for strengths, weaknesses, opportunities and threats’ to organisational change internally and externally (HSE, 2006: 52) (see appendix 2).

3.3.6 Internal strengths

The change agent is a member of the team and has good relationships with team members. Staff in the inpatient service are caring and considerate to the needs of
inpatients and believe that they were working in a user-centred way. On the ward, the local Assistant Director of Nursing (ADON) and the ARI lead were keen to develop the recovery orientation of the inpatient services. Internally the Quality Improvement and Audit (QIA) group, which consisted of all of the multidisciplinary team (MDT) also wanted to improve the recovery orientation of the inpatient service.

3.3.7 **Internal weaknesses**

Staff in the inpatient service were poorly engaged, a previous questionnaire sent to canvas their views on recovery had an extremely poor response rate (10%). The ward is generally very busy and staff experience high levels of stress, research suggests that this working environment can lead to high levels of disengagement in employees (West, and Dawson, 2012). The writer as the lead, is a CMN2 in the inpatient ward West and Dawson (2012) suggest that this disengagement can be influenced by listening to employees directly, the time to do this in a busy ward would be a barrier to the OD strategy. In addition, the education sessions would require time for the staff to be released from the ward for 3 hours and given the low staffing levels and nature of the working environment this would be difficult. And finally the discharge groups would be run by OT and nursing staff with no involvement from medical staff.

3.3.8 **External opportunities and threats**

Many of the factors were outlined in the PEST analysis were similar in the SWOT analysis. External opportunities were that the area was an ARI pilot site and had made significant connections with the local community. The local consumer panel was expressing a desire to see the inpatient services improved. With regards threats, the OD
project was in one service area and there was no guarantee that this would translate to other sites. The training planned was to be co-presented by a staff member and a service-user and funding to pay the service-user had not yet been approved.

To reflect, there were considerable forces both for and against the OD project, however, the driving forces outweighed the resistance for the change. To introduce a change project authorization also had to be secured.

### 3.3.9 Securing mandate

The HSE change model (HSE, 2008) suggests that authorization should be secured as early on in the project as possible and this authority ‘gives credibility to the process’ (HSE, 2008: 21). The writer’s involvement in the nursing education committee was ultimately where involvement with ARI began. Areas that the writer could complete an OD project were discussed with this group and the ARI lead suggested that the recovery orientation of the inpatient services could be developed. This ultimately led to the ARI lead giving authority to the writer to develop this part of the service. The ARI lead agreed to be the writer’s supervisor and to sign off the organisational authorisation form.

Additionally, the QIA were also keen to improve the area of discharge planning and to improve the quality of this particular practice. The QIA group included three consultants, three non consultant hospital doctor’s (NCHD’s), an occupational therapist (OT), social work staff, the local co-ordinator and three ADON’s. This group provided significant and influential buy-in and credibility for the OD project.
Unexpected authority came from an ADON who worked on nights. She was member of the education committee and had bought into the need for change. This assisted the writers credibility at ward level and as she had significant influence with the staff due to her long history on the ward. Any OD project affects the people who are employed by the organisation therefore those people who will be affected by the project needed careful consideration (HSE 2006; Kerridge, 2012).

### 3.3.10 Key Influencers and stakeholders

A stakeholder analysis was conducted to assist the writer to identify the most interested and influential people affected by the OD project. This analysis placed stakeholders into categories of high/low interest and how high/low their influence was on the OD project.

#### Table 2

<table>
<thead>
<tr>
<th>High Interest</th>
<th>Low interest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Impact</strong></td>
<td></td>
</tr>
<tr>
<td>ARI Lead, Consultants, Audit group, Service-users, inpatients, Consumer panel, General manager, Business manager for AVFC, national ARI lead, families, Nurses, CNM's, Carers, Occ Therapist, ADON</td>
<td>NCHD’s, DoN, CMHN, GP’s, Admin Staff, psychologists, national Learning Network, Rehab Care, local TD, National ARI group, local area management team, steering group,</td>
</tr>
<tr>
<td><strong>Low impact</strong></td>
<td></td>
</tr>
<tr>
<td>Education group, Social workers, local mental health groups, Irish Advocacy Network, local advocate</td>
<td>IT Services, support staff,</td>
</tr>
</tbody>
</table>

12139084  Page 39 of 102  12/05/2015
The QIA had a number of the most influential stakeholders, as noted above. The writer, as secretary of this group, was familiar with the areas the group had identified for improvement. Having access to this influential group provided the writer with the perfect opportunity to communicate the change project.

Interestingly the high impact/low interest group could have been very influential on the project. The NCHD’s could have been highly influential on the project however due to their six-monthly rotation the opportunity to be involved was limited. Similarly the psychologists, due to their intense engagement with inpatients would have had great influence on the success of the project but due to the individual nature of their work this would lead to limited involvement. The initiation phase used a business case framework to outline the change. The HSE model suggests that this framework brings structure and focus to the OD process (HSE, 2008).

- **The Vision for the change:** The inpatient service will provide recovery orientated care through staff education and recovery discharge planning.
- **Need, rationale and mandate for the change:** Internationally, nationally and locally there is a drive to improve inpatient services, as noted in the PEST. The local consumer panel have also identified that the inpatient service requires an improvement. The writer has mandate from many sectors of the service to introduce this change.
- **Risks factors:** the SWOT identified several risks to implementation however the opportunities and strengths supporting the change outweighed these risks.
➢ **Key stakeholders:** a stakeholder analysis identified the most influential and most interested stakeholders impacted by the change. Communication of the proposed change has been initiated with this group.

➢ **Purpose, objectives and outcome:** the purpose of the project is to ultimately improve the recovery orientation of the inpatient service. Through education, staff will have an increased awareness of what recovery is and how to provide recovery orientated care. Discharge planning will begin at admission, have a recovery focus and concentrate on improving the service-users ability to self-manage their mental health. The intended outcome is that through self-management readmissions will reduce and therefore costs to the service will be reduced.

➢ **Timeframe and costs:** the OD project will be completed over 7 months, from September to May. In the education section payment will be required for the service-user to provide training. The planned sessions will be three hours long so there will be costs associated with staffing cover. With regards the discharge planning part of the project the costs will be minimal with only paperwork needed. The group will be run by nursing staff and the OT who are already on duty.

To conclude, this brings to an end the initiation section of the change process. The business case summarises the drivers for the change and in the next section planning for the change will be described.
3.4 **Planning**

The HSE model sets out that the planning phase should determine the specific detail of the change and to create support for the change process (HSE, 2008: 37). Kerridge (2012a) asserts that this is a ‘key component’ (23) and that this phase enables the change lead to communicate and share their vision with others. The aim of communication is to build commitment into a shared vision and create momentum for the project (Harkness, 2000; Schein, 2009).

3.4.1 **Building Commitment**

The purpose of this step is to share an understanding of why recovery is important to the staff, the service-users, their families and the service. Vakola (2013) and Amis and Aïssaoui (2013) maintain that it is people who bring about change in an organisation individually and through teams and successful change can be brought about through creating a sense of the shared future.

The stakeholder analysis completed in the first section assisted the author in concentrating their efforts into a ‘whole system approach’ to communicating the vision of improving the recovery orientation of the inpatient service (HSE, 2008: 38). People are one of the most significant factors in change (Kerridge, 2012a; Hewitt-Taylor, 2013) This OD change comes from a bottom-up frontline approach, therefore the stakeholders on the frontline will be the most affected by the change. Both Kerridge, (2012a) and Hewitt-Taylor (2013) are of the same opinion that bottom up approaches to change are often the most successful as change is not seen as imposed on the individuals.
The key stakeholder groups identified with most influence on the success of the change were the nursing staff, the occupational therapist, the inpatient service-users and the medical staff. The nursing staff, as noted above had not engaged with a previous attempt to ascertain their views on recovery. Taking this into account the writer arranged to meet with the nurses during times when best suited them in their working day as the face to face engagement was a way to get them to begin to consider how we could improve the recovery focus of the ward and our discharge practice. Practically, this was also an intention to use a transtheoretical model (TTM) approach to engage staff into buying into the vision of the organisational change.

This model of engaging staff in organisational change has recently come back into vogue and centres around the work of James Prochaska who developed TTM in 1977 in the field of psychotherapy as a way of generating behavioural change (Prochaska et al., 2001). Prochaska et al. (2001) later extended the concept to organisational change strategies. Within a planned approach to change the author intended that nursing staff would begin to consider the ‘idea’ of recovery in their practice. Through focus groups the vision for the proposed changes to practice was shared. Prochanska and Prochaska (2013) describe this as the pre-contemplative phase, where the idea of change has not entered the person’s consciousness and the need to change has not yet been considered. Typically the pros and cons of a change are discussed in a non threatening manner leading to the person becoming more mindful of the idea of change (Prochaska and Prochaska, 2013). In this case, focus group questions that probed each nurse’s concept of recovery and discharge in practice were developed. Approval to use the
focus group questions and run the focus groups was sought for and granted by the local research ethics committee, this added further to the credibility of the focus groups. These groups also provided the writer with an opportunity to put forward a case for the change informing the nurses of the drivers for the change.

Prochaska and Prochaska (2013) state that the next three stages of TTM are contemplation, preparation and action. Continual communication of the benefits for the change is the priority for the change agent at this stage. So the nurse in this case is persuaded to progress from only becoming aware of the need for change, to being ready for the change and then taking action to become involved in the change. This strategy was so effective in bringing the nursing staff on board with the vision that two focus groups were run with the remaining non-nursing stakeholders during meetings that they agreed to attend.

Critically, one vital group of stakeholder views remained absent from these sessions due to approval not being sought to run the groups with service-users. Achieving ethical approval with service-users is fraught with barriers, whilst these are vital to ethical research practice, they are often difficult to overcome (Hutton et al., 2008). In this case the writer believed that views could be sought in a less threatening way. This was overcome by nurses who visited service-users at home canvassing their opinions by asking what they believed aided their recovery as an inpatient and what would have helped them on discharge. This enabled service-users views to be informally involved in the vision for the OD change.
To summarise, the focus groups provided a chance to canvass the views of the staff and service-users but also to begin to build interest and a commitment to improving the recovery orientation of the inpatient service. By the end of the focus groups staff had asked for training on recovery and had begun to consider how we could improve our discharge practice.

### 3.4.2 Determining the detail of the change.

The purpose of this step is to assess where the organisation is currently at (HSE, 2008). The PoRSAT (MHC, 2006) was conducted with the ARI lead to establish a base line of the current situation. The results of this audit and the results of the focus group were fed back to the QIA group, the nursing staff and the senior area management team. This information supported the need for the OD change. The teams felt that a pack a person could take home with them on discharge would be a perfect way of improving our discharge practice. This pack would be developed during inpatient stay and would include strategies that the person could use to cope at home. Also the team felt they would like further training on recovery principals which would improve their understanding of recovery.

### 3.4.3 Developing an implementation plan.

From the information above the writer developed the aim and objectives listed above which stated the interventions required to move from the current provision of care to a new state.
A working group needed to be recruited for the discharge package development therefore the author sent an email out to all staff to recruit interested parties. The working group, who responded, included members from community settings to inpatient staff. The ARI lead recruited a service-user to be part of the working group to ensure anything developed was inclusive of service-user views. With regards the education package a staff member was identified by the ARI lead and the writer to attend a course to provide 3 hour training packages for the inpatient staff. A service-user needed to be recruited as the training would be co-presented and they would need to attend the training course. The time frame, as listed above, was communicated to all stakeholders during the feedback meetings described above.

3.4.4 Implementation plan

To conclude the planning section a detailed implementation plan was developed.

Table 3

<table>
<thead>
<tr>
<th>Overview:</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>This OD project will move the current practice of the inpatient service to have an increased focus on recovery-orientated practice. The key drivers for the change are national and international policies on the need for mental health services to deliver recovery orientated care. Additionally the local stakeholders have expressed a desire to improve practice. The purpose it to delivery high quality care to those who use the inpatient service.</td>
<td>All staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implementation details:</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>A working group should be recruited to develop the discharge package and implement it in the inpatient service. The working group should include community staff and service-users. The discharge groups will begin at admission to the inpatient service. The pack will be tested by running a 6 week pilot.</td>
<td>The Writer, The ARI lead and inpatient staff.</td>
</tr>
<tr>
<td>A staff member and a service-user will attend a course in Dublin to deliver education sessions for staff on recovery.</td>
<td></td>
</tr>
<tr>
<td>The timeframe for the OD project will be for September 2014 through to May 2015, the inpatient service will be impacted by the change.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance and quality measures</th>
<th>The Writer</th>
</tr>
</thead>
<tbody>
<tr>
<td>The PoRSAT (MHC, 2006) will be applied pre and post intervention</td>
<td></td>
</tr>
<tr>
<td>The attendance of inpatient service users will be recorded</td>
<td></td>
</tr>
</tbody>
</table>
measured to ensure 80% of have attended the programme

- The average re-admission rate will be measured prior to the introduction of the discharge package
- Re-admission rate of those post intervention will be measured against the average re-admission rate for the service.
- Attendance of the staff at the education sessions will be recorded to measure percentage of inpatient staff trained.

### Resource Requirements
- Paper, printer and plastic packs to make up the packages
- Staff time to create the packs
- Payment for service-user to provide the 3 hour training sessions
- Cover for staff on the ward attending the session is required

Admin staff, the writer

### Risks and Dependencies
- Convincing staff of the need for change
- Allocation of funds to pay service-users
- Motivation of staff
- Buy-in from senior managers

The writer, all staff, all stakeholders

### Communication and engagement plan
- Present case for change to QI and audit group
- Recruit engaged staff
- Complete focus groups to present the case for change
- Email staff, meet with staff, attend education group and other relevant groups to communicate the proposed change
- Keep up the momentum for the change

The writer, all staff, all stakeholders

The next section of the change model is implementing the change.

### 3.5 Implementation

This is the third stage of the HSE Change model (2008) and considers how the change is actually working in the service, how the change is progressing and how it is impacting on the stakeholders. The writer’s role in this phase is to communicate and to ensure the change is evident in day to day practice (HSE, 2008). The PoRSAT (MHC, 2006) was completed and scored 32% compliance with recovery standards. The readmission rate was also measured prior to the intervention and was 69% of all admissions to the ward.

By this stage the ARI lead had identified a service-user that would commit to providing
the training on recovery. Staff members had responded to the writers email and the working group had been recruited to implement the change. Rogers (2003) maintains there are 5 ways people adopt change.

- Firstly the **innovators**, people who are eager to try new ideas and will understand the positivity of the change.
- Secondly the **early adopters**, who are often well respected in the organisation, are sociable and who will embrace the change.
- Thirdly are the **early majority** who adopt new ideas before the average person but who don’t often hold authority positions. Rodgers (2003) quotes Alexander Pope in relation to this group ‘be not the first new by which the new is tried/nor the last to lay the old aside’.
- The **late majority** who are sceptical and adopt the change after the average member of a group. Adoption is often in relation to peers becoming involved.
- And the final group are the **laggards** who do not want change and prefer the status quo. This group may finally adopt a change only when it has become mainstreamed.

In relation to the change presented here the innovators and early adopters had put themselves forward to become part of the working group. They were motivated and keen to be part of the change. The first working group met and firstly brainstormed what a good discharge package should look like and the writer fed back the findings of the literature review and the focus groups. It was agreed that there should be a general information page with contact details, a relapse prevention page, a crisis page, a short and long term plan page, information on medication and finally general information on
support groups in the area. An action plan was put in place with two objectives; firstly each member would develop a page for one section of the pack and secondly that the community staff would ask the people they visit at home what would be useful for them in the pack. The group agreed to meet in one month.

At the next meeting the group looked at what each member had created. Feedback from the service-users was given and information such as how to get to outpatients appointments and a phone number included should they need to change or cancel and appointment. The writer’s area is divided into 3 sectors so it was decided that the packs would be split into the sectors with information on that sector in that pack. By the next meeting, a month later, the packs were complete. A staff member from the inpatient service had agreed to run a weekly recovery discharge group with the OT. At this point it was decided that the groups should be run as a pilot for 6 weeks to test the paperwork. The staff member and the OT also planned to keep a record of who attended so a comparison could made against pre-intervention.

The OT fed back the results of recovery discharge group 6 weeks later. The service-users in the inpatient service described finding the pack useful and that they were enjoying completing them as it gave them a feeling of control over their mental health. However some of the service-users found working in a group difficult so were working with the nursing staff on the ward on a 1:1 basis. Only minor changes to the pack were required. The crisis page was causing difficulty for the service-users and staff working with the packs. The crisis page in considered a necessary part of discharge planning by the MHC (2009) as a result the format of this was changed following group discussion.
By this point in the change it was decided that a nurse, who was part of the working group, would attend the recovery training with the service-user. This training was completed in January however funding for the service user to provide the training was not secured until March, which delayed the implementation of this part of the OD change. The plan would be to start to deliver the training packages in April.

The working group sustained the momentum for the change in the discharge planning and the writer also sent reminders of responsibilities to the members. The writer frequently communicated with the ARI lead to maintain momentum regarding the education sessions however decisions on funding were at a higher managerial level than the ARI lead or the writer. This concludes the third phase of the HSE change model (HSE, 2008). The next stage of the model considers how a change can be sustained.

3.6 Mainstreaming

By this stage the change process was occurring, the staff had engaged and the feedback from the service-users had positively reinforced the change. The model states that the ‘purpose of mainstreaming is to sustain the new ways of working’ (HSE, 2008:63). Kerridge (2012c) states that sustaining the change should not be left to chance but that the lead must keep the change going. Kerridge (2012c) also asserts that the ultimate goal at this point is that change becomes entrenched in practice and would be difficult to undo.
The HSE (2008) model puts forward that the lead should celebrate any wins achieved with the team. At this point senior management are aware of the changes and the national ARI team are aware of the change implemented by the writer and the working group. This has been fed back to the team and the team had been asked to present the package to a national conference. Locally the discharge groups are running and to cement the practice other staff are now assisting with the delivery of the package. The groups continue to run in the absence of both the OT and the nurse that led out on delivering the groups initially. The working group plan to meet once more to iron out any final difficulties and then to maintain the change plan to meet every three months to allow for continuous quality improvement. The education sessions whilst ready to go have been stalled due to funding issues and staff being released although it is hoped that these will begin soon.

3.6.1 Summary

To conclude this chapter, a strategy for change was developed using the HSE’s own model for change. A thorough analysis of the OD change was conducted conducting a SWOT and PEST and a stakeholder analysis. A plan was then developed to manage this OD process by engaging the stakeholders through focus groups and presenting both the vision for the change and the case for improving the recovery orientation of the inpatient service. The implementation phase was initiated and the writer’s role became focussed on maintaining the momentum of the change and communicating the success during the actual change. Finally the change was mainstreamed as the discharge packages had begun to be completed weekly and this has now been embedded into day
to day practice. New staff and student nurses are now being inducted and involved with this work to become familiar with the packs. The NHSI (2012) guide to improving services states that it is necessary to demonstrate a change has been an improvement therefore the next section will consider evaluating the OD project.

4 Chapter 4: Evaluation

The NHSI guidance states that the gathering of data is essential to demonstrate a change has occurred and if the change is an improvement (NHSI, 2012). Both qualitative and quantitative measures were used to evaluate this OD project. Firstly the focus group feedback was analysed using a simple word count tool. This information would be used to guide the training interventions and in developing the discharge package for the service. The data outlining the re-admission rate prior to and following the recovery discharge group was measured and lastly the PoRSAT (MHC, 2008) was used to measure the recovery-orientation of the service following the OD projects implementation. Finally the writer will consider the initial objectives and conclude with a discussion on achieving these aims and objectives outlines above.

4.1 Focus groups evaluation

Objective 3 set out that the writer would conduct 5 focus groups with all staff by the end of November 2014. This was achieved as the writer conducted all 5 focus groups with 23 staff by this date. The largest of stakeholders in the focus group were nurses (n=14). The remaining stakeholders were consultant psychiatrists (n=3), NCHD’s (n=2), a
community mental health nurse (n=1), an OT (n=1) a social worker (n=1) and the co-
ordinator for the area. The questions asked centred on the stakeholder’s view of
recovery and discharge in the adult inpatient centre. The groups were transcribed by the
writer and their contents analysed.
A simple online word count tool was used to analyse the frequency of words in the text,
the tool was accessed at Seobook.Com (Wall, 2015). Polkinghorne (2005) suggests key
words can be considered as evidence of what participant’s thoughts and ideas are on a
topic.

The most frequent word in use was ‘person’ (n=76) suggesting that the staff involved in
the focus groups do indeed put the person at the centre of recovery and discharge. Staff
frequently cited that any care delivered should be individualised (n=11) and that care
should be patient-centred and the patient must be involved (n=3 and n=15 respectively).
Recovery was mentioned 19 times during the focus groups and that a person should
have a recovery plan as part of their treatment process (23 times).

In keeping with the objectives of this OD project a desire for training was mentioned by
participants 5 times. Of the 14 nurses 6 had received a module on recovery at a level 9
academic course. Only 2 of this group referred to this training with 1 stating ‘I don’t
remember much about that’. However other terms, like education (n=2), could have
reflected the staff’s strong feelings that they would like further education on recovery.

There was strong reference to recovery requiring a MDT approach or a team approach
(n=19). Only the medical profession (n=7) and the nursing profession (n=7) were
mentioned as being needed to provide recovery-orientated care. Other members of the MDT were not specified as needed to be involved to assist recovery.

The focus groups also considered how recovery could be supported on discharge. The terms support, service-user involvement, family/carer involvement were strongly stated (n=13). Planning and plan was mentioned 23 times in the focus groups with staff stating that the patient should be involved in designing their own discharge plan from admission. The staff also stated that they were often not able to plan discharge, did not have the time or the space to complete discharge planning.

The language used by the staff to describe recovery had a strong emphasis on medical language. Staff stated that to be in recovery there needed to be an absence of illness, symptoms or mental health issues (n=6). Two key terms of recovery were either not mentioned or remarked upon infrequently. A staff member commented on the need for inpatients to be empowered once and the highly significant term of hope was completely absent from the focus groups.

As noted above the purpose of using the focus groups was to introduce the need for the organisational change and to improve the recovery-orientation of the inpatient setting. Objective 5, to present the findings of the focus groups was also met but will be discussed below when evaluating the OD project overall with the PoRSAT (MHC, 2006). The staff member’s views sought in the focus groups were to be used during the creation of a discharge package and as a training needs analysis for the education
section of this OD. However, as noted, due to financial constraints training still has not occurred therefore objective 8 had not been achieved.

4.2 Discharge planning metrics

Vigod et al (2013) set out in the beginning of their systematic review set out that a key performance indication is that a person should not be re-admitted in the 90 days following discharge from psychiatric inpatient settings. The re-admission rate is calculated as an overall rate, if a person has previously been admitted then any subsequent admission is considered a re-admission (Vigod et al, 2013). Although a more refined measure may be to consider any person being actually re-admitted within 90 days of discharge. The metrics below will consider both figures. Simple metrics were used to evaluate this particular part of the OD project. Metrics are defined as ‘a standard used to evaluate or measure something’ (Oxford English Dictionary, 2012).

To establish a standard base line the writer measured the general re-admission rate to the service from October 2014 to December 2014. There were 57 admissions to the inpatient service and 39 of these were readmissions (68.5%). December had the lowest rate of admissions with 12 readmissions out of a total of 19 admissions (63%). This equated to readmissions costing the service €490,812.75 and new admissions €288,255.11 in December, using the figure of €1,268.25 per bed per night (Sapouna, 2008). To consider the second more refined figure suggested above, 14 people out of the 57 admissions had been discharged from the unit in the previous 90 days (25%).
On the 27th of November the Discharge working group first met, and began to brainstorm ideas for a pack and agreed to meet monthly, as noted in the methodology section. This met objective 4 set out by the author. The recovery discharge planning group began following completion of the draft pack. The first recovery discharge planning group was conducted on the 20th of February and at the point of writing 7 groups had taken place over 55 days. Overall the intervention was delivered to 26 people, of these 15 had previous admissions so were classed as re-admissions (65%). However as noted above a more refined measure may be how many people had been included in the recovery discharge planning groups and were re-admitted in the 90 days following discharge. At the time of writing 2 people of the intervention group had been readmitted (8%).

To compare and contrast both figures the overall re-admission rate of 65% was lower than the international rate of 70% (Vigod et al, 2013). However should the second and more specific rate be considered there was a drop of 17% of people being re-admitted following being involved in the recovery discharge planning group, albeit only at the 55 day mark measured here. This figure will be measured again at 90 days. Objective 5 set out that by the 31st of March 2015 the recovery discharge pack would be implemented and delivered to 80% of the inpatient service-users. This objective has been achieved as only 1 in-patient out of 26 has not been involved in the group. Therefore 96% of inpatient service-users have been involved in developing their own pack.

4.3 The PoRSAT evaluation
It is important to establish a baseline at the beginning of a project to ensure the impact of a change can be presented (NHSI, 2012). The intention of using the PoRSAT (MHC, 2008) was to audit the current service delivery against recovery standards set out by the MHC (2008). Clinical audit ‘is specifically about measuring actual practice against evidence based clinical standards of care’ (HSE, 2012: 2). The PoRSAT has sixty questions divided into six sections with each standard being rated from 0-3 leading to a maximum score of 180. Objective 3 set out by the writer in the original aims and objectives would be that the initial PoRSAT would be completed by the 3rd of November 2014.

The First PoRSAT was completed on the 28th of October and scored 31% compliance with the recovery standards (See appendix 3). The lowest scores were in the items Education (0/21), Hope inspiring relationships (14/36) and person centred and empowering care (15/36). These areas were targeted by the writer. Having recruited the working group the standards set by the PoRSAT (MHC, 2008) were used as a framework for changing practice. The PoRSAT also supported a need for training sessions on recovery to be rolled out across the sector. The results of the PoRSAT and the pack were presented to the QIA group, the education group and the area management team by the 31st of January as set out in objective 5. The progress the author had made was presented as was the expected outcomes of the OD project in relation to improving the recovery orientation of the service.

The PoRSAT was re measured on 8th of April 2015 (See appendix 4) and scored 69% compliance with the standards. Significant improvement was noted in two of the three
areas targeted. In the section person centred and empowering care the new score was 34/36. The standards in this section state that service-users were involved and engaged in their care choices, they were empowered to use self-management strategies and the plans used offered the service-user the opportunity to meet their own unique needs. The score in hope inspiring relationships also improved significantly scoring 31/36. The new packages were completed by the person themselves, that discharge planning was recovery orientated and the new pack recognised the service-users own capabilities to take control of their own recovery.

Unfortunately the area of education, whilst a modest improvement was made, had only scored 8/21 for the standards. This was due to an educational programme being available but it had not yet been delivered due to funding issues. This quantitative measure demonstrated that improvements had been made on the ward but it would be some way to go to meet objective 8 where 30% of staff would have received training on recovery.

4.4 **Summary**

To conclude the evaluation section, three measures were used to evaluate this project, two quantitative measures and one qualitative measure. The qualitative measure of counting words was used to evaluate the focus groups, using key words to generate ideas and themes from the focus groups. The evaluation found that the staff felt that recovery orientated care was individualised, patient centred and had to involve the patient. Most importantly staff omitted to mention two of the key concepts of recovery,
hope and empowerment. They frequently stated they would like further training on this, despite some staff having recovery training at post-graduate level. The staff also identified that during discharge the patient should be supported to maintain recovery through careful planning and that discharge planning should begin from admission.

The recovery discharge pack developed by the working group is being used during the weekly discharge planning groups. And although this is at an early stage some evidence exists that there is a lower re-admission rate of the intervention group compared to before the implementation of the pack. Finally the PoRSAT (MHC, 2008) was reapplied on the 8th of April 2015, and demonstrated that the recovery orientation of the service had increased by 38%.

At the outset the writer planned to improve the recovery orientation of the acute inpatient ward and the above evaluation demonstrates improvement using the above measures. The final chapter of this project will examine the above results in greater detail and consider how this OD change has impacted the organisation.
Chapter 5: Discussion and Conclusion

Organisational change in healthcare settings impacts on the people that use them, people that work in them and overall impacts on the organisation itself (Hewison, 2012; Shanley, 2007; Liisa Kuokkanen et al., 2007). The introduction of an OD change as described above carefully constructs and introduces a change process that improves the recovery orientation of an adult inpatient psychiatric service in Ireland. At the centre of this process was the desire to improve services for the people, or service-users that use them. The following section will consider the literature outlined in chapter 2 and link the knowledge gained with the process used in chapter 3 and the outcomes of the change described in chapter 4. The section will conclude with an analysis of how this project has impacted on the service as a whole and then set out the writers expectations for the future of the service. To begin the writer will explore the overall experience of leading and managing a change process using the HSE change model (HSE, 2008).

5.1 Leading and managing a change

Throughout this OD project the writer has led out on an OD change management strategy. The writer initiated a project from the bottom up, and through building a momentum for change the delivery of recovery orientated care has improved. During the
initiation stage of the model the writer conducted a thorough assessment of the need for the improvement, conducted an analysis of the external forces and internal forces at play during this process. The relevant stakeholders were considered and communicating the vision was conducted during the focus groups. The planning and implementation stages of the change were creative, challenging and dynamic and required the writer to sustain momentum throughout by keeping up high levels of energy and continuing to promote the vision and the reasons for the change.

On reflection, the experience has given the writer not only the skills to lead a change but also an awareness of how to strategically engineer a change process. This OD project has assisted the writer to consider the emergence of a desire to change through to full fruition. The analysis tools set out by the change model (HSE, 2008) have enabled the writer to have the confidence to lead. The business plan tool particularly, conducted at the initiation stage, assisted the writer to maintain focus with the overall OD project through to the end.

In this OD project the writer set out to introduce two interventions that would increase the recovery orientation of the acute mental health inpatient unit. One of the strategies was successful and one was partially successful, nonetheless both were initiated with the introduction of focus groups.

### 5.2 Focus groups: linking evidence to practice
The results of the focus groups are set out extensively above. However the HSE model (HSE, 2008) suggests a significant part of change is to use the available evidence to support a change process. Indeed, it is vital to link best available evidence to a change in practice (Mitchell, 2013). The focus groups found that staff believed they were working in a person centred way and held the view that they wanted also to work in a recovery-orientated way. Whilst the staff may have the skills and indeed be using them on a daily basis the lack of familiarity with the core principles of recovery caused them difficulty in articulating how they ‘do’ recovery. The research conducted by Beckett et al, (2013), Le Boutellier et al (2014) and Salgado et al (2010) discussed in chapter 2 demonstrates that this is a common phenomena. The staff also had difficulty in describing what recovery actually was, during one focus group two participants engaged in a discussion of the efficacy of the term recovery as both had different understandings. This is in keeping with the themes identified above by both Cleary and Downing (2009) and Salgado et al (2010). The literature review revealed that this confusion can be mitigated by education (Aston and Coffey, 2012; Cleary et al, 2013) discussed below.

The focus groups on discharge and helping a service-user maintain recovery on discharge from inpatient settings found that staff agreed that discharge should be coordinated and supports should be put in place for a person going home. In reality it was rarely planned, often staff did not feel they had the time nor the space to complete discharge plans. This was echoed in the research by Gerson and Rose (2012) and McKenna et al (2014).

5.3 Education sessions: linking evidence to practice
Whilst it is widely recognised that 70% of all organisational changes fail and that change is an integral part of an organisation's life (Vakola, 2013). Kotter and Schlesinger (2008) assert that often a failed change management strategy is rarely a complete collapse. This conversely suggests that a change strategy may not be a complete success either.

As noted above the staff frequently requested education on recovery in the focus groups, they were aware of a need to bridge this knowledge gap. However, the available education packages that staff have attended may not be meeting these needs, as described by Gale and Marshall-Lucette (2012). In fact 2 out of the 6 staff who had completed an educational module on recovery only recognised that fact that they had this module. The remainder of this group could not remember any training they had on recovery. This was a unique finding of the focus groups and perhaps requires further examination. Certainly the evidence seems to suggest that rather than academic courses training in recovery needs to be focused on developing practical skills (Gale and Marshall-Lucette, 2012). The views of staff from the focus groups was gathered as part of a training needs analysis which intended to guide training to meet the needs of the staff locally.

Although this part of the OD change was not a complete success it has not been a complete failure. The trainers have been trained and are ready to go and the funding has only recently been secured and management have bought into the need for education on recovery to happen. On reflection, despite the issue of funding for the
project being recognised from initiation phase more momentum and energy could have been focussed on securing funding first as this priority seems to have been missed. This was part of the writers learning from introducing this OD project, that often change requires financial investment. The second section of the change required little investment and may in fact produce cost savings for the organisation perhaps this factor contributed to its success.

5.4 **Recovery discharge package**

The use of self-management plans have been found to reduce a service-users need for inpatient care and can have significant financial benefits for the service (Jonikas et al., 2013). In this part of the OD service-users were involved in developing packs to manage their own mental health on discharge to support their recovery. The recovery discharge pack and groups are up and running, as noted above, with the service-users reporting that they are finding them enjoyable and useful. The packs include information on medication (Cleary et al, 2003), relapse prevention (Gerson and Rose, 2012), crisis intervention (Alghzawi, 2012) and simple information about supports in the community locally. The service-users requested that the packs should include information about how to get to out-patients appointments and how to change or cancel appointments, this was also included.

The empirical evidence to demonstrate the success of this part of the change has been evaluated and early benefits are evident, as seen in the evaluation section. Continued measurement of the outcomes will be an important part of demonstrating ongoing
success in the future. A further recommendation is to consider if the 1:1 sessions that some service-user prefer could be measured against the group work to see if there is any difference in outcomes regarding re-admission for each group. Finally from the service-users that are currently using the plan a request has been made to include an information sheet laying out why the pack is important and what it is to be used for. There is no doubt that this part of the OD project has been a success and has advanced the practice of maintaining recovery on discharge from adult inpatient mental health services. Finally the overall measure of the PoRSAT (MHC, 2008) will be discussed.

5.5 PoRSAT (MHC, 2008)

The PoRSAT (MHC, 2008) was applied pre and post intervention and the recovery orientation of the service score following the interventions above increased by 38%. Simple cost effective interventions, for example the recovery discharge pack, have made a difference to service-users being able to manage their symptoms. Further work is needed to cement this change into practice. It has been decided by the QIA that the PoRSAT (MHC, 2008) will be carried out every six months to ensure the service is increasing its compliance with recovery standards. Areas targeted for improvement in the PoRSAT (MHC, 2008) are discussed below.

5.6 Future for the organisation

With regards the interventions described herein it has been suggested that a guideline be developed on how to run the groups and how to work with the packs. The writer would hope the guideline would mitigate any need for training as one of the strengths of
the intervention was the cost neutral basis. The introduction of any training around the packs could lead to costs for the organisation. At present the groups are being run by inpatient staff with staff on the ward learning how to run the groups by experience. The majority of staff have at least a undergraduate degree and this ensures that they are aware of the empirical evidence that underpin the intervention. Certainly when the expected training begins on the education section for staff on recovery the evidence to support the recovery discharge planning groups will be clearer.

A limitation of the OD project is that the change occurred in one adult acute inpatient service in Ireland. The current area the writer works in has four adult acute wards. Extending the change to these areas will be challenging without senior managerial support. However some mitigation maybe the national ARI lead asked the writer to present to recovery discharge pack to him and is considering this as part of a national project. This project intends to develop a care pathway of which this pack will be to support recovery on discharge. The limitation of the financial support for the recovery education of staff has been extensively discussed above, but the writer is hopeful that this will finally be implemented. The education sessions are to be implemented area wide.

There also remain areas for improvement for the PoRSAT (MHC, 2008) particularly in the area of service-user satisfaction. Service-users have expressed dissatisfaction with the out-patients clinics with high rates of service-users not turning up for appointments (Did not attend (DNA). The writer has been asked to evaluate the reasons why service-users are not attending and, in conjunction with a service-user, is developing a survey to
understand this phenomenon. This is an opportunity to apply the knowledge gained in this OD project introduce a change that will enhance and improve another section of the service.

5.7 Conclusion

This chapter introduced a change in practice to link the best available evidence to practice and advance the recovery orientated care of one adult inpatient service in Ireland. To finally conclude, owing to the personal experience of leading out on a successful change process has led to a deeper understanding of how change can be managed and planned for. This experience has additionally given the writer confidence to deal with unexpected consequences of implementing a change process. With the involvement in this next organisational change project the writer has already begun apply the learning from this experience to ensure a successful change in that OD project. The writer has commenced a SWOT and stakeholder analysis and how to consider how put into action a change to improve the outpatient experience for service-users. Overall this has been both a challenging and enlightening experience of successfully changing practice.
6 References


## 7 Appendix

### 7.1 Appendix 1: PEST

<table>
<thead>
<tr>
<th>Political</th>
<th>Economic</th>
</tr>
</thead>
<tbody>
<tr>
<td>(P)National/ International: historically</td>
<td>Internationally/ Nationally: Mental health</td>
</tr>
<tr>
<td>politicians have had little interest in</td>
<td>issues account for over 13% of overall</td>
</tr>
<tr>
<td>mental health (OF); AVFC was national strategy</td>
<td>burden of healthcare (WHO); risk of</td>
</tr>
<tr>
<td>to enhance recovery but this has been</td>
<td>developing a MH issue around 33%; funding</td>
</tr>
<tr>
<td>poorly implemented (Amnesty); poor</td>
<td>does not match this and remains inadequate;</td>
</tr>
<tr>
<td>coordination in lobbying politicians;</td>
<td>current service plan allocates 6.5% of budget</td>
</tr>
<tr>
<td>politically saying is ‘no votes in mental</td>
<td>for MH services; AVFC estimated to cost</td>
</tr>
<tr>
<td>health’ (OF). Service user now becoming</td>
<td>€796 million, €417 spent by 2012 (Amnesty)</td>
</tr>
<tr>
<td>politically active (Amnesty); world health</td>
<td></td>
</tr>
<tr>
<td>agenda to improve mental health strategy in</td>
<td></td>
</tr>
<tr>
<td>most countries (WHO)</td>
<td></td>
</tr>
<tr>
<td>(p)Local: ARI pilot site, staff have</td>
<td>Locally: funding in the writers area has been</td>
</tr>
<tr>
<td>been poorly engaged but local interest has</td>
<td>one of the worst in the country; 33% less</td>
</tr>
<tr>
<td>improved following FG; local ARI lead very</td>
<td>than the national average per capita in 2011;</td>
</tr>
<tr>
<td>dynamic and motivated; local consumer panel</td>
<td>in 2011 it was the worst in the country;</td>
</tr>
<tr>
<td>presenting to local area management team</td>
<td>community care and recovery oriented care</td>
</tr>
<tr>
<td>on their views of service; SU now</td>
<td>seen as cost effective; plan suggested will</td>
</tr>
<tr>
<td>looking to be more involved in their care;</td>
<td>have little impact or cost; some costs</td>
</tr>
<tr>
<td>local DoN retired and new DoN has little</td>
<td>associated with training package for SU who</td>
</tr>
<tr>
<td>interest in the area but this has allowed</td>
<td>will co present, this has still to be agreed,</td>
</tr>
<tr>
<td>staff to be more involved in changing</td>
<td>recovery discharge pack will hopefully</td>
</tr>
<tr>
<td>practice; families much more aware of their</td>
<td>reduce readmissions and therefore save money</td>
</tr>
<tr>
<td>role and influence on quality of care</td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>Technological</td>
</tr>
<tr>
<td>Recovery seen as socially acceptable way of</td>
<td>National: national ehealth strategy to</td>
</tr>
<tr>
<td>providing care; stigma a barrier to recovery;</td>
<td>improve access to mental health care; service</td>
</tr>
<tr>
<td>reduced re admissions will reduce a person’s</td>
<td>user centred care pathway implemented in 2015;</td>
</tr>
<tr>
<td>time in hospital and therefore reduce the</td>
<td>national ehealth strategy; national</td>
</tr>
<tr>
<td>loss of social supports; staff delivering</td>
<td>mental health information system to be</td>
</tr>
<tr>
<td>care will be more aware of the need to work</td>
<td>implemented by Q2 of 2015</td>
</tr>
<tr>
<td>with service users and work in partnership;</td>
<td>Local: own website set up March 2013;</td>
</tr>
<tr>
<td>stigma of MH issues will hopefully be</td>
<td>patients have more access to information on</td>
</tr>
<tr>
<td>reduced as the person will be self-managing.</td>
<td>diagnosis, treatment and recovery online;</td>
</tr>
</tbody>
</table>
and staying at home/in work; stigma has reduced to some degree with celebrities admitting to mental health issues; increasingly acceptable however discrimination continues to exist.

7.2 Appendix 2: SWOT

<table>
<thead>
<tr>
<th>SWOT ANALYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Helpful</strong></td>
</tr>
<tr>
<td><strong>Internal Strengths</strong></td>
</tr>
<tr>
<td>• Lead a member of the team</td>
</tr>
<tr>
<td>• Recovery the most acceptable method of care delivery</td>
</tr>
<tr>
<td>• Focus Groups staff identified an interest in learning and an awareness of recovery</td>
</tr>
<tr>
<td>• Audit group want change, credibility due to influential members</td>
</tr>
<tr>
<td>• Authority to change given by Audit group and ARI lead</td>
</tr>
<tr>
<td>• Time to look at new way of working</td>
</tr>
<tr>
<td>• Loss of local DoN has allowed staff to be creative</td>
</tr>
<tr>
<td>• DC planning low cost base to introduce</td>
</tr>
<tr>
<td>• A few engaged staff hoping to make service better for SU</td>
</tr>
<tr>
<td>• ADON on nights with Lead engaged and motivated</td>
</tr>
<tr>
<td>• Hope that readmission rate in intervention group reduced</td>
</tr>
<tr>
<td>• Staff would develop and build on skills in working in partnership with SU</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>External Opportunities</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ahead with ARI due to being a test site</td>
</tr>
<tr>
<td>• ARI now to be mainstreamed in the 2015 service plan</td>
</tr>
<tr>
<td>• AVFC driving national agenda on recovery</td>
</tr>
<tr>
<td>• Local consumer panel have identified that they want improvement</td>
</tr>
<tr>
<td>• Recovery orientated care the preferred method of care for mental health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Internal Weaknesses</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Staff poorly engaged</td>
</tr>
<tr>
<td>• New Executive DoN has little interest in local initiatives.</td>
</tr>
<tr>
<td>• Low staff levels due to cuts and difficult to released staff for training</td>
</tr>
<tr>
<td>• Lead CNM2 but other CNM’s on ward need to buy-in, poor buy-in to services in the past</td>
</tr>
<tr>
<td>• Poor culture on ward, staff burnt out</td>
</tr>
<tr>
<td>• Only being implemented in one area (acute)</td>
</tr>
<tr>
<td>• Staff need to understand and engage with discharge package</td>
</tr>
<tr>
<td>• Needs work on procedure for completing packs and staff responsibilities</td>
</tr>
<tr>
<td>• Groups being run by OT and Nurses, no buy-in from medical staff (vital)</td>
</tr>
<tr>
<td>• Time to do work an issue</td>
</tr>
<tr>
<td>• Resistance to change</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>External Threats</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Funding for SU involvement in training an issue</td>
</tr>
<tr>
<td>• Small area so will only have an impact locally</td>
</tr>
<tr>
<td>• Training heavily dependent on staff being released</td>
</tr>
<tr>
<td>• At any point Lead could be relocated to another sector due to service need</td>
</tr>
<tr>
<td>• Mainstreaming may become an issue due to high turnover of staff and also high</td>
</tr>
</tbody>
</table>

Equilibrium: Status Quo
issues internationally

- Opportunity to empower SU to take control of MH issues
- An opportunity to present project at national level to celebrate service success
- An opportunity to demonstrate cost savings from reduced readmission rate due to skilled staff and service user empowerment

7.3 Appendix 3: PoRSAT 1

Audit 1: 28\textsuperscript{th} of October 2014

<table>
<thead>
<tr>
<th>Pillars of recovery: Service Audit Tool (PoRSAT)</th>
<th>Leadership</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 The service’s mission and vision statement articulates a commitment to the values that underpin a recovery approach.</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 The objectives of the service incorporate recovery principles.</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 The policies for the service are consistent with recovery principles.</td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>4 A written strategy exists for meaningful users involvement in all aspects of service activity</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 A working group exists with responsibility for the development and evaluation of a recovery oriented service.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>6 Staff within the service can articulate strategies they have taken to promote and maintain a recovery oriented service.</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Meaningful user involvement is an integrated and ongoing component of service activity at all levels and people in recovery are represented on committees and working groups.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>8 Procedures exist and are made readily available to users, families and representatives to address their dissatisfaction or satisfaction with the service.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>9 The service can provide evidence that users and/or representatives receive timely feedback on actions taken as an outcome of their evaluations or the rationale if actions could not be</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>The service has a specific budget to reimburse users for their involvement in service activity.</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Person Centred and Empowering Care**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>The service has a written up-to-date policy on person centred care.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>An individual up-to-date care and treatment plan exists for each service user.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Evidence exists that written care and treatment plans are developed in collaboration with the person, based on the individual’s unique needs and are freely available to the service user.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Evidence exists that staff are using self management principles, wellness approaches and relapse prevention planning with service users.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Evidence exists that staff are continually working to engage and empower service users who are involuntarily detained.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Evidence exists that service users’ voices are respected and that staff acknowledge the individual as an expert in their own recovery.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Evidence exists that staff take an assertive proactive approach to enable each service user have opportunities for choice and control in their own care and treatment.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Evidence exists that service users’ right to information is respected and service users are provided with up to date information on their rights,’ illness’, care and treatments.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Evidence exists that staff actively attempt to link service users with peer support and other advocacy groups in the community</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Evidence exists that service users report that staff are respectful of their ethnic background, sexual orientation, religious background and gender</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Service users and families are provided with up-to-date information on how to access local peer groups and peer representatives. This information is service user friendly and provided in a variety of formats, media (notice boards, service websites etc), and languages.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service users and families can access user-friendly educational resources on recovery (eg recovery narratives by users) through a variety of formats, media, and in a variety of languages.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Hope inspiring relationships</strong></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Evidence exists that staff view service users as capable of self management and are willing to support service users self-management goals.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>24</td>
<td>Evidence exists that service users are informed and provided with information on recovery</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Evidence exists that the service users’ strengths and capabilities are a core dimension of the care and treatment plan.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Evidence exists that service users are asked what worked well for them in the past and these ideas are incorporated into the care and treatment plan.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Evidence exists that staff record the individual’s responses verbatim rather than translating the information into professional language.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Evidence exists that staff are proactive in identifying and addressing societal, organisational and attitudinal barriers to recovery.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>29</td>
<td>Evidence exists that staff are mindful of power differences in relationships and make every effort to facilitate service users to challenge professional interpretations.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Evidence exists that due consideration is given in recovery plans to discharge planning from the formal mental health services</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Evidence exists that staff avail of formal and informal professional supervision and support.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Evidence exists that service users continually report feeling respected, listened to and valued by service providers.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Evidence exists that service users continually report that staff take time to develop relationships that instil hope and optimism for the future</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Evidence exists that service users continually report that staff are proactive in seeking their views about the type and quality of care they desire and receive.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Access and Inclusion</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>----------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>35 The service has an educational programme to raise general public awareness about recovery and the impact of stigma on inclusion and participation.</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>36 The service is continually liaising with existing local resources (Voluntary organisations, Health and Social Services Council, Citizens Advice).</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>37 The service is continually working to build peer-support and advocacy capacity within the local community.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38 The service is continually working with training and employment services to enable service users pursue their vocational desires.</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>39 Evidence exists that care and treatment plans focus not just on clinical symptoms but on ways of enhancing meaningful and successful community life.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 Service users report being supported and encouraged in pursuit of their employment and vocational skills.</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>41 Service users are provided, as appropriate, with user friendly guides on training and supportive employment schemes in the local community.</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>42 Service users report being supported to develop recreational activities and social networks other than activities involving the mental health system.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43 The service is continually working with local housing authorities to ensure that suitable affordable housing is available.</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>44 Supportive accommodation is of high quality and does not compromise the person’s rights to privacy or freedom.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>45 The service has an education programme for all staff on recovery and recovery principles.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46 Service users are routinely involved in the development, delivery and evaluation of the education materials and education programmes.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47 Service users are meaningfully involved in curriculum and other education committees within the service.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>48</td>
<td>Cultural and gender issues are addressed within the education programme.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Core competencies for staff in relation to recovery are identified.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>All staff (clinical and non clinical) are facilitated to attend educational programmes on recovery and are knowledgeable of recovery principles, gender sensitive care and are culturally competent.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>The service has educational materials on recovery that users, family members and the public can easily access.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Research and Evaluation

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>52</td>
<td>Process and outcome measures for the service reflect a recovery orientation.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Qualitative and quantitative data on satisfaction with services and involvement in care are collected routinely and in a timely manner from users, family members and advocates.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Qualitative and quantitative data on involvement with peer run services are collected routinely and in a timely manner from service users, family members and advocates.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Qualitative and quantitative data on satisfaction with involvement and integration into local community activities are collected routinely and in a timely manner from service users.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Qualitative and quantitative data on satisfaction with housing and accommodation are collected routinely and in a timely manner from service users.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Qualitative and quantitative data on satisfaction with social relationships and recreational activities, other than activities involving the mental health system, are collected routinely and in a timely manner from service users.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>Independent audits of the service are conducted by people in recovery and people trained in recovery oriented principles.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Service users are meaningfully involved in research committees and research ethics committees.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Service users are involved in identifying research priorities for the service and in designing research.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pillars of Recovery: Service Audit tool</td>
<td>Number of items</td>
<td>Maximum score</td>
<td>Actual score</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>Leadership</td>
<td>10</td>
<td>30</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Person centred and empowering care</td>
<td>36</td>
<td>36</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Hope inspiring relationships</td>
<td>36</td>
<td>36</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Access and inclusion</td>
<td>10</td>
<td>30</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>7</td>
<td>21</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Research and evaluation</td>
<td>9</td>
<td>27</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Total Score/Maximum score</strong></td>
<td><strong>60</strong></td>
<td><strong>180</strong></td>
<td><strong>56</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage scored</strong></td>
<td></td>
<td></td>
<td><strong>31%</strong></td>
<td></td>
</tr>
</tbody>
</table>

Completed by: Jennie Synnott

Reference,


7.4 Appendix 4: PoRSAT 2

Audit 2: 8th of April 2015

<table>
<thead>
<tr>
<th>Pillars of recovery: Service Audit Tool (PoRSAT)</th>
<th>Leadership</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 The service’s mission and vision statement articulates a commitment to the values that underpin a recovery approach.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>2 The objectives of the service incorporate recovery principles.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>3 The policies for the service are consistent with recovery principles.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>A written strategy exists for meaningful users involvement in all aspects of service activity</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>A working group exists with responsibility for the development and evaluation of a recovery oriented service.</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Staff within the service can articulate strategies they have taken to promote and maintain a recovery oriented service.</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Meaningful user involvement is an integrated and ongoing component of service activity at all levels and people in recovery are represented on committees and working groups.</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Procedures exist and are made readily available to users, families and representatives to address their dissatisfaction or satisfaction with the service.</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>The service can provide evidence that users and/or representatives receive timely feedback on actions taken as an outcome of their evaluations or the rationale if actions could not be implemented.</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>The service has a specific budget to reimburse users for their involvement in service activity.</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total 26

**Person Centred and Empowering Care**

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>The service has a written up-to-date policy on person centred care.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>An individual up-to-date care and treatment plan exists for each service user.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Evidence exists that written care and treatment plans are developed in collaboration with the person, based on the individual’s unique needs and are freely available to the service user.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Evidence exists that staff are using self management principles, wellness approaches and relapse prevention planning with service users.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Evidence exists that staff are continually working to engage and empower service users who are involuntarily detained.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Evidence exists that service users’ voices are respected and that staff acknowledge the individual as an expert in their own recovery.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evidence exists that staff take an assertive proactive approach to enable each service user have opportunities for choice and control in their own care and treatment.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>18</td>
<td>Evidence exists that service users’ right to information is respected and service users are provided with up to date information on their rights,’ illness’, care and treatments.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>19</td>
<td>Evidence exists that staff actively attempt to link service users with peer support and other advocacy groups in the community</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>20</td>
<td>Evidence exists that service users report that staff are respectful of their ethnic background, sexual orientation, religious background and gender</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>21</td>
<td>Service users and families are provided with up-to-date information on how to access local peer groups and peer representatives. This information is service user friendly and provided in a variety of formats, media (notice boards, service websites etc), and languages.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>22</td>
<td>Service users and families can access user-friendly educational resources on recovery (eg recovery narratives by users) through a variety of formats, media, and in a variety of languages.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

**Total** 34

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hope inspiring relationships</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Evidence exists that staff view service users as capable of self management and are willing to support service users self-management goals.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>24</td>
<td>Evidence exists that service users are informed and provided with information on recovery.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>25</td>
<td>Evidence exists that the service users’ strengths and capabilities are a core dimension of the care and treatment plan.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>26</td>
<td>Evidence exists that service users are asked what worked well for them in the past and these ideas are incorporated into the care and treatment plan.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>27</td>
<td>Evidence exists that staff record the individual’s responses verbatim rather than translating the information into professional language.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>28</td>
<td>Evidence exists that staff are proactive in identifying and addressing societal, organisational and attitudinal barriers to recovery.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>29</td>
<td>Evidence exists that staff are mindful of power differences in relationships and make every effort.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
to facilitate service users to challenge professional interpretations.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>Evidence exists that due consideration is given in recovery plans to discharge planning from the formal mental health services</td>
<td>✓</td>
</tr>
<tr>
<td>31</td>
<td>Evidence exists that staff avail of formal and informal professional supervision and support.</td>
<td>✓</td>
</tr>
<tr>
<td>32</td>
<td>Evidence exists that service users continually report feeling respected, listened to and valued by service providers.</td>
<td>✓</td>
</tr>
<tr>
<td>33</td>
<td>Evidence exists that service users continually report that staff take time to develop relationships that instil hope and optimism for the future</td>
<td>✓</td>
</tr>
<tr>
<td>34</td>
<td>Evidence exists that service users continually report that staff are proactive in seeking their views about the type and quality of care they desire and receive.</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>31</td>
</tr>
</tbody>
</table>

### Access and Inclusion

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>The service has an educational programme to raise general public awareness about recovery and the impact of stigma on inclusion and participation.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>36</td>
<td>The service is continually liaising with existing local resources (Voluntary organisations, Health and Social Services Council, Citizens Advice).</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>37</td>
<td>The service is continually working to build peer-support and advocacy capacity within the local community.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>38</td>
<td>The service is continually working with training and employment services to enable service users pursue their vocational desires.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>39</td>
<td>Evidence exists that care and treatment plans focus not just on clinical symptoms but on ways of enhancing meaningful and successful community life.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>40</td>
<td>Service users report being supported and encouraged in pursuit of their employment and vocational skills.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>41</td>
<td>Service users are provided, as appropriate, with user friendly guides on training and supportive employment schemes in the local community.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>42</td>
<td>Service users report being supported to develop recreational activities and social networks other</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
than activities involving the mental health system.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>The service is continually working with local housing authorities to ensure that suitable affordable housing is available.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>44</td>
<td>Supportive accommodation is of high quality and does not compromise the person’s rights to privacy or freedom.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total** 20

### Education

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>The service has an education programme for all staff on recovery and recovery principles.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>46</td>
<td>Service users are routinely involved in the development, delivery and evaluation of the education materials and education programmes.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>47</td>
<td>Service users are meaningfully involved in curriculum and other education committees within the service.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Cultural and gender issues are addressed within the education programme.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Core competencies for staff in relation to recovery are identified.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>All staff (clinical and non clinical) are facilitated to attend educational programmes on recovery and are knowledgeable of recovery principles, gender sensitive care and are culturally competent.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>The service has educational materials on recovery that users, family members and the public can easily access.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total** 8

### Research and Evaluation

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>52</td>
<td>Process and outcome measures for the service reflect a recovery orientation.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>53</td>
<td>Qualitative and quantitative data on satisfaction with services and involvement in care are collected routinely and in a timely manner from users, family members and advocates.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>54</td>
<td>Qualitative and quantitative data on involvement with peer run services are collected routinely and in a timely manner from service users, family members and advocates</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Qualitative and quantitative data on satisfaction with involvement and integration into local community activities are collected routinely and in a timely manner from service users.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Qualitative and quantitative data on satisfaction with housing and accommodation are collected routinely and in a timely manner from service users</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Qualitative and quantitative data on satisfaction with social relationships and recreational activities, other than activities involving the mental health system, are collected routinely and in a timely manner from service users</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>Independent audits of the service are conducted by people in recovery and people trained in recovery oriented principles.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Service users are meaningfully involved in research committees and research ethics committees.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Service users are involved in identifying research priorities for the service and in designing research methodologies.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total** 7

<table>
<thead>
<tr>
<th>Pillars of Recovery: Service Audit tool</th>
<th>Number of items</th>
<th>Maximum score</th>
<th>Actual score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td>10</td>
<td>30</td>
<td>24</td>
</tr>
<tr>
<td>Person centred and empowering care</td>
<td>36</td>
<td>36</td>
<td>34</td>
</tr>
<tr>
<td>Hope inspiring relationships</td>
<td>36</td>
<td>36</td>
<td>31</td>
</tr>
<tr>
<td>Access and inclusion</td>
<td>10</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>Education</td>
<td>7</td>
<td>21</td>
<td>8</td>
</tr>
<tr>
<td>Research and evaluation</td>
<td>9</td>
<td>27</td>
<td>7</td>
</tr>
</tbody>
</table>

**Total Score/Maximum score** 60 180 126

**Percentage scored** 69%

Completed by: Jennie Synnott
Reference,


doi:10.1002/9781118326404

doi:citeulike-article-id:126680

Salgado, D. Deane, F. P. Crowe, T. P. and Oades, L. G. (2010). Hope and 
improvements in mental health service providers’ recovery attitudes following 


and Sons.

Slade, M., Amering, M., Farkas, M., Hamilton, B., O’Hagan, M., Panther, G., Perkins, R., 
Shepard, G., Tse, S., Whitley, R. (2014). Uses and abuses of recovery: 
implementing recovery-oriented practices in mental health systems. World 
Psychiatry, 13(Febuary 1), 12–20.


Tedstone-Doherty, Y. K.-O. and D. (2010). Recovering from recurrent mental health 
problems: giving up and fighting to get better. International Journal of Mental Health 


The World Health Organisation. (2012). Global burden of mental disorders and the need 
for a comprehensive , coordinated response from health and social sectors at the 

Turton, P., Demetriou, A., Boland, W., Gillard, S., Kavuma, M., Mezey, G., … Wright, C. 
(2009). One size fits all: or horses for courses? Recovery-based care in specialist 
mental health services. Social Psychiatry and Psychiatric Epidemiology, 46(2), 127– 
136. doi:10.1007/s00127-009-0174-6

Turton, P. Demetriou, A. Boland, W. Gillard, S. Kavuma, M. Mezy, G. Mountford, V. 


