Guiding practice development using the Tidal Commitments

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Introduction

In 2002 we began the transformation of nursing practice at the Royal Ottawa Hospital, a 180-bed psychiatric and mental health facility in Eastern Ontario, Canada. Among other changes, we led the implementation of the Tidal Model of Mental Health Recovery.

Aware that change is constant, we thoughtfully embraced the Tidal Model as a vehicle to change to person-centred, research-based, collaborative care. We began by providing every nurse with Tidal education, using the multimedia education package developed originally in Newcastle, UK (Barker 2000). This ensured a common perspective among the nurses and fidelity to the values, principles and processes of the Tidal Model. However, we also wanted to encourage creative, locally relevant implementation on each unit. We have implemented Tidal in several waves, beginning in 2002 with three
programmes (Forensic Psychiatry, Mood Disorders, and Substance Use and Concurrent Disorders), and the six remaining inpatient units (Crisis and Evaluation, General Psychiatry in Transition, Geriatric Psychiatry, Psychosocial Rehabilitation, Schizophrenia and Youth) in 2004.

About 18 months after we began, we learned about the reaffirmation of core Tidal values in the form of the 10 Tidal Commitments (Buchanan-Barker 2004). We believe that these values need to be embraced by persons who aim to pursue and develop the philosophy of the Tidal Model (Barker & Buchanan-Barker 2005). These commitments provide a guide for practice and also facilitate the teaching of Tidal. We want to share how selected commitments have been realized in our Tidal teaching and concurrent practice development.

Value the voice

We are very respectful of our nursing colleagues, and are always interested in and curious about what our colleagues have to share with us. As we began Tidal implementation, we participated in weekly nurses’ meetings on the different units and listened to what the nurses had to say: their questions, concerns, challenges and issues. Frequently, nurses shared their stories in informal ‘hallway’ consultations as well. We encouraged them to create their own local implementation, rather than imposing a one-size-fits-all plan.

We heard over and over many complaints about paperwork. While we valued this feedback, the complaints and concerns became repetitive and tiresome. In the spirit of the Tidal Model, we refocused and reframed concerns as searching for solutions, and sharing success stories – and humorous ones as well!

We were dismayed to hear some nurses tell us that they should really not talk to persons living with psychosis as this could reinforce their illness, and the stories would not make sense anyway. Other nurses would discount stories, saying that persons were just telling us what they thought we wanted to hear. We consistently reassured the nurses that everyone has a story and what persons chose to share with us was what we wanted and needed to hear from persons in care.

One of our implementation strategies was to visit all the units on all shifts, to provide support and encouragement, and to engage in dialogue around Tidal implementation. There were, however, some surprises. For example, while reviewing a newly completed holistic assessment on one unit, solely written in the person’s voice, the nurse admitted that she had added an interpretation of the person’s words on the holistic assessment: ‘But she really didn’t mean what she said, what she meant was . . .’

We celebrated with the nurses who were able to capture the voices of persons in care in holistic assessments and daily care plans. Some nurses shared their astonishment as persons with whom they had worked for years now began to share their stories, affording the nurses new insights into established ways of being. Nurses often seemed surprised when ‘It (Tidal) worked!’ We are quick to respond that Tidal is just words on paper: it didn’t work – rather they had done the necessary work.

Respect the language

We know that nurses work ‘in the everyday’, and that ordinary, everyday language has little currency among psychiatric professionals. Nurses have learned the insider language of psychiatry, and this is useful in communicating with the interdisciplinary team. There was also the cumbersome, arcane language of nursing diagnosis that did not enhance communication, and was not helpful for persons in care and their families. This had come and gone in our facility. Not only are nurses relearning and becoming reacquainted with everyday language for their own practice, they are also learning the natural, plainspoken language of persons in care and are representing this voice, complete with idiosyncrasies, within the interdisciplinary team.

We consistently refer to persons or persons in care having replaced the patient/client terminology with, we believe, the more respectful – and accurate ‘person.’ This is true for presentations, classes, etc. However, we also recognize that we are out of sync with the larger nursing community. When we recommended that our national psychiatric and mental health nursing organization replace ‘client’ with person in documents relating to our competencies and the certification examination, they demanded references and evidence for this. After much discussion, this remains a contentious issue.

Nurses have generously shared a number of stories with us that we have added to our toolkit. One nurse shared a striking example of respecting the
language. After participating in a holistic assessment, the nurse moved on to the Immediate Care Plan A. Under the section entitled ‘mental state’ she wrote delusional. The person reacted immediately saying, ‘you weren’t listening to anything I said’. The person took the form and scribbled all over it with the pen, crossing everything out and then tore up the assessment. Another nurse told us a story of ‘scare exaggeration’, another vignette for our toolkit. During the holistic assessment, the person identified one of her problems as scare exaggeration. The nurse helped her to describe this ‘nervous state’ so the nurse could translate it for the interdisciplinary team, demonstrating the team’s respect for the person’s unique expression of her lived experience. This term was retained in interactions and all Tidal documentation.

Become the apprentice

This Tidal Commitment to ‘become the apprentice’ was a good fit with the Tidal implementation team as we have for many years been quite comfortable learning from others. Our values and beliefs about learning and practice are congruent with becoming the apprentice. We learned about Tidal from the seminal Perspectives in Psychiatric Care article (Barker 2001). We read all the Tidal literature we could find, as well as other literature related to person-centred, solution-focused, strength-based nursing. We talked with other nurses about the gift of Tidal. We learned what it was like to participate in holistic assessments with people in care – Margaret in her Acute Care Nurse Practitioner role, Nancy in consultations throughout the hospital and Lisa through her nurse educator role. We recognized that this was a different way of being in relationship with persons in care. Perhaps more accurately this was back to our roots in a system that had not supported such practice. Fortunately, we are completely comfortable not being the experts. We learn from the nurses; they teach us, so we can teach them.

We learn from our colleagues including each other. Persons in care teach us about the value of the model. We practise the model. We continue to experiment with different strategies, timing and activities, and contribute to the evolution of the model. We appreciate that practising Tidal is the best way to learn it.

We learned that we had made assumptions about nurses’ attitudes, skills and knowledge – we had assumed that if we introduced them to collaborative, strength-based, solution-focused, person-centred nursing, they would know what to do. Many of the nurses have minimal expertise in psychiatry and mental health nursing. Some have little interest in learning new skills or changing their established values and beliefs. Others are eager to practise in new or different ways. We learned that nurses seemed to think that they must become like clean slates, tabula rasa, to practise Tidal. So, we built in the strong message that we expect nurses will come to this enterprise with all their knowledge, skill and experience and build on this, rather than ‘starting fresh’. We continue to search for solutions to help nurses understand, appreciate and practise person-centred, strength-based, collaborative nursing.

Use the available toolkit

We valued the nurses’ stories. Now we collect stories that nurses tell of their successes and their frustrations practising Tidal. Some stories are posted on the Tidal Model website (http://www.tidal-model.co.uk). Some units have a book where the stories of persons in care and other Tidal anecdotes can be recorded and shared with one another. One of the nurses who completed a Tidal fellowship wrote her story for the website. She also wrote her story for the fellowship newsletter and has presented her story at several conferences and internal events. We are privileged to have her stories in our toolkit, so we can share them too.

Valuing the voice of experience led to the creation of a video. Sharing Tidal Stories has four nurses telling their stories illustrating the model in practice. The video is a wonderful teaching tool that is used widely in education and practice. Our first Tidal presentation at an international best practice conference in 2003 featured Sharing Tidal Stories. We use the video with our own staff, for example, in orientation, with other facilities implementing the Tidal Model, and with those who come for site visits. The video portrays the real stories of nurses practising the model and illustrates both challenges and successes.

One nurse tells of writing a paper for a Theories and Concepts course in the post-basic degree programme and how the Tidal Model gave her a different appreciation of nursing theory. She also speaks of the ‘honour’ of joining the Tidal community even though she was not officially part of the
first wave. Another nurse came to psychiatric and mental health nursing from Intensive Care where she was quite ‘directive and certain . . . the expert!’ She continued this stance until she was introduced to the Tidal Model. She speaks eloquently of her struggles with control as she learned to work collaboratively with persons in care. Another is an out-patient nurse’s story of practising Tidal early on and how it resulted in a true connection with the person in care and how she shared the goals they developed collaboratively with the team.

We have enjoyed other discoveries about Tidal. In collecting the data for the Tidal study, we found that a psychiatrist had used the holistic assessment in his assessment around the dangerous offender status. A nurse shared a poignant story about using the miracle question that resulted in a connection and collaboration with the person. A psychologist in the Forensic programme told us that she finds the holistic assessment invaluable to learn about persons before she begins her assessment.

Our Tidal toolkit contains many stories and vignettes that nurses and persons in care have generously shared with us, so we can share them with others. We are creating a library of Tidal stories for use in practice, education and research.

**Give the gift of time**

We recognize that change takes time and changes in practice take time to practise. We first introduced Tidal in education days, several months before we began the actual implementation. We suggested that the nurses take the opportunity to practise Tidal. Perhaps we should not have been surprised that few actually took the opportunity.

We built developmental support into our commitment to transform nursing and to create time and space for Tidal practice. In the beginning, we provided extra nursing staff so nurses could spend dedicated time to complete holistic assessments and daily care plans. In our second wave of implementation, we were fortunate to have a Tidal implementation facilitator spend time coaching with each nurse to ensure that they understood Tidal and the requirements for Tidal practice. This facilitator would review holistic assessments, participate in holistic assessments with nurses or participate in assessments with nurses observing. She took along a ‘float’ nurse to cover the unit nurses’ persons in care, so the nurses could attend to the work without worrying about ‘coverage’.

Many nurses told us that they were too busy and that there was too much paperwork with the model. They complained that they never have enough time. We know that precious time is spent on administrative, non-nursing tasks. We challenged the nurses to spend at least 10–15 min a day in focused time with persons, completing collaborative and person-centred daily care plans. In our Tidal study, we thought that we would see an increase in time from admission to holistic assessment completion. So we were surprised to find in a study that we did over 4 years that the length of time from admission to completion of the five-page holistic assessment remained on average 1 day.

We continue to strive to transform nursing practice and contribute to persons’ journeys of recovery. There is ebb and flow in the process of implementing the model. Sometimes we faced setbacks, or at times we felt becalmed. There would also be times of success, great celebration and breakthroughs. We are sustained by our passion for excellence in psychiatric and mental health nursing and care – and by the stories.

**References**


