

# Finding solutions through empowerment: a preliminary study of a solution-orientated approach to nursing in acute psychiatric settings

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## Finding solutions through empowerment: a preliminary study of a solution-orientated approach to nursing in acute psychiatric settings

Acute inpatient care is not a therapeutic milieu, perhaps owing to the lack of nursing skills. Solution-focused therapy (SFT) has been successful in US inpatient facilities in relation to both objective and subjective 'measures'. This paper reports a study of SFT in a UK context, with the aim of developing a user-friendly SFT training course and assessing its impact on both nurses and clients, via a multifaceted, triangulated data collection design. Nurses' knowledge and clinical performance were assessed, as was the client's perspective. There was a significant difference in nurses' SFT knowledge after training and strong evidence of the model being used in practice during the course of training, although nursing documentation was not fully completed. Eighty-three per cent of nurses said that they would continue using the model, and clients found the SFT approach helpful. The findings match the US experience of using SFT.

*Keywords:* acute inpatient care, mental health nursing, solution-focused therapy (SFT), therapeutic milieu

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## Background to the study

Acute inpatient psychiatric wards are failing to meet the needs of those who experience them (Sainsbury Centre 1998). The Department of Health (DoH 1999) reported that mental health wards were becoming more custodial, contact with nurses was inadequate and there was little or no formal therapy taking place. More recently, the DoH (2002) has recommended that skilled nurses are needed who can offer active therapeutic engagement. Improving the mental health nurses' skill base should facilitate the development of a therapeutic milieu. An evidence-based model of therapy is needed, upon which to establish the

acute mental health nurses' practice from the moment of admission to the completion of discharge. Such a model might stabilize the crisis that necessitated the person's admission and might begin to frame the process that, ultimately, might be called 'recovery' (Barker 2001).

Carpenter (unpublished) has pointed out that the rhetoric of evidence-based interventions in mental health does not match the reality. In a comprehensive review, he noted that few interventions in mental health are convincingly evidence based, but added that some showed promise including solution-focused therapy (SFT). In the US, Webster *et al.* (1994) and Vaughn *et al.* (1995) found that the introduction of SFT required acute mental health nurses to

rethink their philosophy of care. Instead of looking at underlying causes of crisis, they needed to focus on helping clients find or construct solutions to their presenting problems. Within this approach, the client is viewed as the expert on the solution to their problems, and change itself is viewed as a naturally occurring process. The nurse's role is to notice and draw attention to change, however small. The benefits reported included the mobilization of a person's sense of hope, supporting the client's strengths and using existing support systems (Webster 1990, Tuyn 1992). Montgomery & Webster (1993) noted that SFT fitted well with the nurses' moral imperative to be a client advocate, and to try and include them more in their own recovery. Vaughn *et al.* (1995) also reported that nurses were comfortable working within the SFT framework. Both nurses and clients stated that they felt 'tremendously empowered' by the experience. In addition, nurses found that there was less conflict between themselves and the clients. Periods in hospital were reduced but with no increase in recidivism or adverse effects. Most importantly, clients were satisfied with the care that they had received.

Although the US experience has been positive, SFT there is delivered within the framework of 'managed care', which differs markedly from UK provision. The US system places time limits on care packages and the providers have a vested interest in ensuring quick turnover of patients. The current study aimed to assess what happens when SFT is introduced to nurses and clients in acute psychiatric inpatient settings in the UK. The study objectives were to:

- develop a SFT training course that is user-friendly and that raises nurses' knowledge of SFT;
- provide training to nurses in the use of individual SFT interventions within an acute care setting; and
- assess the impact of SFT training and practice on nurses and clients.

## Study design

Given that there was an expectation of change in practice through the process of the research, the study was multi-faceted and followed a research and development model. Such projects often require multiple measures, or approaches to data gathering (Mohr 1999) rather than a randomized control trial. This is because the focus is on 'what happens' when a new practice is introduced and not on 'testing' the model or the practice (Barker & Stevenson 2002). To do the latter would be impossible as there can be no certainty in advance about what the impact of the new practice might be, or how such impact might be measured. By inquiring of the people involved, information with high face validity is generated. In the study, this information was triangulated with other data sources, namely care plan

information and case reports. Thus, a weight of evidence concerning the course was collected via the following means.

- Prior to the course, trainees completed a pre-course test (see Appendix 1). This enabled the researchers to measure their level of SFT knowledge. A set of model answers was prepared to help gain inter-rater reliability (assessed by Pearson's *r*). The same test was administered at the end of the course giving two sets of scores (nonparametric data, repeated measures, analysed with Wilcoxon test).
- For their final course assignment, trainees were asked to write a case summary, describing the SFT work undertaken with one client in their clinical area. The content of the case summary was indicative of the impact the course had made on the trainee's clinical practice. The two course facilitators (S.J., C.S.) judged the summaries (pass/fail) according to the degree to which the trainees demonstrated fidelity to SFT, as set out in the assignment requirements shown in Appendix 2.
- The assessment of clinical work was backed up with an audit of nursing notes. At the time of the commencement of study, the Tidal Model (Barker 2000, 2001) had been used in clinical areas covered by the present study for over 2 years. This model required nurses and clients to work collaboratively to develop and document the individual plan of care. The trainees' care plans were audited for evidence of the use of SFT interventions, using the following criteria:
  - Well documented** – Writes that solution-focused session has taken place. The problem the client chose to focus upon is clearly documented. The client's choice of assignment is noted.
  - Poorly documented** – May document that a 1 : 1 sessions has taken place but does not state that it was solution-focused specifically. There may be a list of the client's problems but it is not stated which problem the client chose to focus upon. Solutions to problems may be recorded but the negotiated assignment is not reported.
  - Missing/not completed** – There are blank areas on the form. There is no documentation of the solution-focused session. There is only part, or no documentation related to the negotiated assignment.
  - Refused to document** – The nurse has actively refused to fill in a care plan with the client.
- The client's experience of being involved in SFT also was elicited. (Ethical approval was obtained for this aspect of the study and course trainees gained informed consent from the clients with whom they were planning to work.) Once the SFT intervention

was completed, clients completed a brief questionnaire regarding the effectiveness of the session (see Appendix 3).

- Trainees were asked to fill in a brief evaluation questionnaire, which assessed the impact of the course on their everyday nursing practice (see Appendix 4).

## Course materials

The course was focused on the use of specifically tailored educational materials (© Barker 2001), which comprised a semi-self-directed learning course handbook augmented by a series of videotape programmes. Prior to the study, the teaching materials were piloted with a group of senior mental health nursing staff from within a Mental Health Trust who suggested only minor changes.

### Handbook

The handbook was intended for use in conjunction with the viewing of video series. Along with each programme, there were a number of formative assignments to be undertaken by the individual, in pairs or in small groups. Some of the programmes required the trainee to participate in role-play sessions. Through role-play, trainees had the chance to practise skills and to experience solution-focused work from the client's perspective, before attempting to use SFT in the clinical setting. Space for general discussion was built into the programme.

### The videos

The videos contained footage of a solution-focused therapist talking to people about their problems of living, whether service users or professionals. This enabled the trainees to view the therapeutic process in action.

All trainees found the course material 'easy to use', suggesting that the first objective (user-friendliness) had been met. There was some constructive criticism regarding the length and number of videos shown during the course. In future, it may be beneficial to hold the course over a longer time span, with smaller sections, perhaps also reducing the length of some of the live video sessions.

## Course delivery

Three SFT courses were run between April and July of 2002. Fifteen qualified mental health nurses working in acute inpatient areas in Newcastle, Northumberland and North Tyneside National Health Service Mental Health Trust (NNN Trust) attended. A further eight qualified nursing staff attended from Mental Health Concern, a

charity with several group homes within the community, which had until recently been in partnership with NNN Trust. Because of practice demands, the trainees were not randomly selected, but represented a convenience sample in that they were available and willing to attend the course. The trainees had diverse profiles, with 65% ( $n = 15$ ) having an RMN qualification, 30% ( $n = 7$ ) had Dip. HE (MH) and 4% ( $n = 1$ ) EN (M) (these and the following figures do not total 100% owing to rounding). The majority (61%,  $n = 14$ ) were practising at E grade. D grades made up for 17% ( $n = 4$ ) of the course attendees, while 13% ( $n = 3$ ) were a grade F, 4% a G ( $n = 1$ ) and 4% ( $n = 1$ ) an H. Only one of the course members had a post-graduate academic qualification. The number of years of experience working within mental health ranged from 18 months to 25 years. The average number of years of experience was 11. The course was run over 20 hours, made up of two full days and a half day consolidation. The course was not a solely classroom-based learning exercise. The DoH (1999) stresses the importance of ensuring that post-registration education for a nurse is not only based within higher education institutions. The authors recognized the importance of practice-based training within the acute mental health ward setting (Parsons & Barker 2000). Trainees had to take their newly acquired, or further developed, skills back into the clinical environment to complete the course assignments identified above.

As well as steering the evaluation, the facilitator's role was to stimulate active learning through discussion, role-play, feedback, etc., within a relaxed and informal learning environment. Solution-focused therapy in the clinical arena is best suited to 'the language of conversation' as reported by Barker (1999, p. 110) and it was decided that this should be mirrored within the learning environment. Feedback from trainees was positive. For example:

Very relaxed, friendly atmosphere. Made to feel at ease.  
A very positive and helpful course to attend – Thank You (Nurse 2).

## Results

### Assessment of solution-focused therapy knowledge

Eleven out of the 23 course trainees complete both the pre- and post-course test. There was a high level of inter-rater reliability ( $r = 0.9$ ) in marking the test. This was established by using the first cohort of trainees to discuss and agree the marking schema and gain a level of agreement in independent marking. Table 1 displays the pre- and post-course SFT test results for the three cohorts. Means and standard deviations are reported as the simplest way to show group

**Table 1**  
Pre- and post-test scores for trainees for the three courses

	Pre-test % (n)	Post-test % (n)
Course 1 (n = 8)	–	75 (8) <sup>1</sup>
Course 2 (n = 7)	26 (7)	67 (6)
Course 3 (n = 8)	30 (8)	80 (5)
Overall (n = 23)	28 (15)	74 (19)

<sup>1</sup>Disregarded in Wilcoxon Test and means and SDs reported.

**Table 2**  
Audit of care plan B (groups 1 and 2 only, n = 15)

	% (n)
Pass (well documented)	47 (7)
Fail (poorly documented)	20 (3)
Unfilled/missing (not completed)	26 (4)
Refused to document	7 (1)

NB: care plan B is not used in Mental Health Concern homes.

behaviour, although medians and ranges are often given alongside nonparametric tests.

There was a significant difference ( $P < 0.01$ ;  $n = 11$ ) between the scores on the pre- and post-test. The mean 'knowledge score' for the pre-test was 28% (SD = 16.4;  $n = 15$ ) and the post-test 74% (SD = 15.6;  $n = 11$ ).

### The nurses' reflective review of a solution-focused therapy session with a client

All candidates passed the written assignment, indicating that there was a real and positive impact on the trainees' clinical practice.

### Audit of nursing documentation

Table 2 shows the results of the audit.

### The client's perspective

Fifteen clients (65%) agreed to take part in the study by completing a short questionnaire relating to their experience of SFT. The results of this part of the study were very positive. Seventy-four per cent of clients thought that the nurse had focused on their problem. Twenty-six per cent said that the nurse has sometimes focused on their problem. Half the clients found the session 'totally' helpful while the remaining found it 'helpful'. Clients were happy with the SFT session offered by nurses on the course, as indicated by the following quotes that are divided into four main groups:

1. focusing on the problem;
2. looking forwards;
3. making the client comfortable;
4. uplifting mood.

### Focusing on the problem

The first five quotes indicate that the nurse was able to focus the session on problems the client had identified:

It was helpful in that he tried to address the problem in hand (Client 1).

Giving a sympathetic ear to my problems giving encouragement to thinking things out. Helping putting my problems into context (Client 2).

The nurse was empathic and practical in approaching problems and finding resolutions. The questions asked were pertinent and helped to clarify matters (Client 3).

It helps to focus in on a problem and find a new way to work with it. It can improve my mood through being encouraged in a positive way (Client 4).

Opportunity to discuss the problem and focus on it. Also provided the opportunity to discuss possible solutions (Client 5).

### Looking to the future

The next four quotes relate to the nurses' ability to move the clients thoughts towards the future. This suggests that nurses were effectively giving the client hope:

X made a scale of 1–10 and she helped me believe I'm stronger than I thought and has helped me believe I can gradually get a bit further ahead in the future (Client 6).

I was able to look at what I needed to do next (Client 8).

I thought numbers helpful to visualise, plus scale and 'one step beyond'. Numbers and diagrams of when and number of cigarettes, now, ideal and 8 on scale and proposed (Client 9).

She covered most issues regarding my present situation and looking towards the future (Client 10).

### Making the client comfortable

The nurses were able to make the client comfortable during the SFT session. Being nonjudgemental was important to clients too. This is shown by the following two quotes:

I found the time spent with X very beneficial. She had a nice relaxed approach and made me feel comfortable. She didn't push or pry. She just seemed to point the discussion in the right direction, which made it easy for me to try and explain my feelings. At the end of the chat she recounted what we had discussed and gave the impression that she fully understood the way I feel (Client 7).

It helps to be able to talk with someone who is non-judgemental and able to rationalise my fears. Also she was aware that my thoughts, etc. were a normal feature in my illness and she helped support me and this made me feel better (Client 12).

### Uplifting mood

Three quotes concerned the clients' mood after the session:

I feel a bit more positive about things (Client 11).  
Mood became buoyant (Client 13).  
. . . she helped support me and this made me feel better  
(Client 12).

### The trainees' evaluation of the course

All of those attending the course rated the course as very useful or excellent. Eighty-three per cent said that they would continue to use SFT within their clinical work.

## Discussion

The DoH (1999) report, *Mental Health Nursing: Acute Concerns*, identified gaps in the knowledge, skills and attitudes of mental health nurses, which were not met by some educational programmes. In assessing what happened when a SFT training course was developed and the practice implemented, the authors aimed to ensure that these three areas were examined and that the clients' experiences were foregrounded.

There was a significant increase in SFT knowledge shown within the comparison of pre- and post-course knowledge scores. To date, only 11 trainees have been tested (pre and post) in relation to SFT knowledge. This is a small, yet significant, sample, but a larger sample would be needed to better assess the SFT training.

The trainees' skill potential within the clinical environment was assessed in three ways:

1. The trainees documented their experiences by reflecting on the SFT process and the effects this had on the client and themselves as a clinician. Overall, they were able to present reflective and competent case studies.
2. Trainees were asked to document their SFT nursing intervention in the nursing notes. However, half either did not do so, or did so poorly. It would seem that the trainees had enacted the care but had failed to record the intervention. Weight is given to this argument by the fact that all 15 nurses had completed the written assignment and all 15 clients had agreed to complete their questionnaire.
3. Finally, the clients involved with the trainees provided an assessment. Carter *et al.* (1995) noted that the assessment of clients' satisfaction with a service or a session is value laden. Clients might be concerned, for example, that their feedback might cause the trainee to fail the course. However, complete avoidance of bias is impossible when researching peoples' opinions (Strauss & Corbin 1998). Ultimately, the only person able to judge the value of any therapeutic contact is the person receiving it (Liss 1993). Analyses of the qualitative comments by clients, however, do mirror the SFT process, suggest-

ing that the trainees were employing these processes during the contact with the client. The quality of clients' responses to the SFT session (reported above) suggests a genuine appreciation of the experience of SFT.

All those involved evaluated the course positively as a whole. All those attending rated the course as either 'very useful' or 'excellent'. The vast majority of trainees said that they would use SFT within their future work.

This study followed 23 trainees through the SFT course. However, this represents only a small proportion of the numbers of nurses working within the NNN Trust. If, as Vaughn *et al.* (1995) advocate, SFT is to be embraced as a nursing culture rather than just a therapeutic tool then many more staff will need to be aware of the SFT processes and the implications these have on working with clients in their care.

In relation to implications for practice, there has been criticism from DoH (1999) that university- and college-based nurse education courses bear little relevance to what actually happens in the clinical work place. As the SFT course bridged the gap between classroom and ward, learning was easily transferable into achievable practice goals. However, documentation of SFT sessions was poor within clinical areas. As documentation of all nursing activity is a legal and professional requirement, it is important that this is addressed as part of implementing SFT.

The solution-oriented approach, which already is established philosophically within the Tidal Model (Barker 2001, 2002), represents something of a psychotherapeutic paradigm shift. Rather than approaching people as if they require 'fixing', this approach assumes that they person already has all the resources needed to resolve current problems. In that sense, it operates from a discretely 'empowering' base and, as a result, the positive feedback from the clients was, to some extent, to be expected. In terms of specific forms of therapeutic engagement, the solution-oriented approach may provide the basis for the development of genuinely 'empowering' forms of nursing care in acute settings.

## Conclusions

The aim of the study was to provide training to qualified nurses in the use of SFT within an inpatient psychiatric setting and to assess the impact on nurses themselves and on client care experience. The results indicate that both nurses and clients found SFT a helpful approach. Clients reported sessions more focused on their problems. They felt listened to and understood. Following a SFT session, clients talked of feeling uplifted in their mood and there was a sense that clients were more able to look forwards in their lives. These findings are similar to those of Vaughn *et al.* (1995), who

had reported that clients felt 'empowered' by the sessions. Nurses too found SFT sessions beneficial to their work with the client, as did the trainees of Vaughn's study. The majority of nurses stated that they would continue to use SFT in their clinical areas.

## Acknowledgments

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## References

- Barker P. (1999) *Talking Cures: A Guide to the Psychotherapies for Health Care Professionals*. NT Books, London.
- Barker P. (2000) *The Tidal Model: Theory and Practice*. University of Newcastle, Newcastle Upon Tyne.
- Barker P. (2001) The Tidal Model: Developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing* 8, 233–240.
- Barker P. (2002) The Tidal Model: The healing potential of metaphor within the patient's narrative. *Journal of Psychosocial Nursing* 4, 7.
- Barker P. & Stevenson C. (2002) A response to Gamble and Wellman. *Journal of Psychiatric and Mental Health Nursing* 9, 743–745.
- Carter M.F., Crosby C. *et al.* (1995) A patient-centred assessment of needs assessment. *Journal of Mental Health* 4, 383–394.
- Department of Health (DoH) (1999) *Mental Health Nursing: Acute Concerns*. DoH, London.
- Department of Health (DoH) (2002) *Mental Health Policy Implementation Guide: Adult Acute In-Patient Care Provision*. DoH, London.
- Liss P.E. (1993) *Health Care Needs*. Avebury Press, Aldershot.
- Mohr W.K. (1999) Beyond cause and effect. *Journal of Child and Adolescent Psychiatric Nursing* 12, 118–127.
- Montgomery C. & Webster D. (1993) Caring and nursing meta-paradigm: can they survive in the area of managed care? *Perspectives in Psychiatric Nursing* 29, 5–12.
- Parsons S. & Barker P. (2000) The Phil Hearne Course: An evaluation of a multidisciplinary mental health education programme for clinical practitioners. *Journal of Psychiatric and Mental Health Nursing* 7, 101–108.
- Sainsbury Centre for Mental Health (1998) *Acute Problems: A Survey of the Quality of Care in Acute Psychiatric Wards*. SCMH, London.
- Strauss A. & Corbin J. (1998) *Basics of Qualitative Research*. Sage Publications, London.
- Tuyn L. (1992) Solution-oriented therapy and Rogerian nursing science: An integrated approach. *Archives of Psychiatric Nursing* 6, 83–89.
- Vaughn K., Webster D.C. *et al.* (1995) Brief inpatient psychiatric treatment: Finding solutions. *Issues in Mental Health Nursing* 16, 519–531.
- Webster D. (1990) Solution-focused approach in psychiatric/mental health nursing. *Perspectives in Psychiatric Care* 26, 17–21.
- Webster D.C., Vaughn K. & Martinez R. (1994) Introducing solution-focused approaches to staff in inpatient psychiatric setting. *Archives of Psychiatric Nursing* 8, 254–261.

## Appendix 1

### Pre-course test/Marking Strategy (Max score/60)

1. What do you need to know about the client before the session? (5 marks)

*Name – nothing else (5)*

2. In order to gain rapport with the client what questions might you ask? (5 marks)

*Problem free talk (1)*

*Express an interest (1)*

*Notice strengths and changes, however small (1)*

*Chat that is unrelated to the problem (2)*

3. Having found out about the person's problems how would you take them from the *past* and into the *future*? (5 marks)

*Look for exceptions to the problem rule (1)*

*Describe what life would be like without the problem (1)*

*Miracle question (1)*

*How will it feel (1)*

*Scaling (1)*

4. When looking for 'exceptions to the problem rule' what is the therapist trying to do? (4 marks)

*Look for times when the problem did not exist, was less of a problem (2)*

*Find 'keys' to the solutions (2)*

5. How would you help the person gain a 'perspective' on their problem? (3 marks)

*Scale question (1)*

*Identify where the 'solution' stands in relation to the worst times (1)*

*Get the person to identify where they stand now (1)*

6. Describe how you would take the person 'one step beyond' their problems? (4 marks)

*Get the person to describe what they need to do to step up on the scale (1)*

*What would it feel like? (1)*

*What would others notice? (1)*

*What would others need to be doing to help? (1)*

7. What is the purpose of 'the miracle question'? (3 marks)

*To help the person visualise life without the problem (1)*

*Imagine life problem free (1)*

*Explore in detail a problem free life (1)*

8. What is the 'therapeutic gift'? (4 marks)

*Positive reinforcement of their ability to deal with problems in the past (1)*

*What the therapist has learnt from the client is enhanced then returned to the client (1)*

*Review of the person's story highlighting how they are dealing with the problem (1)*

*Acknowledge the person's wisdom in knowing what needs to happen (1)*

9. What do you think it means for the client to be given an 'assignment'? (4 marks)

*Keep them thinking about the session (1)*

*Keep them noticing changes (1)*

*Let them be creative (1)*

*Gives them control (1)*

10. Which one of these statements describes the core empowerment assumption? (5 marks)

a) The person cannot make rational choices (0)

b) The person is able to make personally appropriate choices (5).

11. How would you show the person that you view them as an equal? (10 marks)

*Active listening (1)*

*Be relaxed (1)*

*Don't use jargon (1)*

*Be interested (1)*

*Don't judge the person (1)*

*Use the client's own words (1)*

*Appreciate that they are experts on their own life (1)*

*Don't give advice (1)*

*Let the client guide the topic of conversation (1)*

*Any other (1)*

12. How would you show the person that they are 'experts' on their own life? (5 marks)

*Accept their ways of dealing with the problem (1)*

*Show them that they have found solutions in the past (1)*

*Positive feedback (1)*

*Show the person that they have been doing the hard work (1)*

*Do not give advice (1)*

13. Suggest two ways of encouraging the person to take control of the therapeutic session? (3 marks)

*The person to take charge of the session time (1)*

*Let them lead the talk (1)*

*Let them be responsible for arranging future sessions (1)*

## Appendix 2

### End of course assignment

You have now completed the theory sessions underpinning solution-focussed work. It is now important that you take what you have practised back into your clinical environment. You will have a minimum of 2 weeks back on the ward in which to try out your new, or further developed, skills. During this two-week period, we would like you to undertake the following exercise working closely with one client.

### Case summary

Describe your SF work with one client (a case story). This summary needs to be approximately 1000 words long (about 4 sides of A4 paper) and MUST include the following information:

- A *description* of the person's problem, in his or her own words.
- An *account* of the steps you took with the client to help her/him to find *solutions* to the problem.
- Any *difficulties* you incurred at the time.
- Changes* which you *noted* in the person during the sessions.
- Changes* which the person *reported* in himself or herself.

The facilitator will collect these summaries during the half-day consolidation after the two-week return to the ward.

## Appendix 3

### Patient questionnaire

Thank you for agreeing to complete this short questionnaire about the care that you have been receiving. Please answer the questions below then put the form in the enclosed envelope. Please seal your envelope.

All your answers will be confidential.

Who is your named nurse?

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When you last saw your nurse what were your main concerns/problem or feelings?

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To what extent did your nurse focus on the problem? (Please circle)

Not at all	Sometimes	Totally
1	5	10

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How helpful was your last meeting with your nurse? (Please circle)

Not at all	OK	Totally
1	5	10

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If you found your time with your nurse helpful please can you give an example of how it was helpful?

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Thank you for your help. After you have sealed your envelope please hand it to one of the nurses or the ward clerk.

## Appendix 4

### Course evaluation questionnaire

How useful to your practice have you found this course? (Please circle)

1                      2                      3                      4                      5

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Not very              A bit                      Useful                      Very useful              Excellent

Will the course make a difference to your clinical practice? (Please circle)

1                      2                      3                      4                      5

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No                      Perhaps                      Some                      Yes                      Certainly

### ABOUT THE TEACHING MATERIALS

#### The manual (tick)

Easy to use?                      Yes               No   
A good reference after the course?              Yes               No   
The layout?                      Good               OK               Poor

Please write any additional comments regarding the manual here.

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#### Assignments and role plays (tick)

How did you find the assignments?              Good               OK               Poor   
How did you find the role-plays?              Useful               OK               Poor

Please write any additional comments regarding the practical assignments here.

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#### The video programmes (tick)

Were the videos informative?              Yes               No   
Did the videos support the manual?              Yes               No   
What about the quality?              Good               OK               Poor

Please write any additional comments regarding the videos here.

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Please feel free to comment on the facilitation of the course.

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