The perceptions of staff, working at the High & Intensive Care in mental health care, about inpatients' perceived unsafety

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Background Staff, working at the High Intensive Care (HIC) in mental health care, needs to be sensitive to the possibility that their inpatients feel unsafe. It is unknown if staff-members are aware of the feelings of unsafety of psychiatric inpatients.

Aim and research questions The aim of this study is to gain understanding of the perceptions of staff, regarding inpatients' perceived feelings of safety and the way staff encourages these feelings in their work in order to advance feelings of safety of psychiatric inpatients. Research questions are: (1) "What are the perceptions of staff, working at the HIC in mental health care, about patient's perceived safety?"; and (2) "In which way do staff encourage patient's perceived safety in their work?"

Method A qualitative descriptive design was chosen, using convenience sampling. Interviews with ten staff-members working at the HIC were conducted. The Grounded Theory approach was used for data analysis.

Results Two main themes arose from data-analysis: 1) awareness of staff about perceived unsafety of psychiatric inpatients; and 2) interventions and attitude of staff to advance feelings of safety.

Conclusion Differences were found in the degree of knowledge about the terminology and the perceptions of staff about inpatients' perceived feelings of unsafety. This variety in interpretation of, and dealing with, perceived unsafety implies that the staff-members of the HIC act on basis of their individual knowledge and experience. Greater awareness of staff about perceived feelings of unsafety of psychiatric inpatients is required to improve patient safety in mental health care. A consistent policy in treatment and interventions at the HIC is recommended to advance perceived feelings of safety of inpatients.

Keywords: Perceptions, staff, feelings of unsafety, psychiatry, HIC

Het perspectief van verpleegkundigen, werkzaam op de High Intensive Care in de psychiatrie, ten aanzien van gevoelens van onveiligheid van psychiatrische patiënten.

Achtergrond Verpleegkundigen, werkzaam op de High Intensive Care in de psychiatrie, moeten rekening houden met gevoelens van onveiligheid van psychiatrische patiënten. Het is onduidelijk of verpleegkundigen zich bewust zijn van ervaren gevoelens van onveiligheid van patiënten.

Doel en onderzoeksvragen Deze studie beoogd inzicht te krijgen in het perspectief van verpleegkundigen ten aanzien van de gevoelens van onveiligheid van psychiatrische patiënten en de manier waarop verpleegkundigen deze gevoelens waarborgen in hun werk. Onderzoeksvragen zijn: (1) “Wat is het perspectief van verpleegkundigen, werkzaam op een HIC in de psychiatrie, ten aanzien van gevoelens van onveiligheid van psychiatrische patiënten?”; en (2) “Hoe waarborgen verpleegkundigen gevoelens van onveiligheid van psychiatrische patiënten in hun werkzaamheden?”

Methode Deze kwalitatieve studie hanteert een generiek beschrijvend design. Data werd verzameld door interviews met tien verpleegkundigen. Om tot een beschrijving van thema’s te komen, werd gebruik gemaakt van de Grounded Theory benadering.

Resultaten Het perspectief van verpleegkundigen ten aanzien van gevoelens van onveiligheid, werd onderverdeeld in twee thema’s: (1) bewustzijn van gevoelens van onveiligheid van psychiatrische patiënten; en (2) interventies en houding van verpleegkundigen om gevoelens van onveiligheid te voorkomen.

Conclusie Verpleegkundigen hebben geen eenduidig beeld van gevoelens van onveiligheid van patiënten en zijn tijdens hun werk niet bewust bezig met het creëren van gevoelens van veiligheid van patiënten. Gevoelens van onveiligheid worden bespreekbaar gemaakt als verpleegkundigen een verandering in gedrag waarnemen. Verpleegkundigen moeten zich bewust zijn van gevoelens van onveiligheid van psychiatrische patiënten om er voor te zorgen dat de ervaren onveiligheid minder wordt. Het is aanbevolen om een consistent beleid te ontwikkelen waarin verpleegkundigen aandacht hebben voor ervaren gevoelens van onveiligheid van psychiatrische patiënten.

Trefwoorden: perspectief, personeel, gevoel van onveiligheid, psychiatrie, HIC

INTRODUCTION

Acute inpatient psychiatric care, at the High & Intensive Care (HIC), is part of mental health services. HIC provides treatment and support to those whose behavior requires immediate care, because of the risk of harm to themselves or others (Stenhouse, 2013). In 2010, 876.500 psychiatric patients received care from mental health services in The Netherlands and an estimated 17.611 psychiatric inpatients were involuntary admitted to an acute ward (GGZ Nederland, 2010). These psychiatric inpatients are vulnerable to a number of potential safety risks, related to their own behavior or to the behavior of other patients. Although patient safety includes both physical, psychological and emotional safety, patient safety is often defined in physical terms to make it possible to measure the numbers of incidents (National Patient Safety Agency 2008). This perception disregards the physiological and emotional impact of being a psychiatric inpatient (Delaney & Johnson, 2008).

Stenhouse (2013) studied the experiences of psychiatric inpatients in feeling safe in an acute psychiatric inpatient ward. Results of the study (Stenhouse, 2013) showed that psychiatric inpatients often felt unsafe. Psychiatric inpatients were unsured that staff could keep them safe. Their perceptions about safety concerned both physical and psychological safety (Stenhouse, 2013). Interestingly, the most commonly identified safety issues did not relate to physical safety, but to psychological safety. It is notable, that when Thibeault et al. (2010) asked patients about the environment on an acute ward, patients wanted to talk about their relationship with staff. This relationship is a central feature of their experience of the ward (Thibeault et al., 2010). A key role of acute mental health care is maintaining patient safety (Delaney & Johnson 2008), with much of the responsibility falling to staff (Seed et al. 2010). Staff might decrease the psychological impact of being in an acute ward and could improve the feelings of safety (Stenhouse, 2013). The question is whether a complex environment in which other inpatients do not feel safe, is conducive to promoting recovery from their mental illness (Stenhouse, 2013).

Staff needs to be sensitive to the possibility that their patients feel unsafe. It is unknown if staff are aware of the feelings of unsafety of psychiatric inpatients. There is need for understanding of the perceptions of staff on patient's feelings of safety, in order to reduce patients' feelings of unsafety.
This study will focus on the question whether nursing staff takes patients' feelings of safety into account and if they consider these feelings as an aspect of the safe,

therapeutic environment of the acute ward. Insight in the perceptions of nursing staff can improve nursing interactions with psychiatric inpatients in order to facilitate a sense of safety.

Problem statement

Before interventions could be shaped to reduce the feelings of unsafety of psychiatric inpatients, it is necessary to get insight in both perceptions of staff and psychiatric inpatients. This qualitative study aimed to obtain insight in staff' perceptions about inpatients' feelings of unsafety and the way they consider these feelings in their work.

Aim

The primary aim of this study is to gain an understanding of the perceptions of staff, working at a HIC in mental health care, regarding patients' perceived unsafety in order to advance feelings of safety of psychiatric inpatients.

The secondary aim is to investigate how staff encourages patient's perceived safety in order to reduce the feelings of unsafety.

Research questions

The following question in the study was leading: *"What are the perceptions of staff, working at the HIC in mental health care, about patient's perceived unsafety?"*

The secondary question was: *"In which way do staff encourage patient's perceived safety in their work?"*

METHODS

Design

A qualitative descriptive design (Boeije, 2010), based on the Grounded Theory approach (Polit & Beck, 2012) was chosen to investigate the research question. To gain understanding of staff perception of patient's perceived safety during their treatment, the study was conducted using semi-structured, face-to-face, in-depth interviews with staff to gather data. A topic-list, based on literature (Stenhouse 2013, Jones 2010) and discussion with an expert (L.S.), was used to make sure that every important topic was addressed. No topics were added during the study.
In the current study, conceptual categories were described in thematic descriptions. There has been no development of theory, due to the limited time available for this research.

Participants

The study population consisted of nurses and social workers working at a HIC for mental health care in The Netherlands. A convenience sample of staff from two HIC units was approached for this study. In cooperation with the manager of the HIC, all staff members of both HIC units received an information letter and were requested to participate in the study by email. Inclusion criteria: staff-members must be nurse or social workers at the HIC in mental health care. There were no exclusion criteria. A total of ten staff-members responded and met the inclusion criteria. Demographic data of included staff-members were gathered (Table 1).

[Insert Table 1]

Data collection

The researcher conducted ten interviews at the worksite of the staff-member between March and May 2014. Each interview took approximately 30 to 45 minutes and was audio recorded. During the unstructured interviews, general questions were asked inviting staff to share their perspective on patient's perceived feelings of safety. The first question was: "What comes up if you think about perceived unsafety?"
Thereafter, detailed questions were asked, which arose from actively listening to the staff-member (Boeije, 2010). A supervisor (L.S.) provided feedback on the data-collection in the first two interviews.
The researcher highlighted issues and wrote field-notes after each interview.

Ethical consideration

The study has been conducted according to the principles of the Declaration of Helsinki, Version Seoul, October 2008 (Declaration of Helsinki, 2009) and in accordance with the Medical Research Involving Human Subjects Act (WMO).
Permission for the study was obtained by sending the research proposal to the Comittee for Scientific Research of mental health care Breburg.
Staff received written and verbal information about the study, sent by the researcher. It was emphasized that participation was voluntary, confidential and could be withdrawn at any time. Written (informed) consent was gained.
Throughout the study, anonymity of staff was maintained through assignment of pseudonyms in the transcriptions. Consent was explicitly sought regarding use of quotations from data, that were used in the results. The key to the code of pseudonyms was safeguarded by the researcher and supervisor (L.S.).

Data analysis

After each interview, data were transcribed verbatim for analysis. Transcripts were sent by email to the participants as a member-check. In this member check, interviewed staff-members were asked for agreement in order to achieve member-validation for credibility of the results (Polit & Beck, 2012). After agreement, data were analyzed using the analytical steps (open, axial and selective coding) described by Creswell (2007). At first, data were divided into codes. These codes were compared, grouped into categories and were labeled with a subtheme. Thereafter, properties and dimensions of main themes were specified. Finally, during selective coding, connections between the themes were reassembled (Creswell, 2007). Throughout this process, there was a constant comparison with data. Data analysis was conducted iteratively with data-collection (Boeije, 2010). This process of data-analysis was discussed with the supervisor (L.S). The first two interviews were both independently coded by the researcher and a supervisor (L.S.) to check inter-coder agreement. Both, discussion and the check of inter-coder agreement constituted researcher triangulation and increased reliability of data-analysis. Differences were discussed until agreement was established. Saturation was achieved after the tenth interview, in which no new additional information emerged (Polit & Beck, 2012).

The qualitative software program QSR NVivo 10 was used for data-analysis.
The consolidated criteria for reporting qualitative research (COREQ) were used to ensure that the study meets appropriate standards for qualitative research.

RESULTS

Two main themes arose from analyzing the transcribed interviews: 1) awareness of staff about perceived unsafety of psychiatric inpatients; and 2) interventions and attitude of staff to advance feelings of safety or prevent feelings of unsafety of psychiatric inpatients (Table 2).

[Insert Table 2]

Theme: Awareness

Three categories emerged around this theme: (1) recognition; (2) behavior of inpatients which perceived unsafety; and (3) causes for perceived unsafety.

Recognition

All staff-members were asked for their perceptions about psychiatric inpatients perceived feelings of unsafety. Not every staff-member answered this question immediately. They needed some time to answer the question or asked for explanation about the terminology. Some staff-members indicated that they did not recognize the terminology “feelings of perceived unsafety” or they identified the questions about perceived unsafety as difficult questions.

Not all staff-members were aware of perceived feelings of unsafety of psychiatric inpatients. Differences were found in the way staff recognizes and deals with inpatients’ perceived feelings of unsafety in their work. Despite the differences in the degree of knowledge about the terminology and awareness of perceived unsafety, staff came up with descriptions in the behavior of inpatients if they perceived unsafety and causes of perceived unsafety of inpatients.

Behavior

Staff identified two contrasting kinds of behavior as result of perceived unsafety: (1) inpatients avoid common areas at a HIC and stay in their sleeping rooms; and (2) some inpatients force contact with other inpatients and manifest themselves at the HIC.

Furthermore, staff identified that inpatients show both nonverbal and verbal behavior when feelings of unsafety are perceived. According to staff, avoiding contact and a

closed attitude were recognized as nonverbal behavior of psychiatric inpatients. Verbal behavior was indicated by staff if inpatients came up to discuss perceived feelings of unsafety by themselves. Inpatients share and discuss their feelings of unsafety with staff-members on a regular basis.

Causes

The third category presented on the causes of perceived feelings of unsafety. According to staff, those feelings are a result of both internal and external factors. The mental disease and the current state of wellbeing were identified as internal factors. Especially, in the case of inpatients with psychotic diseases. Staff suggested that psychotic experiences give inpatients feelings of fear, which result in feelings of unsafety.

On the other hand, a different kind of external factors was identified by staff. For example, the negative atmosphere at a HIC, the influence to see or hear the aggressive behavior of other inpatients, feelings of dependence, the importance of clarity and prior admissions to a HIC.

Staff suggested that negative feelings or tension, created by patients' aggressive behavior, can result in a negative atmosphere. A negative atmosphere creates feelings of unsafety and influences other inpatients in their state of wellbeing. Some staff-members assumed that inpatients experience the fact that they cannot exit the HIC freely. Inpatients have feelings of being locked up which result in feelings of dependence of staff. According to staff, these feelings of dependence result in perceived unsafety. This feature is even more pronounced when a certain inpatient experiences due to their current illness, as well as negative feelings due to prior experiences at a HIC.

Some staff-members identified that the number of prior admissions in mental health care affects inpatients perceived feelings of unsafety. The experience in feeling safe differs for inpatients who are admitted at a HIC in mental health care for the first time, compared to inpatients that were admitted more than once at a HIC. According to staff, inpatients who are admitted for the first time perceived more feelings of unsafety because of new experiences.

Theme: Interventions and attitude

There are two categories within this theme: (1) collaboration; and (2) communication between staff and the inpatient.

Collaboration

All staff-members were aware of the responsibility to keep inpatients safe. However, the interventions identified by staff-members for creating a safe environment for inpatients vary widely. Staff suggested that both staff and inpatient have to invest in a mutual collaboration. According to staff, collaboration is necessary at a HIC to advance perceived safety. They assumed that they create several opportunities for inpatients to develop such collaboration. Especially, the attitude of staff was identified as one of the most important interventions to develop a fruitful collaboration. Trust is, according to staff, the essential ingredient for the development of a mutual collaboration. Staff assumed patients will not discuss everything with them and stated that inpatients are not totally honest about their current state of wellbeing and perceived feelings of unsafety.

The importance of being present in the common areas on the ward was named by all staff members as an essential factor. They assumed that psychiatric inpatients perceived increased feelings of safety, when staff is present on the ward constantly. According to staff, just being present at the ward is already an intervention that provides inpatients the opportunity to discuss their feelings. Some staff-members mentioned the five minutes intervention. In this intervention, individual contact is made with all psychiatric inpatients on their ward, in the beginning of every shift. They suggested that this strategy creates clarity about the presence of staff. Moreover, when staff constantly observes inpatients on the ward, staff identified they are able to recognize changes in behavior of individual inpatients or changes in the group dynamics.

Furthermore, interest, transparency and clarity, calmness and sense of humor were identified as factors of importance in the possibility to create and provoke a fruitful collaboration between staff and the inpatient.

Communication

During a work-shift, all staff-members attempted to speak with all inpatients at a HIC individually. During these individual moments, staff discusses the current state of

wellbeing with the inpatient and reflects on that state with colleagues. Furthermore staff stated that opportunities for inpatients are created to discuss feelings of unsafety. However, staff also stated that they did not specifically ask inpatients for perceived feelings of unsafety. They suggested that the fact that patients are encouraged to share their feelings, will ensure that such feelings are shared with them. When staff identifies perceived feelings of unsafety in the behavior of inpatients by themselves, they feel responsible to discuss their observations with inpatients. Some staff-members talked about transparency and clarity. They noticed the importance of being transparent and clear in the chosen interventions and treatment. According to them perceived unsafety can be prevented or diminished by being transparent and clear about treatment, interventions, rules at a HIC and consequences if inpatients do not confirm these rules.

All staff-members noticed the importance of awareness for the impact and influence of aggressive behavior or incidents at a HIC. Elaborating on this, some staff members identified calmness as an important aspect to reduce feelings of unsafety of inpatients during an aggressive incident. After each incident, staff-members mentioned they pay attention to all inpatients to ensure that they can share their experiences in order to reestablish and advance feelings of safety.

At last, sense of humor was named by some staff-members. Staff suggested that a positive, relaxed atmosphere creates the possibility for inpatients to discuss their feelings. Staff-members assumed that such an environment enhances the change that inpatients share their perceived feelings of safety on their own accord.

DISCUSSION

In the current study, perceptions of staff working at a HIC in mental health care, regarding inpatient's perceived unsafety were investigated. Differences were found in the knowledge of staff about the terminology of perceived safety. Some staff-members indicated that they did not recognize the terminology “feelings of perceived unsafety”. Results suggest that staff is not directly aware of perceived feelings of unsafety of psychiatric inpatients. Staff identified the importance of a staff-patient relationship and is interested in the current state of wellbeing; however, staff did not discuss perceived feelings of unsafety with patients.

Brickell et al. (2011) showed the importance to develop awareness and strategies for responding to patient safety incidents in mental health care. The presence of a consistent policy with workable protocols and guidelines regarding perceived unsafety is an essential part in establishing a culture of patient safety (Brickwell et al., 2011). These policies or solutions were not encountered during the current study. Results identified a lack of clinical guidelines or implemented interventions in paying attention to inpatients’ perceived feelings of safety. Observations in the behavior of inpatients are the trigger to pay attention to inpatients which might perceive unsafety. Interventions that were shaped are based on experience, knowledge and feelings of staff themselves. Staff has the intention to develop relationships with inpatients, where they can discuss perceived feelings of unsafety. Due to the development of these relationships possibilities are created for inpatients to share perceived feelings of unsafety. However, perceived unsafety is not a common part of the discussion in the development of interventions. Initiatives which do not have clearly defined objectives are unlikely to achieve desired results (Brickell et al., 2011). There is need for a clear understanding of what perceived unsafety in mental health entails (Brickell, 2011). The absence of a definition of inpatient perceived unsafety contributes to confusion over what safety is covered by the term (Brickell et al., 2011).

Staff should involve psychiatric inpatients more in the structure and build-up of their treatment and have to discuss perceived feelings of unsafety. An important aspect of the approach of staff is the degree to which patients are involved in decision making concerning the treatment (Delaney, 2012). Environmental, treatment-related or interactional factors influence the cooperation and the confidence between staff and inpatients (Jansen et al., 2005). Interestingly, results of the study of Stenhouse

(2013) about the expectations and experiences of inpatients in mental health care showed that patients did not always feel safe to discuss their feelings with staff. Staff needs to understand and accept their responsibility for the creation of a safe and therapeutic environment on the ward (Alexander J., 2006) and needs to be sensitive and aware of the possibility that their patients feel unsafe (Stenhouse, 2013). Therapeutic interventions need to be developed based on consistency, security, trust and the encouraging of a positive patient outcome in order to advance perceived safety (Zuzelo et al., 2012).

Strengths and limitations

A strength of the current study is the use of member-validation in data-collection and a software program for qualitative data-analysis. A member-check ensured the authenticity of the data and the credibility in qualitative research. There was no preconceived code tree. The code tree is developed during the study by arranging and rearranging the codes, categories and themes in discussion with a supervisor. Encoding of the interviews with NVivo made it possible to analyze data with less chance of error.

In order to appreciate the strengths of this study, some limitations need to be considered. Data-collection and data-analysis were conducted by one researcher. The researcher was not totally independent in research because of the fact the researcher had clinical experience in mental health care. This may imply that the researcher was not always unprejudiced during the data-collection and data-analysis. However, both data-collection and data-analysis were discussed with an independent expert, who had no experience in mental health care. Furthermore, an expert provided feedback in the way of interviewing and two interviews were coded separately, to check inter-rater reliability. Recommendations which arose were implemented in the following interviews. This provided an independent external audit of the research and increased the quality of the study.

CONCLUSION

This study described the perceptions of staff, working at a HIC in mental health care, about inpatient's perceived safety. Differences were found in the degree of knowledge about the terminology and the perceptions of staff about inpatients' perceived feelings of unsafety. This variety in interpretation of, and dealing with, perceived unsafety implies that the staff-members of a HIC act on basis of their individual knowledge and experience.

Recommendations

Greater awareness of staff about perceived feelings of unsafety of psychiatric inpatients is required to improve patient safety in mental health care. Staff-members need to be aware of perceived unsafety of psychiatric inpatients in order to reduce these feelings. A consistent policy in treatment and interventions at a HIC in mental health care is recommended to advance perceived safety of psychiatric inpatients. Staff needs to examine ward practices that challenge patients' sense of safety.

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TABELS

Table 1. Characteristics of interviewed staff-members (N=10)

Characteristics of staff	N	Mean
Gender		
Male	6	
Female	4	
Age		35.4 (11,33)
Total work experience mental health care (years)		
<10	8	
10-20	-	
>20	2	
Work experience High Intensive Care (years)		
<5	8	
5-10	1	
>10	1	

Table 2. Themes, categories, codes and illustrative quotations after analyzing the transcribed interviews

THEME	CATEGORY	CODES	QUOTATIONS
Awareness	Recognition	Terminology	Resp. 3: “Perceived feeling of safety? I don’t know the terminology.” Resp. 5: “Perceived feelings of safety (moment of silence). Uuh, sounds like a new word for me.” Korver: When you look at yourself, are you conscious of the fact that, uh, are you referring to the sense of unsafety of the client? Resp. 6: Yes. It is contradictory, but I am aware of that, even though I do not ask the question consciously. It’s just, I try to notice. Korver: How would you say clients would describe the sense of unsafety? Resp. 1: Tough one, especially because I am not used to pinpointing the subject. I normally do not ask for a person’s perception of safety.
	Behavior	Inpatients avoided common areas Inpatients force contact with other inpatients and manifested themselves Nonverbal and verbal behavior	Korver: So, how do you feel about it then? Especially about feelings of fear. Resp. 1: Well, uhm, you notice that people get restrained, reticent even. Resp. 6: Actually, in my experience, patients who feel unsafe would generally put themself forward and attract attention, especially young men. This attitude bothers me. Resp. 1: Especially since I work at the HIC in mental health care I wonder if our patients actually reveal their true emotions. Korver: Do they mention it explicitly, or to you notice it in their behaviour? Resp. 3: Yes, they mention it. Some show it in their behaviour as well; they get anxious and walk around a lot and come to us, the nurses. Resp. 2: You just notice, even though they don’t tell you.
	Causes	Internal factors External Factors: • Negative atmosphere • Aggressive behavior	Resp. 2: Mostly due to their illness, like a psychosis. That makes them feel scared. Resp. 1: Mostly because they do not know what is coming. Resp. 1: Sometimes people are at ease and quite open to others, but they get scared if things are busy in the department. Afterwards they mention that they do not feel at ease due to their surroundings. Resp. 2: An aggressive act by one client can have a long-lasting effect on the group.

		• Feelings of dependence • Prior admissions	Resp. 2: Or, due to a new client who behaves aggressively. It even happens with patients who come back from a so called 'acting out'. You can actually feel the tension when that person enters the room for the first time. Resp. 2: I see why people feel anxious then, they have been through a lot. Resp. 4: It's hard to imagine their situation; all of the sudden, they depend on us. Say they want to go for a walk, they need us to hand them the key. Resp. 9: I see why this creates a feeling of uncertainty and unsafety; clients do not know what awaits them.
Interventions and attitude	Collaboration	Feelings of responsibility Trust Accessible	Korver: When you look at yourself, are you conscious of the fact that, uh, are you referring to the sense of unsafety of the client? Resp. 6: Yes. It is contradictory, but I am aware of that, even though I do not ask the question consciously. It's just, I try to notice. Resp. 1: It was not a deliberate decision to avoid that question. The reason for that would be that I am, how do I put it, like to create a situation fit for discussion and cover the topic. Resp. 3: I try to create a sense of trust, make them feel at home. Resp. 8: The most important thing is to be around; once they notice that you are there, and that you have the key, they feel more at ease. Resp. 8: It is comforting to know that someone is around, just in case you need help.
	Communication	Interest Transparency and clarity Calmness Sense of humor	Resp. 2: I show them that I care, that I am interested. Resp. 9: I try to explain why we act as we do. And I tell them it is OK to express their feelings, should they desire to do so. Resp. 2: It helps to create a positive vibe, a good mood. Korver: Would it help to make a joke, every now and then? Resp. 10: Yes, it's good to unwind, to relax.