Keeping the Unit Safe: Mapping Psychiatric Nursing Skills

Kathleen R. Delaney and Mary E. Johnson

BACKGROUND: The de-escalation skills of inpatient psychiatric nurses are considered key to violence prevention. Yet their efficacy and translation into practice remains in question. OBJECTIVE: The aim of this study is to describe the de-escalation skills of psychiatric nurses. In the process, the investigators uncover ways nurses interact with patients to create and maintain a safe environment. STUDY DESIGN: Grounded theory methods are used to collect and analyze data derived from staff interviews and direct observation of milieu interactions. RESULTS: Staff behaviors are seen to create a safe milieu and promote a positive unit culture. Skills critical to maintaining a safe environment center on nurses’ awareness, attending, caring, and connecting. CONCLUSIONS: The behaviors identified in this study are at the heart of managing the clinical context of acute psychiatric units. Attention to these behaviors is especially critical in light of the staff expertise needed to keep the unit safe. J Am Psychiatr Nurses Assoc, 2006; 12(4), 198-207. DOI: 10.1177/1078390306294462

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Violence on psychiatric units continues to be a significant issue for both patients and nursing staff (Duxbury & Whittington, 2005; Flannery & Walker, 2003; Nijman, Bowers, Oud, & Jansen, 2005). The issue of violence is often tied to restraint use, which itself carries significant psychological and physical risk (Bonner, Lowe, Rawcliffe, & Wellman, 2002; Mohr, Petti, & Mohr, 2003; Paterson et al., 2003). In the past 2 decades, clinicians have embraced the use of de-escalation strategies as key to both violence prevention and restraint reduction (Calabro, Mackey, & Williams, 2002; Cowin et al., 2003; Huckshorn, 2004). Although the techniques have intuitive appeal, there is actually scant research on their efficacy in either restraint reduction or violence prevention (Morrison & Love, 2003). Although many training programs exist to educate staff in these techniques, questions remain about their translation into practice and the standardization of de-escalation methods (Duxbury & Whittington, 2005). The aim of this study is to increase knowledge of how nurses enact de-escalation strategies on inpatient psychiatric units. Inasmuch as de-escalation events are often embedded in the flow of milieu interaction, the study is designed to observe naturally occurring interactions on inpatient psychiatric units and to gather staff and patient perceptions about such incidents.

STUDY PURPOSE

The purpose of this study is to construct a substantive theory of the de-escalation process by observing how nurses handled volatile situations, ones where patients were dysregulated, threatening, or aggressive. Using qualitative methods, the investigators (a) describe the context of these tense, volatile situations and (b) identify the interventions that nurses used to de-escalate situations. As the study progressed, what emerged as the core category of the study was a multidimensional process titled Keeping the Unit Safe. Its context and dimensions are detailed in a previous publication (Johnson & Delaney, 2006). This article presents the data connected to the second aim, to describe the
strategies used to handle volatile situations and keep the unit safe.

**RESEARCH PROCESS**

This qualitative study used grounded theory methods to access, observe, and understand the de-escalation strategies of inpatient nurses. The study sites were two inpatient psychiatric units that treat individuals with serious mental illness. Both units rarely used mechanical restraints and did so only when the patient posed a serious threat to self or others. The units differed in several aspects. Unit A was housed in a large, university-affiliated medical center, and its staffing plan ranged from a 2:1 to 3:1 patient-to-staff ratio. Unit B was slightly larger, housed in a general medical hospital that is part of a nonprofit hospital chain, and its staffing plan ranged from a 4:1 to 5:1 patient-to-staff ratio. As data analysis progressed, what surfaced were the similarities in unit culture, staff’s approach to patients, and the basic social process of keeping the unit safe.

Data collection was consistent with grounded theory methods, which are organized so the researcher can get close to, describe, and factually represent the participants under study (Glaser & Strauss, 1967). The theoretic base was symbolic interactionism, which directs researchers to understand how people see the world, their meaning systems, and the influence of social interaction on the defining process (Blumer, 1969). In line with this framework, the data collection methods allowed for prolonged periods of observation and in-depth interviews of the participants, structured to gather their perceptions of de-escalation and the experiences that shaped those perceptions.

**Data Collection**

Following institutional review board approval, the study purpose was explained thoroughly to the staff on both units. On each day, upon arriving on the unit, the investigator would make contact with the staff and, when the schedule allowed, introduce herself to patients at the community meeting. Each day, staff were queried about the tone of the milieu and which, if any, patients were presenting particular challenges. We rarely entered the nurses’ station and while in the milieu did not engage staff in conversation about the patients. The investigators used the interview time to ask staff about specific milieu incidents.

The investigators chose a central place in the hall or day area to observe milieu interaction. While on the unit, the investigators did not initiate conversations with patients. We did respond to patient questions concerning our role on the unit and at times engaged in patient-initiated casual conversation. Mostly we sat silently in the hallway or day area. At times, particular patients choose to sit by the investigators, some sitting in silence and some talking quite a bit. Our tone was polite and attentive, but we did not respond with leading questions or a phrase encouraging elaboration.

Notes were not taken during observation times, but each hour the investigator went to a staff area and recorded topics for further elaboration. These detailed field notes were later typed and entered into the data analysis program, Atlas-ti 4.2 (Muhr, 1997). While in the milieu, the investigators noted the general tone of the unit, how patients traveled about the unit, the structure and activities, and any incidents of impending escalation or aggression. The investigators spent approximately 400 hr on the two units. To facilitate immersion in the unit process, each investigator assigned herself to a unit and remained on the same unit for the entire study.

The nonparticipant observation spanned 9 months, usually occurring in 4-hr blocks scattered throughout a week, including weekends and evenings. Times were selected to maximize the possibility of the investigators observing instances of patient aggression or dysregulation and staff’s subsequent response. For instance, one investigator often observed the milieu on Friday midday when there were usually multiple discharges and at 3 p.m. transition times when the switchover of staff created a sense of uncertainty. Even in these periods, considered by staff as tense or hectic, very few explosive incidents were observed. Instead, we came to understand how both units were organized around providing safe care that minimized escalation. Critical to this process were staff efforts to create supportive environments that served to dampen threat, thus decreasing violence. As months progressed, the study focus slowly shifted from studying specific de-escalation techniques to capturing the broader process of keeping the unit safe.

Interviews with unit staff and with patients also occurred over the 9-month observation period. Staff and patients were interviewed who were English speaking, over the age of 18, and agreed to talk about their experiences with tense or challenging situations. No staff refused to be interviewed, but at one site, 4 patients refused to be interviewed. They did not give specific reasons for their refusal nor were they pressed to provide one. All interviews were audiotaped, and written, informed consent was obtained from each participant. The interviews were unstructured; there was no interview guide. The
patient interviews began with one question, “Could you tell me about a time when you were feeling tense and a staff member helped you calm?” The staff interviews began with a similar question, asking participants to tell us about an instance when they intervened in a tense situation. The interviewers followed the progression of the participant’s stories, at times asking for elaborations on specific points. As the study focus shifted to the idea of keeping the unit safe, nurse participants were also queried about what contributed to a sense of safety on the unit. In line with theoretical sampling, we directed questions to confirm and elaborate the codes and categories emerging around keeping the unit safe. At that point, several nurses were purposively selected to be interviewed based on their years of inpatient experience; several additional interviews were conducted with staff relatively new to the unit as well as managers with 10-plus years of experience. Interviews were typed and transcribed verbatim and entered into the Atlas-ti 4.2 program.

Sixteen staff and 12 patients were interviewed. Of the staff group, 5 were mental health workers and 11 were registered nurses. The staff group was a mix of nurse managers (n = 3) and direct care staff (n = 13). The staff group represented a wide range of ages (22 to over 50) and years of tenure on the units (1-15 years). Of the patient participants, 6 were males and 6 were females, with an age range of 22 to 56. The patients carried a diagnosis of depression (n = 3), schizophrenia (n = 5), schizoaffective disorder (n = 2), and bipolar disorder (n = 2). The investigators took great care in selecting patients to be interviewed, always checking first with staff about the timing and appropriateness of approaching a particular patient. During the interview, the investigators relied on their years of clinical experience to gauge if the patient was tolerating the interview. In one instance, the investigator terminated the interview when the patient was increasingly concerned about the tape recording and appeared to be becoming agitated. Data collection stopped when the categories were saturated (Glaser, 1978; Lincoln & Guba, 1985).

Data Analysis

Interviews and field notes were coded, codes grouped into themes and then into categories, all of which were named to depict the salient aspects of a behavior, idea, incident, interventions, or approach. All data were analyzed via Atlas-ti software, which allowed for both line-by-line coding and the use of the constant comparative method to build models from the codes and categories. As the data were examined, what emerged were the various ways inpatient psychiatric nurses think about and interact with patients that were central to the process of keeping the unit safe. In line with this core category, the data were further analyzed for contexts, contingencies, covariances, and conditions (Glaser, 1978). Strategies to establish the trustworthiness of the data included prolonged engagement in the setting, triangulation of sources (patient and staff) and methods, peer debriefing between the principal and coinvestigator, and establishment of an audit trail.

INPATIENT PSYCHIATRIC NURSES’ SKILLS RELATED TO CREATING SAFETY

There exists scant research on the particular nursing skills that create a safe milieu. The majority of inpatient research approaches the matter of safety via an indirect route, through the issue of aggression management via de-escalation methods (Calabro et al., 2002; Jambunathan & Bellaire, 1996). In addition to the de-escalation literature, several investigators have tested programs that teach additional nursing skills necessary for dealing with aggressive patients (Grenyer et al., 2004; Martin, 1995; Whittington & Wykes, 1996). In a slightly different approach, nurse researchers have explored the ways expert nurses think about and approach aggressive clients and challenging situations (Carlsson, Dahlberg, & Drew, 2000; Johnson & Hauser, 2001). The findings of these studies converge on particular nursing abilities: learning to respect the client as an individual, the use of intersubjective communication, and the ability to be fully present in the situation. Using participants’ elaboration of paradigm cases, McElroy (1996) illustrated how expert nurses developed an “embodied knowing” when dealing with aggressive patients, meaning their interventions flowed not just from theory but also from a “gut response” or their intuitive sense of the patient and the entire situation.

The nurses involved in the current study displayed many of the behaviors detailed in this literature on expert practice. Rolfe (1996) maintained that to understand nursing one must examine practice on the microlevel, at how individuals react in each unique situation. To this end, we watched the subtleties of the nurses’ behaviors when interacting with patients and when simply being present in the milieu. Described here are the strategies observed at that microlevel, which are seen as key to the process of keeping the unit safe.
For the nurses in the study, their practice was marked by an awareness of patient behaviors and their attending to both particular situations and to the flow of milieu action. In the milieu, nurses maintained their focus and attention outward. We noted that even while sitting quietly in a hallway, nurses were attending to movement and noticing patients’ subtle behavioral changes. The practice of keeping one’s focus outward was named “being there.” They noticed behavior changes and often patterned a patient’s behavior, meaning over successive incidents they tracked the antecedents and the unfolding set of behaviors that composed the escalation. If the patient was known to staff, they compared the current pattern of escalation to what they knew to be the patient’s usual presentation. In this process, the staff developed a sense of a patient’s presence on the unit, which helped them gain an understanding of the current status of the individual. Via this watching and patterning, the staff also developed an attunement with patients, where the patients were psychologically and behaviorally on a particular shift. We coded this process as “getting a feel for the patient.”

I’m thinking of a particular situation in which I know that periods of escalation were occurring throughout the shift. And in this particular situation, I thought it kept from escalating, number one because I had worked with the patient before and recognized the common signs of what their escalation was like and then going back periodically and talking and calming and providing reassuring instead of waiting until it got to the point where it was really explosive . . . escalating . . . just making sure that I was in tune and noticing. ‘Cause it’s more subtle changes that you notice over time and you kind of become more receptive to.

This example illustrates another aspect of keeping the unit safe, the ongoing process of becoming aware of behaviors. Awareness of behavior does not occur simply by intently gazing outward. Nurses applied what they observed to a patient’s typical patterns of escalation. In turn, this knowing usually guided their response. As one would expect, staff picked up much quicker on behaviors of the patients that were known to them, usually patients who had been on the unit numerous times. For instance, one day a man well known to the staff began to slam his door in anger. The staff did not move. They assured the researcher that this gentleman often acted this way the first few days of hospitalization. The tension was usually over his obsession with the newspaper, and they were certain the anger would dissipate, which it did. Many such incidents unfolded in a typical day. During interviews, nurses recalled these events and consistently provided a rationale for their response and a hypothesis for why the behavior might be occurring.

On one of the units, several patients usually paced the hallways or moved in circles about the day area. In the main, the patients seemed to float by one another, unaware of the others’ presence. Staff, however, noticed when these pass-by-pacers generated strain, a tension often not obvious to the researcher. It was not necessarily the loud patients or patients with paranoia that staff viewed as potential problems. Rather, the staff particularly watched patients who knew each other from the streets, explaining that patients sometimes brought outside conflicts into the hospital. They also knew which patients had hairpin trigger reactions and what situations generated explosions, which for one unit was often competition to use one of the two public phones.

Along with developing awareness of patient behaviors, nurses also demonstrated an awareness of when the milieu was getting out of hand, when the noise, pace, and tone of interactions were building to a dangerous point.

Oh, yeah, I can hear it. Of course I can always hear it . . . I think that’s where you have to be really hypervigilant, but discreetly so. You don’t want to look like you’re a sentry, but you just kind of keep your eyes and ears open as much as possible . . . ’cause things usually happen a lot faster here.

Staff told us various ways they judged that things were getting out of hand. For instance, they could feel it in their gut or they were feeling ragged. One staff said he knew that the unit was getting too loud when the noise on the milieu caused him to repeatedly restart a progress note. At this point, he always put down his chart and walked about to see what was going on.

The category of awareness also includes the quality of awareness of oneself. During interviews, nurses and mental health workers frequently expressed their awareness of what feelings the patient and situation generated in them and how they used that knowledge. One staff member described his reaction to the noise level on the unit and how, when it seemed to be getting loud, he paused to listen for what might be going on. He explained that sometimes the patients are just having fun and sometimes they are being threatening. His interventions were based on his feel of the situation.
Interestingly, although the units contained acutely ill patients who often took on threatening postures, the staff remained generally unflapped; they rarely raised their voice or put force into their statements. When asked, the nurses attributed their calm demeanor to confidence and self-assurance they derived from knowing the patients and from the support of the nursing team, a group that had worked together for many years.

### Caring and Connecting

Staff’s efforts at keeping the unit safe meant not just being and remaining aware of patients but also intervening to help patients deal with frustrations and episodes of dysregulation. In one interview, a patient explained how staff had helped him develop a simple strategy for dealing with his mounting frustration.

They sit . . . they sit down and talk to me and explain to me things more about . . . they try and calm me down. [Patient begins to talk as staff speak to him] “You need to understand this. We have got protocols and rules and this and that.” . . . they try and make me see what I was doing . . . you know like I said earlier they were saying . . . “Try and hide your frustrations . . . your yelling and stuff.” You know what I am saying? . . . I got to humble myself like you say stay calm in special situations. ‘Cause my anger gets in my way and I cannot handle nothing. ‘Cause if I don’t stay calm . . . how am I going to be able to function in the world?

This particular patient was a young, large male who displayed explosive aggression. During the interview, he noted how he drew upon staff’s advice of walking away from frustrating situations. Moreover, this patient came to understand that the key to leaving his residence in the nursing home was learning how to control his frustration. An interesting by-product of dealing together with frustration and dysregulation was the connection it forged between patients and staff.

This seemingly small response of staff often resulted in patients experiencing being connected to and cared about. This subtle process was sometimes articulated by patients, albeit often in a terse or somewhat indirect manner. For instance, one patient discussed how when she was feeling upset, she recalled the staff asked her over and over how they could help her. She thought the staff were tired of her situation and saw their sustained inquiry as their being worried about her, something she acknowledged as important. This patient may not have used the terms caring and connecting, but as she walked through the moments of the event, it became apparent that staff overtures were both helpful and meaningful. Other times, patients expressed the sentiment directly, for example, in talking about a staff member, a patient commented, “He says hi with you or sits with you and lets you ramble all the time, man. That person lets you ramble ‘til you get calm. That person really does care for you.”

### Balancing

The nurses in the study maintained awareness not just of particular patients but also of the total milieu situation. This understanding was most obvious in the way seasoned nurses balanced the needs of the individual with the needs of the milieu. These nurses were always watching the tone and pace of the milieu as they formulated an approach to that patient, a theme we termed balancing. Balancing occurred as nurses moved through their thinking as they considered whether and how to respond to challenging behaviors. Often, staff’s nonresponse became the more intriguing aspect of their practice. Interviews and observation uncovered seasoned nurses’ intuitive grasp of a situation and their instinct not to respond to certain behaviors or engage in particular battles. This included patients’ threatening behaviors, incidents where most inpatient staff would take action. During the interviews, when asked about patients’ behavior, nurses explained how they balanced several factor as they moved toward responding to a patient.

I mean there’s a gentlemen who gets admitted very frequently . . . confrontational and he comes from the streets and he’s used to posturing and things like that. I guess to not respond to the posturing so much with him, . . . not to address it . . . I think is better for him. ‘Cause that’s his deal, as long as it doesn’t become, as long as he doesn’t posture to other patients or it becomes threatening. . . . But I think up here, it’s just making sure you’re on top of them, making sure that you know where they are at all times, what they’re doing at all times, just so there’s no problems.

In this process, nurses were balancing their response to an individual patient with a sense of how that response would affect the milieu. They also considered pragmatic variables such as the number of available staff and the consequences of a strong response. At one site, patients often paced, cruising up and down a long corridor. As one man did so, he muttered constantly under his breadth. Sometimes what he was saying was incomprehensible; sometimes it
had a threatening tone. The staff watched but did not respond. Later, the nurse explained her decision as a trade-off, to tolerate the under-the-breath-muttering rather than having a “squad of security guards coming to the unit and carrying the man off screaming and yelling,” an event she perceived would be even more disruptive to the milieu.

Also striking were nurses’ muted responses to explosive situations. In one instance, two patients’ verbal altercation quickly escalated into a physical one. The nurse who was present simply pulled the patients apart, asked each to go to their room, and later gave one of the patients a pro re nata (PRN) medication. The patients were not given room time or any other sanctions save being asked to cool down. The unit and the nurses returned to a normal pace within minutes. Interviews of the nurse at the scene revealed that his subdued action was a conscious decision. The nurse explained that keeping a still outward demeanor was the more efficient way to control milieu contagion. “I’m the type of person who tries to stay calm.”

This calm, muted response to escalating situations was in line with the unit norm of how patients should be treated. At one study site, an experienced staff explained the unit value of treating patients like adults who must re-achieve self-determination.

The hospital is a place, yes everyone has problems, but everybody is still expected to go back out to wherever they live and live their life. . . . We have this high expectation of our patients because most of them do return to that environment and we want them to be able to function. Our goal is hopefully, maybe they can learn something here so they don’t have to come back to the hospital as often. . . . And part of that is treating them with respect. If you don’t treat them as if they’re human beings . . . to me I feel like they’re not going to get that sense of being able to take care of themselves once they leave.

In line with this sentiment, field notes recorded numerous instances where staff avoided overcontrol in their conscious decision on behaviors that must be contained versus the ones that are tolerated. In one instance, a patient was very loud all day long. No one seemed to be fazed by it, staff or patients. When asked about the muted response, staff acknowledged the patient was loud but “that’s pretty much how he is.” The behavior was viewed as loud but benign, and everyone learned to tolerate the noise.

In the everydayness of their responses to small behaviors, staff’s respect for patients was obvious, and by these behaviors they operationalized the unit culture of respect for the individual. In one such instance, an extremely disorganized man came out of his room with shampoo on half his head. The staff did not react quickly, they listened to what the man was saying, and only as he was leaving did they quietly ask if he would be willing to accompany staff to his room to make sure he had washed out all the soap. The demeanor of the staff was willingness to help, not needing to correct.

Deciding How to Respond

In the interviews, nurses were sometimes asked about particular incidents the researchers had witnessed. In turn, nurses also selected their own patient events to explain how they saw themselves maintaining the tone of the milieu. What became apparent in both instances were the streams of thought that crossed the nurses’ minds as they formulated a response. Frequently, the response involved balancing the patient’s need for control and the nurses’ need to control the situation. Nurses also said that they “read” the precursors of the patient’s behavior, which played into their subsequent response.

In deciphering the precursors of behavior, seasoned nurses relied on both patterned and what they perceived as the reason for behavior. In patterned behaviors, nurses often relied on knowledge gleaned from past hospitalizations, because in many cases these were patients the nurses knew well. But, they took a broad view of the factors contributing to a piece of behavior, such as the patient’s psychopathology, understanding its sometimes complex interplay in a behavioral incident. One nurse explained how she decided to deal with a patient who had spit on another patient. First, the nurse thought that the behavior was not typical for the patient. She also realized that several staff were dealing with another patient who was escalating so she did not have much backup should this incident escalate. The nurse also took into consideration her rapport with the patient, feeling fairly certain the patient would comply with what she requested. Two other factors came into play: One was the need for the patient who was spit on to feel safe, and the second was the need to separate the two patients. This example illustrates that while an intervention is occurring very quickly, the background thinking involved balancing multiple factors.

Staff judgments on behavior also included their attribution of how much control the patient had over the behavior. Very loud and rambling behavior was often overlooked because it was seen as part of the
person’s way of being, not related to any attempt to intimidate. Staff’s attribution that the behavior was arising out of the patient’s psychopathology seemed to make the behavior more acceptable. One woman frequently went to the unit door and pulled on it, loudly chanting a man’s name or a place. Some days this occurred several times an hour. The staff would gently pry her away from the door, but for the most part the staff tolerated it because they believed it was part of the woman’s delusions. At other times, this same woman was seen to have more control over her behavior. For instance, she frequently made sexually toned advances to male patients, a behavior the staff saw as something under her control. In these instances, she was dealt with a bit more emphatically.

In interviews, the expert nurses were able to articulate the reflective process that occurred as they determined how and when to respond. They often described the themes and patterns that emerge during their reflection on practice.

One that stands out is we admitted a patient who was very paranoid, has a long history of paranoia. Unfortunately, because of his paranoia he was so scared that he does self-harm to himself . . . sometimes very, very lethal type things. And on the outside it can lead to the point of not only harming himself, but being threatening towards other people . . . So we got this history when he came in. And we wanted to see kind of how he would be, is he going to be too paranoid to be out in the milieu? Are we putting the other patients at risk? I mean is he going to do anything to harm himself because he’s just so scared? And so we kind of had those questions in our heads and we talked about it . . . But I admitted him and right away integrated him into the milieu, encouraging him to go to group, but by the same token being around a little bit more with him, talking about safety and . . . he did well.

The nurse now continued to talk about the decisional process around this patient and her fluid assessment of the situation, often watching how it was playing out in the milieu.

But later in the admission when he started getting to know us better, he confided in me about not feeling safe with his roommate. And saying these things like they don’t like me, they this, they that. Do we need to be more careful with this guy in his room? Does he need a private room? Do we need to close the other bed? Do we need to explore, is it just a particular person that he is threatened by? So then at that point, we looked at, not being more restricted in the milieu but being a little bit more particular about where he sat for lunch and during safety checks really being careful about what he had in his room.

Summing up, these nurses’ interventions were informed by several factors: an awareness of their own reactions, an awareness of the patient, a critical analysis of the situation, and balancing of the milieu situation against the patient’s presenting behavior.

DISCUSSION

In our recently completed qualitative study, we observed staff on two inpatient psychiatric units and uncovered particular skills critical to each unit’s goal of creating a safe, noncoercive environment for acutely ill psychiatric patients. Although de-escalation skills are important tools in dealing with angry or aggressive incidents, the investigators found that use of particular interventions was actually only part of the requisite background process, a process we called keeping the unit safe. This core process is described in detail in a previous publication (Johnson & Delaney, 2006). The data categorized and elaborated on here are the particular staff behaviors that were critical to the staff’s efforts to create a safe milieu and positive unit culture.

The skills uncovered here are similar to ones cited in studies of expert nurses, finding they operate from both theoretical knowledge and their intuitive sense in managing escalating situations (McElroy, 1996). Essential to managing aggressive patients was the connection nurses formed with patients. This connection was grounded in a sense of attunement with the patient’s affect, understanding what the patient needed, and how the patient was expressing that need. As Raingruber (2001) suggests, the connection was often a nonverbal attunement where the nurse was able to communicate an understanding of the patient’s needs.

The ability to balance control was an essential element of nursing practice on the units. Lowe (1992) believes that a central dilemma inpatient psychiatric nurses face is striking a balance between tolerance and control. Reflecting this idea, our data revealed that effective interventions also embraced an attitude of respect for the individual and a confirmation of their autonomy. The investigators were continually impressed by how many small actions nurses attempted to preserve the dignity of the patient. This finding echoes Hummelvoll and Severinsson’s (2001) study of inpatient nurses. They uncovered an ideology nurses maintained, which was grounded in the notion of personal responsibility, choice, and freedom.
This ideology of respect for the individual stands in marked contrast to reports of nurses’ management of aggression that find nurses employing coercive styles when dealing with patients (Harris & Morrison, 1995; Olofsson & Norberg, 2001). Although the investigators witnessed incidents where a staff member handled a situation in what might be considered a terse manner, none of these events escalated to the point of coercive methods. Thus it is not that these were perfect units but, rather, units where, in the main, staff consistently responded in a manner that recognized the patient as a person with legitimate needs.

What might explain such differences in how one views staff behaviors? One explanation is that this study was designed to collect data on units that maintained low restraint rates. In a sense, the researchers sought to observe units that, based on the restraint indicator, were able to treat very ill patients using few restrictive interventions. In some sense, these units had found the balance of vigilance and ease, tolerance and control all within a framework where nurses connected with patients around their needs (Heifner, 1993).

Our study also differs with two ethnographic studies of psychiatric units that reported the perceived frustration and difficulties nurses encountered when trying to establish relationships with persons hospitalized on their units (Bray, 1999; Cleary & Edwards, 1999). It might be that much depends on the lens one uses to view inpatient nursing practice. Look to evaluate the quality and quantity of one-to-one interaction, and nurses come up frustrated. Look to see how nurses manage safety and preserve the patient’s dignity, at least on the units observed in this study, and nurses come up efficacious. The relationship, grounded in very different qualities, comes up as positive and workable. Similar to the work of Graham (2000) in the current study, the nurse-patient relationship was examined with an eye on uncovering how nurses interacted with a patient on a practical level, especially how nurses picked up cues from the patient, interpreted them, and then communicated those perceptions back to the patient.

**Limitations of the Study**

As common to qualitative studies, generalization of the findings becomes an issue. This was a study conducted on inner-city psychiatric units that treated patients with chronic mental illnesses. In many instances, the patients were well known to staff. These factors may have created situations unique to the settings, and thus findings should be restricted to similar units. Observation sessions were 4 hr at a time, spaced throughout a week, with times changing month to month. Still, it may be that important aspects of the staff’s response to escalation were not observed. We took great care in how and when patients were approached to discuss incidents that they perceived as difficult. Even though the interviews took place toward the end of hospitalization, the interviews with patients often were clipped, at times circumstantial, and often failed to provide a sequenced accounting of interaction and staff response.

**Implications for practice.** On inpatient psychiatric units, nurse managers are increasingly called upon to compare their staffing numbers (nurse-to-patient ratio) against other psychiatric units’ staffing plans, a system called benchmarking. To conduct this exercise, there must be some similarities in the comparison units such as size, average daily census, average length of stay, RN-to-mental health worker ratio, and perhaps restraint use. Usually missing are data on quality measures and, given the population, what nursing skills or expertise is required to maintain a milieu where patients and staff feel safe. Without these data, this benchmarking exercise boils down to analysis of staffing ratios with an eye on “right-sizing” the amount of staff down to the lowest possible number. The data from this study may provide a more accurate sense of what type of staff is required to operate a safe, structured, and supportive environment. Such knowledge will help create benchmarks for calculating staffing based on not just numbers but also the requisite expertise.

Data from this study uncovered many nursing behaviors that are relatively unexamined in the nursing literature. As is often the case with clinical knowledge, they remain embedded in the everyday practice of nurses (Benner, 2001). Benner believes that this embedded knowledge is best captured in patient exemplars. For nurses to learn about clinical management and build a theory of practice, these exemplars must be purposively uncovered and articulated. Staff meetings provide an excellent opportunity for staff to share their case examples and together build an articulated understanding of how the group manages the clinical context.

**Implications for education.** If the skills outlined here are critical to keeping a unit safe, a key question is how the profession develops inpatient nurses with sophisticated assessment skills and an intuitive sense of managing co-occurring situations. The obvious answer is education, but it might be that the traditional methods of staff education may not fit with
this process. Rather, staff education might follow a reflective practice model where nurses learn in and from everyday clinical situations (Schön, 1987). In this model, via the examination of clinical situations (the reflection), novice staff come to appreciate how best to balance the multiple factors at play in a challenging incident.

Planning clinical education is often a strenuous task. Psychiatric units are by their very nature busy and unpredictable places (Hummelvoll & Severinsson, 2001). But in a reflective learning model, learning is occurring by immersion in practice and repeated experience in interpreting practice situations (Edmond, 2001). By exposing novice staff to the thinking and assessment skills of expert staff, transmission of contextual knowledge occurs. Research demonstrates that within a year of working with seasoned staff, the novice begins to pick up on the skills of the expert nurse (Hanneman, 1996). Obviously for dialogue on practice to occur, novice staff need to work alongside expert nurses and unit managers need to focus on retaining a cadre of seasoned staff or advanced-practice nurses.

Future research might continue to explore the inpatient psychiatric nursing behaviors critical to keeping the unit safe and how nurses develop these skills. Using these data, psychiatric nursing may then elaborate the Benner model of novice to expert, which might help managers articulate the value of seasoned nurses and devise strategies for connecting expertise to patient outcomes (Shapiro, 1998). In the end, nursing holds the responsibility for keeping the unit safe. Thus, there is a need to keep focused on securing the conditions and staffing expertise to help staff learn how to manage the clinical context and maintain a culture of respect for patients hospitalized at a critical juncture in their illness.

REFERENCES


